Gender-based Violence Sub-Cluster Yemen

Strategy for the Prevention of and Response to Gender-based Violence (GBV) in emergency in Yemen

Objective

The overall objective of the Strategy and Action Plan is to strengthen prevention and response to GBV in emergency in Yemen. This GBV strategic framework aims at ensuring that priorities are identified, plans to address priorities are clear and that responsibilities are assigned to actors to avoid duplications and ensure accountability and quality of services to GBV survivors. The strategy will be reviewed every six months by the GBV Sub-cluster.

Scope

The present strategy covers areas of displacement, including host communities, areas of return and areas of arrival and transit of migrants. Areas include Haradh, Amran, Aden, Abyan, Lajh. The focus areas might be revised during the implementation of this Strategy.

Emergency and transition challenges

As a result of successive conflicts in Saada Governorate, in Abyan Governorate and of political unrest, an estimated 300,000 people remain internally displaced while some 140,000 internally displaced people have so far returned to their areas of origin in the southern Abyan Governorate and in neighboring areas thanks to improved security. Although a ceasefire in the North remains in place, localized conflicts are ongoing in different parts of the country. A transition process is ongoing through the National Dialogue Conference which began in March 2013 for 6 months. The objective of the Conference is to revise the Constitution, including enhancing protection of vulnerable groups and their rights.

A collapse of public services following the civil unrest in 2011 has severely disrupted access to health assistance, clean water and basic sanitation. Humanitarian access is hampered by insecurity across several areas of the country.

Gender based violence in Yemen

Yemen is the 160th place out of 186th countries of the Gender Inequality Index. Fertility rate is one of the highest in the world and maternal mortality is the worst in the MENA region. The national legislation is highly discriminatory against women. For example, Article 40 of the Personal Status Law provides that a woman has to obey her husband in all matters including not leaving home without

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1 This is information was collected through meetings with practitioners and service providers and through key publications like: ‘Gender Based Violence in Yemeni Society, a Quantitative and Qualitative Assessment’, Sana’a University, Aden University and UNFPA, 2010; Country Assessment on Violence Against Women, United Nations, 2008; ‘How Come you allow little girls to be married? – Child Marriage in Yemen’, Human Rights Watch, 2011; Desperate Choices, RMMS-DRC, 2012.
his permission. Polygamy is another source of discrimination as well as conditions for divorce. Yemen has the highest illiteracy rates in MENA with an important inequality to access to education between men and women. The ratio of female to male teachers in primary education is 12:100 and 8/11:100 in secondary schools.

Women are subjected to different forms of violence including intimate partner violence, sexual violence, early marriage, forced marriage, deprivation of freedom of movement and of choice, forced pregnancy and FGM. Perpetrators are partners, family members, community members, security personnel.

According to UNICEF MICS (2006), 14 per cent of girls in Yemen are married before 15 and 52 per cent before 18 years old. In some rural areas girls as young as eight are married. In 1999 Yemen’s parliament abolished the minimum age for marriage for boys and girls (15 years): Yemen legislation has now no minimum age of marriage. Normally early marriage is associated to girls having to abandon education. Early married girls are also more at risk of pregnancy-related deaths, have no chance to control how many children they have, are at increased risk of intimate partner violence and are often not allowed to leave home.

It is estimated that internal trafficking is affecting thousands of Yemeni women and children. Often these children are sold to traffickers by poor families. Since there is very poor documentation and mainly anecdotal information, it is not clear how extensive is trafficking for sexual exploitation purposes. Anti-trafficking legislation has not been passed yet in Yemen with wide impunity of traffickers.

## Gender Based Violence and Internal Displacement

The recent crisis and displacement has exacerbated the structural girls’ and women’s exposure to GBV, especially sexual violence, domestic violence, early marriage and survival sex.

Types of emergency-related GBV identified among populations in areas of displacement include:

**Sexual violence:** Sexual violence when walking long distances to collect water and firewood is a significant problem. Sexual violence is also perpetrated against girls and boys within the community.

**Conflict related sexual violence:** Forced marriage, rape and sexual slavery by armed actors has been documented in the Secretary General Report on Conflict Related Sexual Violence. ‘Parties to a conflict forcibly abduct women and girls, take them as wives and then rape and use them as sex slaves... up to 100 girls in Abyan have been forcibly married to leaders or members of the armed groups. A bride price reportedly as high as $5,000 is paid to the girls’ families, whose average monthly income is several thousand rial ($20-25). In other cases, girls were offered as a token of appreciation by their brothers who had been allowed to join the armed groups. The majority of girls come from Yafe’a, Lawdar and Khanfar districts in Abyan. Many have been impregnated following their marriage. The girls and their families are reluctant to report the abuses for fear of reprisal by members of the armed groups still present in Abyan, among other reasons.’2

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programs addressing conflict related sexual violence and assisting girls who have been associated to armed groups.

Transactional or “survival sex” in order to obtain cash or foodstuffs for themselves and their families is a risk factor for adolescent girls.

 Trafficking IDPs children, including girls, are recruited by traffickers in IDP camps and are trafficked to Saudi Arabia. Anecdotal evidence suggests that girls, boys and women are exposed to sexual exploitation and rape.

Intimate partner violence/Domestic violence is the most reported form of violence and it is often reportedly linked to the distress caused by protracted displacement.

Early marriage practices are being impacted by the protracted emergency. Although early marriages are widespread and girls get married as young as 8 years old, early marriage reportedly increases in areas of displacement as a ‘protective measure’ and to obtain money and reduce the family size.
Gender Based Violence and Migration

For more than 20 years Yemen has received people fleeing war and poverty from the Horn of Africa. 2012 was the largest recorded influx to Yemen yet with more than 107,000 people arriving to Yemen. Arrivals include individuals from Somalia who are recognised by the Yemeni government as refugees on a *prima facie* basis, as well as asylum seekers, victims of trafficking and migrants, all with specific protection needs. Most of the mixed flow including migrants, refugees and asylum seekers normally crosses the sea through two main routes: Arabian Sea route and Red Sea route. New arrivals can be received by community committees who offer first assistance and protection, by UNHCR/SHS/DRC/YRC Protection Patrols but often by smugglers, at this point ‘men and women are separated and it is unclear what happens to the women as their male relatives and travel companions often never see them again…Trafficking of women appears to be a very serious reality for Ethiopian new arrivals…reports suggest they may be sold to Saudi Arabia families as domestic workers while others are used in clandestine sexual exploitation networks’³.

Migrants are often kidnapped by smugglers and detained in camps for extortion and in some cases for exploitation and trafficking. During detention, migrants are almost systematically submitted to torture, including sexual violence against women, girls, men and boys.

Although disclosure remains limited, service providers confirm that all migrants reported to have ‘heard’ of rape being perpetrated against migrants through the migration cycle. NGOs reported that Ethiopian women who accessed their services had contraceptive devices (implants) inserted before arriving in Yemen as they are well aware of the high likelihood of being raped during their journey.

Rape is reportedly perpetrated against women and girls and to a lesser extent against men and boys during the crossing of the sea, when migrants arrive on the coast and they are collected by smugglers, during detention in smuggler’s camps, while stranded in Haradh waiting to cross the border to Saudi Arabia. Reports of rape against boys in detention centres waiting to be repatriated have also been collected.

Ethiopian migrants who manage to escape from traffickers and be employed as domestic workers are often raped by male employers, this also includes male children.

Gaps in services and barriers to disclosure

Disclosure

Intimate partner violence or physical and psychological violence perpetrated by the husband’s family members is widely spread although rarely reported to the police because victims are instead

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expected to report such incidents to a male relative, who should offer them the necessary protection. Women victims of violence also tend to cover up the crimes committed against them, fearing retribution from the assailant if the crimes are reported. It is in fact not rare that survivors are jailed for ‘immoral acts’ or adultery instead of being assisted.

Even doctors rarely report a case of assault, fearing reprisals from perpetrators. When cases of sexual assault are reported to the police, they often do not receive priority attention, especially when the abuse was committed by a family member. Although no laws or policies prescribe it, access to services is also limited by the unfunded conviction among the population as well as among health care workers that husbands (or male relatives) must provide their authorisation for women to seek health care. In general, women prefer not to disclose GBV because of stigma, reprisals and honor killings.

**Prevention**

Women and girls are living in IDP camps and with host communities, with minimal privacy and high risks when going to fetch firewood and water. In most cases, facilities and services are not planned in consultation with women, girls, boys and men. Limited economic resources push families and individuals to resort to negative copying mechanisms including survival sex and early marriages. The most vulnerable include single-headed households, females with disabilities, elderly women and unaccompanied girls and boys.

Prevention activities have been limited to mass sensitizations whose impact has not been measured so far. Prevention should be strengthened mainly through risk mitigation activities and involvement of men and boys and decision makers, developing an advocacy strategy but also strategically expanding empowerment and livelihood activities. Currently there are no clear strategies in place to prevent trafficking of Yemeni women and children.

**Response**

The minimum GBV health in emergency response is not available in targeted areas and minimum quality international standards are not upheld in the current response. The lack of a national Protocol on Clinical Management of Rape (CMR) and of adequately trained medical personnel on CMR have been identified has the major gap in terms of medical response to GBV as well as the limited availability of drugs for post-rape care in health facilities. In addition, medical and paramedical personnel are not trained on immediate psychosocial support and most of medical facilities lack adapted spaces to receive survivors. Medical personnel often do not feel comfortable to manage sexual violence cases because of cultural beliefs and security issues (fear of reprisals by perpetrators). In addition, often medical personnel refuses to issue medical certificates that might be essential to file a complaint for fear of reprisals by perpetrators and the survivor’s family.

Survivors rarely resort to police and statutory justice mechanisms as often referring a case to the police has proved to have very negative consequences on survivors, including breaches of confidentiality and advertising of rape cases with media, lack of respect for survivors and absence of any follow up. Most sexual violence cases are dealt with within families or between tribes, often
ending with discriminatory decisions against survivors, like forcing survivors to marry their perpetrators.

**Information Management and Advocacy**

In Yemen organisations are currently implementing several information management tools and there is no centralised IM system. Often these tools are not in line with international best practices. Comprehensive data and analysis on GBV are not available. There is a need to introduce an interagency IM for safe and ethical collection, analysis and sharing of information about gender-based violence.

There is no comprehensive advocacy strategy on GBV: as a first consequence, GBV is not currently prioritised within the humanitarian response nor by decision makers. An advocacy strategy should be developed and messages about GBV should be consistently shared with national authorities, decision makers and donors.

**Strategic Priorities**

**Key principles and approaches of intervention will guide the implementation of GBV activities:**

- Ensure the physical **safety** of the survivor and those who help them;
- Guarantee **confidentiality**;
- Respect the wishes, rights, and dignity of the survivor, and be guided by the best interests of the child; and
- Ensure **non-discrimination**.

Utilization of an **age- and gender-appropriate approach** will be essential. Although GBV is affecting women and girls disproportionately, men and boys are survivors of GBV and services should be adapted to provide medical and emotional response to men and boys. Services will also be adapted to child survivors, including the rollout of the *Caring for Child Survivors of Sexual Abuse training tool*.

**Prevention**

- **GBV integration in the multi-sectoral response**

Work with other sectors including health, nutrition, education, WASH, camp management, security, food and NFI distribution to ensure minimum standards are met to prevent or mitigate the risk of violence as outlined in the *IASC GBV Guidelines in Emergencies*. This will include consulting with women, girls, men and boys to identify the best ways to provide services and ensure safe access, including in site design and site planning (placement of WASH facilities, installation of lights, water points, etc.), distribution of dignity kits including sanitary and safety items (Lamp, whistle, etc). To mitigate the risks associated with collection of fuel, consult with women for selection of the type of energy-saving fuel stove and promote the use of energy-saving stoves through sensitisation and trainings also developing interagency longer term solutions for fuel consumption.
Ensure that GBV prevention and response are addressed throughout the Child Protection response. Child-friendly spaces staff, staff working with CAAF and other child protection programs should be trained on communicating about GBV in a sensitive manner, appropriately handling disclosure and making age and gender-sensitive referrals.

- **Reduce vulnerabilities through women and girls empowerment and livelihood activities**

Strengthen women’s and community centres to ensure that women and girls have access to livelihood activities to prevent survival sex and early marriages. Availability of accessible community based women’s centres will also allow women and girls who are not normally allowed to leave home to access basic messages and referral to services. Emotional support should be provided in women’s centres.

- **Community prevention of child and women trafficking**

Conduct a study on trafficking of Yemeni women and children to inform the development of community-based prevention mechanisms to prevent trafficking of Yemeni women and children, especially of the most vulnerable living in areas of conflict and displacement. Prevention could be strengthened through raising awareness on the consequences of trafficking, strengthening accountability of traffickers, advocating with authorities and introducing livelihood activities in the most affected communities.

- **involve communities and mobilise men and boys to prevent GBV**

Men have the potential to stop violence. They can choose not to perpetrate acts of violence, to challenge the attitudes and assumptions that support GBV: men and boys could become agents of change. Men and boys listen to their peers. It will be a priority to develop a strategy to mobilize men and boys, including key decision makers, to spread violence prevention message in their families, workplaces, and communities and in general to involve men and boys as supporters, role models and actors for change.

- **Protection from Sexual Exploitation and Abuse (PSEA)**

Most of local organisations do not have a policy prohibiting SEA. International organisations have policies and Codes of Conduct but have not appointed PSEA focal points and safe and confidential reporting mechanisms are not systematically establishes at field level.

Although PSEA is not under the responsibility of the GBV sub-cluster, given the sub-cluster’s capacity on this issue it is a priority to support the office of the RC/HC to put in place a PSEA Task Force, ensure that humanitarian aid worker providing assistance have adequate training and have signed a code of conduct and that community safe and confidential reporting mechanisms are in place.
Strengthening Entry Points for assistance and referrals

- **Protection patrols**: train protection patrols and registration officers to identify and refer survivors to specialized GBV services
- **Communities**: train personnel to provide age appropriate and confidential referrals
- **Women’s centers**: train personnel to provide age appropriate and confidential referrals
- **Mobile medical teams**: Medical teams should be provided with referral cards and other materials to timely inform survivors about existing specialized services
- **Migrant’s centers/Detention centers**: Social workers and doctors working in these centers should be trained to identify GBV cases and properly and timely referring them
- **Registration**: Registration points are accessed by asylum seekers and are an important entry point for disclosure and to provide information on existing services.

Several barriers limit survivor’s access to services, including cultural values, fear of stigma and exclusion from family and community, fear of honour killing, checkpoints, no resources to cover transport to services and limited information on available services. It is important that outreach activities are organised in villages to reach communities.

Specialised services should be expanded in Southern Yemen as well as reinforced in Haradh. All personnel working with GBV survivors should be trained on survivor-centred approaches and key principles of working with survivors.

Referral pathways should be developed in all locations and information on available services should be made available through sensitisations, posters and other culturally appropriate materials. Case management should be strengthened to ensure that survivors are assisted throughout the referral system with compassion and respect.

Response

- **Short term: Clinical Management of rape and health response to GBV**
  Health partners should ensure access to quality health services for women, girls, men and boys who are survivors of sexual violence and other forms of GBV. This should include training of health staff on survivor-centered GBV approaches, gender and age appropriate treatment methodologies, case identification and case management protocols. Ensure that there is constant information provision in camps and at reception/registration centers for migrants about health services available to adult and child GBV survivors.
  Personnel working in migrant centres should be trained to provide compassionate medical aid to GBV survivors. Male staff should be recruited to provide medical aid to men and boys survivors.

  The number of health centers provided with post rape kits should be increased, to cover prioritized areas. Clinical management trainings should be organized in cooperation with UNFPA, YFCA, MSF, IRC, IMC, YRC using the *Clinical Management of Sexual Assault: A Multimedia Tool* and UNFPA, UNHCR, WHO *Clinical Management of Rape training Tool*. 
In the medium term, support the Ministry of Health to introduce the internationally agreed CMR protocol in Yemen and train medical personnel working in public primary and secondary health care facilities.

- **Short term: Build the capacity of service providers to improve safe and confidential access to quality comprehensive care**
  Build capacity of service providers (health, social workers, protection, and legal/justice sectors) with a focus on skills and attitudes. Capacity building will be based on the identified capacity building plan (see below). Personnel working in migrant centers should be trained to provide compassionate GBV care and referral.

- **Short term: Provide quality emotional support to survivors**
  Ensure the delivery of age-appropriate emotional support activities to women, men, boys and girls and ensure appropriate support to survivors including training of child protection and GBV actors on the guiding principles of working with child survivors, psychological first aid and emotional support. Personnel working in migrant centers should be trained to provide compassionate psychological first aid and emotional support to GBV survivors. Male staff should be recruited to provide emotional support to men and boys survivors.

- **Medium term: facilitate safe and dignified access to justice**
  As most of GBV cases are dealt with within families and communities, access to justice is very low. Strengthening access to justice will require a longer-term approach, involving strengthening accountability and fight against impunity, empowerment of women’s organisations, capacity building of community-based paralegals, strengthening of security and protection measures for those who seek justice, strengthening capacity of the judiciary and of the police. In particular, police will have to guarantee respect and confidentiality and will have to include trained female officers to receive and follow up GBV complaints.

  Support the strengthening of capacities of the judiciary and police to investigate and judge GBV cases with a survivor centred approach. GBV prevention and response should be prioritised in Justice and Security Sector reforms. Fight against impunity of perpetrators should be strengthened.

  Conduct a comparative study on how GBV cases are addressed through customary law and support the training of community leaders to include women and girl’s rights in their decisions and to refer cases to statutory justice.

- **Short term: Inform communities through an interagency communications strategy**
  Ensure that coherent messaging is developed to both prevent GBV and provide information on existing services. Integrate culturally sensitive messages in hygiene promotion, health mobile clinics, CFS and through theatre and mobile cinema campaigns.
GBV coordination

Coordination mechanisms could be strengthened to build the response capacity, timely addressing capacity gaps and ensuring that all actors are working in line with accepted GBV prevention and response standards, linking with other sector coordination mechanisms, mobilizing resources, advocating on GBV related issues.

At national level, the accountability of the GBV Sub-cluster could be strengthened and the GBV sub-cluster could become more action-oriented to effectively coordinate the overall prevention and response. Meetings could be used as venues to build partner capacity, identify training needs and improve collective action to address GBV.

National GBV emergency Standard Operating Procedures will be finalized in the next months, including minimum standards for prevention and response and referral pathways at governorate/district levels. It will be a priority to ensure that SOP are widely disseminated through one-day interagency trainings in field locations.

National and field-based GBV coordination could be streamlined and communication between the national GBV sub-cluster and the GBV WGs should be strengthened through regular information sharing and follow up.

A co-lead for the GBV sub-cluster with strong field presence could be identified in consultation with sub-cluster members. The participation of relevant Ministries in the GBV sub-cluster could also be strengthened.

Ethical and Safe Information Management

The GBV sub-cluster supports the roll-out of the GBVIMS in Yemen to harmonize data collection on GBV, to collect, store and analyse data in a safe and ethical way. The first step of the GBVIMS will be the request of a mission of the GBVIMS Surge Team.

Link the humanitarian response with transition and social norms changes

Support the establishment of legal and policy frameworks to prevent and respond to GBV. Support the Government to ensure accountability for all forms of gender based violence and amend discriminatory legislation, including lifting reservations imposed on CEDAW and developing strategies to uphold UNSCRs 1325, 1820, 1888, 1960 and 2106. Legislation should be amended to recognise marital rape as a criminal offense, ensure equal rights to women in compensation, ensure the full and free consent to marriage; ensure freedom of movement.

Longer term strategies should also be adopted to prevent early marriages and ensure assistance to girls who get married early. Among the priorities: ensure the adoption of laws that set the minimum age for marriage, in accordance with the CRC and ensure fight against impunity of those who
promote and facilitate early marriages. With the support of the Ministry of Religious Endowments engage with religious leaders to prevent early marriages and GBV. In addition, support access to education for girls by providing incentives to families, transport and books fees, etc. An interagency national campaign against early marriage should be conducted involving all actors fighting against child marriage.

**Capacity Building Plan – Key trainings**

<table>
<thead>
<tr>
<th>Training title/Type</th>
<th>Key target</th>
<th>Location</th>
<th>Timing</th>
<th>Organiser</th>
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<tbody>
<tr>
<td>GBV in emergency programming</td>
<td>GBV providers, GBV coordinators, PMs</td>
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<tr>
<td>GBV case management and psychosocial support</td>
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<tr>
<td>Clinical Management of Rape – this should include specific parts on CRM of men and boys</td>
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<td>UNFPA/YFCA</td>
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<tr>
<td>Caring for child survivors of sexual abuse</td>
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<td>UNICEF</td>
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<tr>
<td>Roll out SOP trainings</td>
<td>Front line relief workers, GBV specialised providers</td>
<td>Abyan, Aden, Haradh, Amran</td>
<td>August/September 2013</td>
<td>UNFPA, UNICEF, UNHCR, YWU, YFCA, Intersos</td>
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<tr>
<td>Integrating GBV in the multisectoral reponse - GBV mainstreaming trainings</td>
<td>Relief workers</td>
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<td>GBV sub-cluster</td>
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<tr>
<td>Involving men and boys in GBV prevention</td>
<td>Relief workers</td>
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<td>GBV sub-cluster</td>
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<tr>
<td>Police GBV trainings</td>
<td>Police Focal Points</td>
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<td>GBV sub-cluster/</td>
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## Action Plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Expected Result</th>
<th>Indicators</th>
<th>Activity</th>
<th>Responsible agency</th>
<th>Location</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen prevention of gender-based violence</td>
<td>Community based Prevention mechanisms are strengthened</td>
<td># women, girls, men and boys who believe protection threats are reduced # of community members trained/sensitised # women and girls who had access to empowerment activities</td>
<td>Develop an interagency communication and advocacy strategy to prevent GBV Conduct safety audits to identify key prevention issues or high risk areas Develop a communication IEC culturally appropriate materials and train key members of community structures on prevention and response to GBV Develop radio/drama and mobile outreach on prevention of SGBV and on available services Support cash and livelihood programs to address vulnerabilities Focus groups and campaign involving men and boys in GBV prevention Advocacy with authorities and religious and community leaders Support provision of formal and non-formal education for girls</td>
<td>UNFPA in consultation with GBV sub-cluster members</td>
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</tbody>
</table>
| GBV is prevented through all humanitarian sectors | # clusters who introduce GBV activities in action plan  
# relief workers trained in GBV integration | Develop checklists to integrate GBV in humanitarian response  
Organise trainings for service providers to include GBV in all humanitarian sectors |
| Protection from Sexual Abuse and Exploitation is strengthened | # organisations who adopt and implement the Code of Conduct  
# safe and confidential community based reporting mechanisms introduced | Support Humanitarian actors to Introduce a Code of Conduct  
Conduct advocacy for the Establishment of a SEA Task Force  
Advocate and Support Senior Management to Conduct trainings on PSEA  
Advocate and Support Senior Management to Introduce Confidential Community Based Complaint Mechanisms |
| Increase the availability and strengthen the quality of multi-sectoral response services for GBV survivors including adapting services to survivor’s age and gender | Quality clinical care is available and accessible  
# survivors (women, girls, men and boys) who have access to safe and confidential medical care | Preposition and distribute post-rape kits available in cooperation with Health WG/RH sub-WG + Distribution strategy available  
Equip Health centers with rooms ensuring survivor’s dignity/confidentiality  
Conduct ToT on CMR and create a pool of trainers in cooperation with Health WG  
Establish functional, safe and confidential community based reporting mechanisms |
| Psychosocial support is available and accessible | # survivors (women, girls, men and boys) who have access to safe and confidential psychosocial care | Establish confidential spaces for case management, emotional support and counselling of survivors
Equip centers with child friendly spaces and train social workers and psychologists on emotional support of child survivors
Train social workers on GBV psychosocial response, including with a focus on caring for boys and men survivors of GBV and increase number of trained male service providers as case managers, psychosocial providers
Establish functional, safe and confidential referral pathways between service providers |
|---|---|---|
| Access to justice for GBV survivors is strengthened | # survivors (women, girls, men and boys) who have access to legal aid and judiciary proceedings | Support women centres
Strengthen the capacity of existing legal aid providers ensuring a survivor centred approach
Support special procedures to protect GBV survivors, including children
Train community based paralegals
Train judges on treatment of
<table>
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<tr>
<th><strong>Protection of GBV survivors is strengthened</strong></th>
<th>GBV cases in court in line with international provisions</th>
<th>Train traditional leaders on minimum international human rights and GBV standards</th>
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</thead>
<tbody>
<tr>
<td># survivors (women, girls, men and boys) who have access to protection services</td>
<td>Train and select police focal points on GBV – selected focal points will be included in referral pathways</td>
<td>Train anti-trafficking police</td>
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<tr>
<td>Establish a GBV hotline</td>
<td>Support existing shelter and expand safe shelter capacity outside of Sana’a</td>
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**Strengthen safe and ethical data collection and information sharing**

<table>
<thead>
<tr>
<th>Safe and ethical data and analysis on GBV patterns is available</th>
<th># ethical and safe reports on GBV trends and patterns and survivors assisted</th>
<th>Support the safe collection, analysis and sharing of SGBV data though the rollout and implementation of the GBVIMS: initial assessment, GBVIMS trainings, ISP, etc.</th>
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<tbody>
<tr>
<td>Establish a GBV hotline</td>
<td>Prepare quarterly updates and briefings on GBV patterns and existing prevention and response</td>
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**Strengthen GBV coordination**

<table>
<thead>
<tr>
<th>The GBV Sub-cluster is functional and promotes minimum international standards and GBV prioritisation</th>
<th># partners participating in coordination</th>
<th>Revised and update ToR of the sub-cluster every 12 months</th>
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<tbody>
<tr>
<td># safe and confidential referrals</td>
<td>National GBV Standard Operating</td>
<td>Develop and maintain a training information matrix</td>
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<tr>
<td>Ensure co-ordination with other WGs: attend other clusters meetings to raise GBV concerns and ensure GBV issues are considered in multi-</td>
<td>Finalise and update the mapping matrix</td>
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<td>Procedures are finalized and disseminated and referral pathways and service guides adopted in at least two areas</td>
<td>sectoral response</td>
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<tr>
<td>Referral cards and posters printed and distributed</td>
<td>Promote increased and consistent participation of members of the SGBV TF and always share information and maintained an updated mailing list</td>
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<td>% increase GBV funding in one year</td>
<td>Strengthen information sharing, coordination and support decentralised coordination mechanisms in Haradh and Aden</td>
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<tr>
<td>GBV programming is prioritised in humanitarian response and adequately funded</td>
<td>Coordinate monitoring and evaluation including sharing and harmonizing tools and reporting on sector results</td>
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<tr>
<td>Minimum response standards are in place and interagency referrals are strengthened</td>
<td>Conduct advocacy and fundraising with key decision makers and donors</td>
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<tr>
<td>GBV programming is prioritised in humanitarian response and adequately funded</td>
<td>Provide necessary information to GBV partners about funding opportunities, including facilitating presentations during meetings and ensuring circulation of relevant documents</td>
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<tr>
<td>Finalise the SOP and constantly update them (every 3 months)</td>
<td>Develop, implement and monitor the referral pathway to ensure the referral system focus on providing timely and appropriate services to GBV survivors</td>
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<td>Develop messages to inform communities on services</td>
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<tr>
<td>Develop and print referral cards and posters on available services to be distributed to service providers, registration centres, etc.</td>
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<tr>
<td>Develop and support Radio Programs, theatre and mobile cinema to inform communities on existing services</td>
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