

TRAINING MANUAL ON



SEXUAL AND GENDER-BASED VIOLENCE (SGBV) AND HARMFUL TRADITIONAL PRACTICES (HTP)

actionaid

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LIST OF ACRONYMS

AAITG:	Action Aid International The Gambia
CBOs:	Community Based Organisations
CEDAW:	Convention for the Elimination of All forms of Discrimination Against Women
DHS:	Demographic Household Survey
FBO:	Faith Based Organisation
FGM/C	Female Genital Mutilation/Cutting
FC:	Female Circumcision
GBoS:	Gambia Bureau of Statistics
SGBV:	Gender Based Violence
GFPA:	Gambia Family Planning Association
HTTP:	Harmful Traditional Practices
IPV	Intimate Partner Violence
MICS:	Multiple Indicators Cluster Survey
NGBV	Network Against Gender Based Violence
NGOs:	Non- Governmental Organizations
RMNCAH	Reproductive, Maternal Neonatal Child and Adolescent Health Unit
SGVB:	Sexual and Gender Based Violence
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children's Fund
URR:	Upper River Region
VAW	Violence Against Women
WB	Wold Bank
WHO:	World Health Organisation

ACKNOWLEDGEMENT

We acknowledge and appreciate the dedication and commitment of the management and staff of Action Aid International The Gambia for initiating the formulation of a standardised Training Manual on Sexual and Gender Based Violence in The Gambia with support from The Global Fund. We also equally appreciate and thank the Technical Working Group (TWG) for their contribution to the development of the training manual.

Special thanks and appreciation also to SGBV the management and staff of the Ministry of Gender, Children and Social Welfare for their support during the manual development process.

INTRODUCTION

The manual for building capacity of actors in the fight against Sexual and Gender Based Violence and Harmful Traditional Practices in The Gambia is critical to sustain gains made in increase reported cases during the COVID19 pandemic. All violations of women's and girls' rights may be described as harmful practices, but there are particular forms of violence against women and girls which are defended on the basis of tradition, culture, religion or superstition by some community members.[1] These are often known as 'harmful traditional practices.' Harmful traditional practices are largely carried out on women and children child and thus constitute a violation of human rights as set out in the Universal Declaration of Human Rights. As with all forms of violence against women and girls, harmful traditional practices are mostly caused by gender inequality including unequal power relations between women and men, rigid gender roles, norms and hierarchies, and ascribing women lower status in society.

Harmful practices are referred to in the Convention on the Rights of the Child (Article 24(3), CEDAW (Articles 2, 5 and 16) and regional instruments like: African Charter on the rights of the child and the Maputo protocol. Harmful traditional practices constituting violence against women and girls can include: acid violence, breast flattening, cosmetic mutilation, dowry and bride price, early/forced marriage and marriage by abduction/rape, female genital mutilation/cutting (FGM/C), 'honour' crimes, corrective rape, and female infanticide, ritual sexual slavery, virginity testing, practices related to initiation or menstruation, some widowhood rituals and accusations of witchcraft levied at older women.[2]

In many countries there are specific laws aiming to curtail these practices, in most instances they also contravene countries' existing laws relating to physical and sexual violence. Harmful traditional practices are a product of social norms which aim to uphold cultural ideas about gender roles and social relations. Many of these practices, including acid violence and sex-selective abortion, have become common relatively recently but may be considered harmful traditional

[1] 1 OHCHR, Fact Sheet No.23, Harmful Traditional Practices Affecting the Health of Women and Children. http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf, accessed February 2013.
[2] The International NGO Council on Violence against Children, Violating Children's Rights: Harmful practices based on tradition, culture or superstition, 2012

practices as they are rooted in and upheld by such ideas. Where such practices exist, there may be negative social sanctions which are experienced by individuals if the harmful traditional practice is not carried out. As a result, women themselves often play a role in perpetuating such violence.

Female Genital Mutilation/cutting (FGM/C) has long been classified as a harmful traditional practice.[3] FGM/C is the removal of part or all of a female genitalia for non-medical reasons, and is a human rights violation. It occurs in many countries in Africa, some countries in the Middle East, Asia, and Europe. It can cause long term physical and psychological harm of a survivor such as haemorrhage, shock, keloid, infertility etc. during and after the process as well as transmission of HIV infections and, problems with urination, menses, and obstetric complications in some cases.[4]

Girls are usually cut before age 12, and FGM/C is often a precursor to early/child marriage. FGM/C persists because it is a social norm, linked with marriageability, which ensures that it continues, although the health consequences may be severe. Child and forced marriage is classified as any marriage of a person under the age of 18[5] without their consent and constitutes a violation of the Convention on the Rights of the Child. Early and forced marriage happens globally but is most common in Africa and Southern Asia, and especially among the poorest, most rural communities. UNICEF estimates that in Africa 42% of girls are married before the age of 18.[6] It likely leads to sexual activity for a girl at an age when she is neither physically nor sexually mature. Young brides may become pregnant at an early age; meaning they are more likely to die in childbirth and to experience obstetric fistula and Sexual Transmitted Infections including HIV and AIDs.[7]

[3] OHCHR, Fact Sheet No.23, Harmful Traditional Practices Affecting the Health of Women and Children. http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf, accessed February 2013.
[4] WHO, Fact sheet N°241: Female Genital Mutilation, 2013. http://www.who.int/mediacentre/factsheets/fs241/en/ accessed February 2013
[5] UNICEF Child Info, Child Marriage: Progress. January 2012 http://www.childinfo.org/marriage_progress.html accessed February 2013
[6] UNICEF, Early Marriage: A Harmful Traditional Practice. 2005
[7] UNFPA, Child marriage Factsheet, 2005

CONTEXT

Sexual and Gender-based violence (SGBV) and Harmful Traditional Practices (HTP) are long standing complex global problems. It is a pervasive public health concern and human rights violation throughout the world. Anyone can experience SSGBV and HTP, but women and girls are affected more frequently than men and boys. It requires attention and effort from a wide range of actors. It is a priority protection issue, and therefore Medical and Public Health Organizations, Humanitarian Aid Organizations, United Nations (UN) Agencies, Governments, and Private Donors can and must cooperate to eradicate SGBV and HTP. These actors have responsibility to establish effective prevention strategies , to deal with perpetrators, and taking action to ensure appropriate survivor support. .

According to evidence, there are different forms of violence perpetrated against all Genders, particularly people living with HIV/AIDs that need to be addressed. These includes childChild Marriage especially among girls, child pregnancy and inadequate access to maternal health care, forced marriage, FGM/C/C, rape and other forms of sexual abuse which also make them vulnerable to HIV infection. The study found out that 90% of trainees were convinced that, Violence Against Women (VAW) could contribute to HIV/AIDS and only 10% know of a person living with HIV/AIDS as a result of violence committed against the person[8].

Series of studies revealed that, major factors that contribute to Sexual and Gender Based Violence and Harmful Traditional Practices, includes culture of silence, shame, lack of political will, weak law enforcement, gender in equality and power relations, social pressure, fear and lack of knowledge of existing laws. These among others are identified as the biggest barriers in addressing SSGBV in the Gambia.. With regard to child marriage, the national prevalence rate is 33%, with disparities according to region (DHS V 2021-2012);[9] nearly one girl in three is married before her 18th birthday. In the Gambia, according to a UNICEF study, among women aged 20 to 24, 9% were married before the age of 15 and 30% were married before the age of 18.. In The Gambia 9% of girls marry by 15years and it is more common in rural areas than urban, Child Marriage is a harsh reality for many girls under the age of 18. About 46.5% of girls marry before age 18 (MICS

[8] Study on Domestic Violence in The Gambia 2008
[9] Demographic Health Survey (DHS 2010-2021)

2010)[10]. The overall prevalence of FGC among women age 15-49 in The Gambia is 75 percent, slightly lower than 76 percent as reported in the 2010 MICS (GBoS, 2011)[11].

The practice of FGM/C/C varies little by age. It is higher among women in rural (79 percent) than in urban (72 percent) areas. The proportion of women who are circumcised is highest in Basse and Mansakonko (97 percent and 94 percent, respectively) and lowest in Banjul (47 percent GDHS, 2013). In the majority of women in The Gambia, Genital Mutilation involved cutting and removal of flesh (85 percent). Less than 1 percent of women reported that they were cut but that no flesh was removed. According to the MICS of 2018, the prevalence rate among girls 0 – 14years is 51%. Also, there are significant ethnic differences in the practice based on the 2010 MICS data: 98 percent of women in households whose head is Sarahuleh, Mandinka/Jahanka (97 percent) and Banbara (92 percent), down to under I8 percent for Manjago and Wollof (12 percent).

The NSP evaluation in 2016 noted that limited action was taken to mainstream gender into the national response due to inadequate funding; poor understanding of gender dimensions of HIV and limited activities to address gender inequalities. There is weak capacity and coordination among actors for gender mainstreaming from program design to implementation as evident by various assessments noting the limited capacity of existing CSOs, community-based organisations and public sector to respond to HIV, TB-related stigma, discrimination, inequality and violence and the need to build capacity.

To address the on-going gender inequalities effectively and efficiently, it is imperative that a comprehensive training manual that addresses the capacity needs of all key stakeholders in the public and private sectors, Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs), Community Based Organisations (CBOs), Faith Based Organisations (FBOs) (including young women-led organisations), as well as the Key Population Community (KP community) and other vulnerable populations be developed. This manual will include a comprehensive module on Sexual and Gender Based Violence and Harmful Traditional Practices (HTP) to further highlight the linkages of SSGBV and HTP and their impact towards achievement of gender equality as well

[10] Multi Indicator Cluster Survey (MICS 2010)
[11] Gambia Bureau of Statistics (GBoS 2011)

as patriarchy and cultural practices that limit the rights of women and girls to freely participate in their social, economic, political, and public spaces.

As a result, AAITG with funding from the Global Fund is seeking a local consultant (content expert) to support the development of a Reference and Training Manual on SSGBV and HTP for all relevant stakeholders including the Ministry of Gender, Children and Social Welfare and all partners.

PURPOSE OF THE MANUAL

This training manual has been developed to guide community volunteers/activists who will serve as trainers/facilitators through four (4) modules, each lasting between two (2) and three (3) days. The facilitators should ideally have been trained in all the modules themselves and be well-equipped with information on the topics at hand before they start training others. We also recommend that all facilitators/trainers should have participated in a "Training of Trainers – (ToT)" course before they start training others.

DEVELOPMENT OF THE TRAINING MANUAL

Based on the findings from the desk review and consultations, a Training Manual on Sexual and Gender Based Violence and Harmful Traditional Practices was developed with support from the Technical Working Groups. Based on the ToR, key components of the manual includes introduction of SGBV and HTP (definition, concepts, prevention, and response, preparatory requirements for the training, the approaches/methodology in carrying out the training. Role of public, private sectors, CSOs and relevant organizations working in this field, SGBV culture, HTP and culture, SGBV and HTP: intersecting identities and key and vulnerable groups (Adolescent Boys and Young Men and Adolescent Girls and Young Women, key population groups, People with disabilities, people in humanitarian crisis, increasingly vulnerable segments on groups, people affected by disaster and crisis)

The Manual also contain modules on Prevention and Mitigation of SSGBV and effects of HTP: Assessing, designing, and implementing SSGBV prevention and mitigation measures into

programming and Integrating SSGBV and HTP interventions in thematic program activities (e.g., health, HIV/ AIDS, education, food security, economic empowerment, etc.) Response measures: understanding it, tips and tools to design and implement it into programming this will look at preparedness to respond to SSGBV and HTP cases

Setting up bare minimum standard operating procedures to respond to SSGBV and HTP cases (includes consent, do no harm, protection of survivors, confidentiality, etc.) Creating SSGBV and HTP referral pathway Psychological first aid/psychosocial support to respond to SSGBV and HTP informant Psychological/psychosocial support to victims/survivors, staff and partners.

In-country and International advocacy considering Multi/stakeholder approach and collaborating with other actors to address SGBV and HTP, and to exchange information, case studies, and research on SSGBV and HTP.

MANUAL USERS

This manual will be used by all sectors of society stakeholders in the public and private sectors, Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs), Community Based Organisations (CBOs), and Faith Based Organisations (FBOs) (including young women-led organisations). It can also be used at the following levels:

- Training of Facilitators
- Training of Supervisors
- Training of Trainers
- Community level training

PREPARATORY REQUIREMENTS FOR THE TRAINING

This is a standard Training Manual on Sexual and Gender Based Violence and Harmful Traditional Practices in the prevention, promotion and response to Sexual and Gender Based Violence and Harmful Traditional Practices. Trainers and Course Facilitators may utilize the manual as reference material when designing training programmes related to SSGBV and HTP. The training modules are divided into sections which introduces the following:

- Topic objective

- Topic content
- Training methodology
- Learning resources

The training is envisage to exercise responsiveness to trainees levels and created other training materials and a method to support what is in the manual.

SOCIAL LEARNING BEHAVIOUR THEORY AND SOCIO-ECOLOGICAL MODEL FOR EXPLAINING SGBV AND HTP

Learned Behaviour

Social Learning Theory: This theory posits that all human learning are learnt through personal experience or observation. The most widely used model for explaining SGBV is the Socio-Ecological Model – this aligns with the Social Learning Behaviour Theory – it posits that all human behavior are learned through personal experience or exposure to it. Thus there are factors at the individual level, relationship (interpersonal) level, community factors and Societal factors which either act as risk or protective factors for being either a victim/survivor or a perpetrator of SSGBV and HTP (Figure 1).

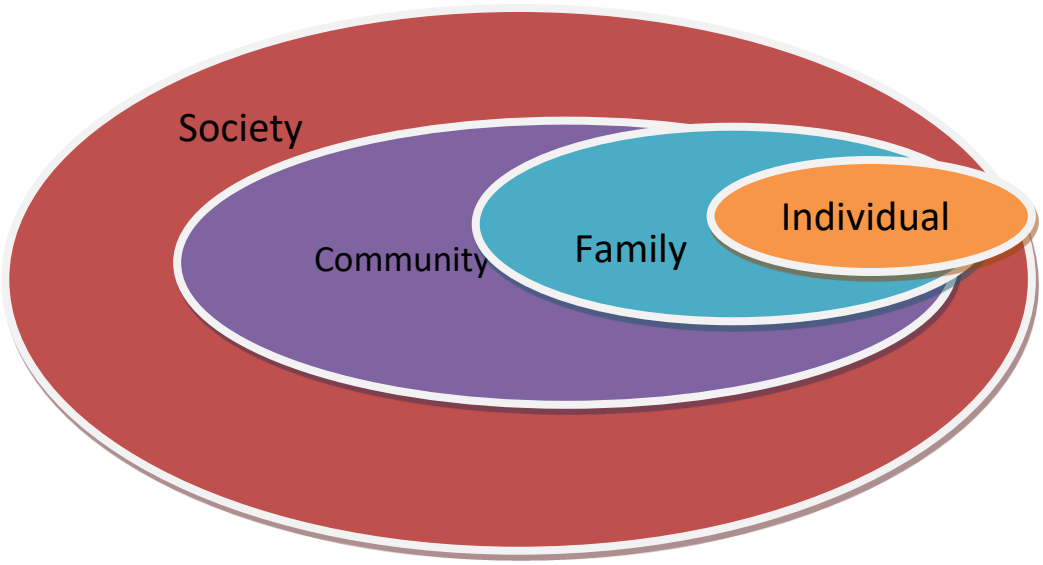
Individual factors include: Witnessing or experiencing abuse as a child (associated with future perpetration of violence for boys and experiencing violence for girls); Substance (including alcohol) abuse (associated with increased incidences of violence); Women's membership in marginalized or excluded groups.

Family\Inter-Relationship Factors: Low levels of education (for boys associated with perpetrating violence in the future and for girls, experiencing violence); The presence of economic, educational and employment disparities between men and women in an intimate relationship; Conflict and tension within an intimate partner relationship or marriage; Women's insecure access to and control over property and land rights; Male control over decision-making and assets; and family instability.

Community Factors: Limited economic opportunities (an aggravating factor for unemployed or underemployed men associated with perpetrating violence; and as a risk factor for women and girls, including of domestic abuse, child and forced marriage, sexual exploitation and trafficking.

Societal Factors: Attitudes and practices that reinforce female subordination and tolerate male violence (e.g. dowry, bride price, child marriage); Lack of safe spaces for women and girls, which can be physical or virtual meeting spaces that allow free expression and communication; a place to develop friendships and social networks, engage with mentors and seek advice from a supportive environment etc.

***Figure 1*: Ecological model of SGBV and HTP**



Adapted from UN General Assembly, 2006 cited in UN Women, 2013

PROTECTIVE FACTORS

On the other hand, there are protective factors that can reduce women and girls' risk of violence, including:

- Completion of secondary education for girls (and boys);
- Delaying the age of marriage to 18;
- Women's economic autonomy and access to skills acquisition, training, credit and employment;
- Social norms that promote gender equality;
- Quality response services (judicial, security/protection, social and medical) staffed with knowledgeable, skilled and trained personnel;
- Availability of safe spaces or shelters; and,
- Child spacing and use of contraceptive (Family Planning Services).
- Access to support groups (UN Women, 2013).

MODULE 1: UNDERSTANDING SEXUAL AND GENDER BASED VIOLENCE (SGBV) AND HARMFUL TRADITIONAL PRACTICES (HTP).

Sessions 1: What is SGBV and HTP

Introduction

This session provides trainees the understanding of sexual and gender based violence and Harmful Traditional Practices, clarify the differences between SGBV and HTP as well as raise participant's understanding of the definitions, concepts, prevention, and response to SGBV- HTP .

Session Objectives

- To provide an understanding of SGBV-HTP
- Clarify the difference between SGBV – HTP
- Raise participant's understanding of SGBV- HTP definition, concepts, prevention, and response

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector
- Training manual

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Ice breakers

- Role plays

- Take home Assignments

Some working Definitions

Sexual Violence refers to any sexual act performed on an individual without their consent through intimidation, threats, coercion, or the use of force. Sexual violence can take the form of rape or sexual assault, marital rape, attempted rape, child sexual abuse, online sexual abuse, sexual violence as a weapon of war or torture and genital mutilation. The effect of SGBV and HTP can lead to transmission of STDs including HIV and AIDs

Gender Based Violence refers to any violence directed against a person because of their gender. Both women and men experience gender-based violence but the majority of victims are women and girls.

Harmful Traditional Practices refers to the **belief, customs and ways of life that are capable of endangering the life and wellbeing of the people**. Such practices which are passed from one generation to another has negative impact on physical, psychological and social effect on the people. **Example, Early / forced** Marriage, Female Genital Mutilation, Maltreatment of Widow, Tribal Marks, Child Abuse, Superstitions, Taboo.

(UN Office of the Special Advisor on Gender Issues and Advancement of Women) 10/05/00)

Sessions 1.1: What is SGBV and HTP?

Sexual and Gender-Based Violence (SGBV) and all other forms of Harmful Traditional Practices (HTP) notably Female Genital Mutilation/Cutting (FGM/C), Female Circumcision (FC) and Child Marriage are all violations of human rights. This kind of violence perpetuates the stereotyping of gender roles that denies human dignity of the individual and stymies human development. The overwhelming majority of the victims/survivors of sexual and gender-based violence are women and girls. Sexual and gender-based violence includes much more than sexual assault and rape. Although it may occur in public contexts, it is largely rooted in individual attitudes that condone violence within the family, the community and the State. The root causes and consequences of sexual and gender-based violence must be understood, before appropriate programmes to prevent and respond to these violence can be planned.

SEXUAL AND GENDER- BASED VIOLENCE:

The term sexual and gender-based violence encompasses a wide variety of abuses that includes sexual threats, exploitation, Intimate Partner Violence, humiliation, assaults, harassment, molestation, domestic violence, incest, involuntary prostitution (sexual battering), torture, rape, and attempted rape. Female Genital Mutilation/Cutting (FGM/C) and other harmful traditional practices (including Child Marriage, which substantially increases maternal morbidity and mortality) are forms of sexual and gender-based violence against women which cannot be overlooked nor justified on the grounds of tradition, religion, culture or social conformity.

VIOLENCE AGAINST WOMEN (VAW):

The term VAW is used to define SGBV from the perspective of women's subordinate position in society. It is used to define women's experiences of violence.

Key facts

- Violence against women – particularly intimate partner violence and sexual violence – is a major public health problem and a violation of women's human rights.

- Estimates published by WHO (report and year) indicate that globally about 1 in 3 (30%) of women worldwide have been subjected to either physical and/or sexual violence, intimate partner violence or non-partner sexual violence in their lifetime.
- Most of this violence is intimate partner violence. Worldwide, almost one third (27%) of women aged 15-49 years who have been in a relationship reported that they have been subjected to some form of physical and/or sexual violence by their intimate partner.
- Violence can negatively affect women's physical, mental, sexual, and reproductive health, and may increase the risk of acquiring HIV in some settings.
- Violence against women is preventable. The health sector has an important role to play to provide comprehensive health care to women subjected to violence, and as an entry point for referring women to other support services they may need.





Sessions 2: Gender and Gender Based Violence

Introduction

This session provides a basic understanding of concepts on gender and gender based violence that will encourage trainees to view the root causes of gender based violence. It also emphasizes the fact that how we define gender as a society influences injustices girls and women face daily. Biological differences may determine sex, but gender and gender roles are determined by society and culture, and have the ability to be influenced overtime.

Training Objectives

- Strengthen trainees' understanding of (Should this not be GBV hence the heading is Gender and Gender Based Violence instead of SGBV?) SGBV and its terminologies.
- Strengthen trainees understanding of different categories of SGBV.
- Enable trainees to understand how SGBV is manifested throughout one's life cycle.
- Highlight the most common forms of SGBV in The Gambian context.

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- pens
- Note Pads
- Name Tags
- Projector
- Training Manual

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Film shows/edutainment
- Ice breakers

- Role plays

Definition of Gender Based Violence

"Sexual Gender- based violence (SGBV) is violence that results in, or is likely to result in, physical, economic, sexual or psychological harm or suffering to both genders, including threats such as acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life. It is violence that people experience on the basis of their gender."

1. Welcome trainees to the training.

2. Identify an interpreter where necessary.
3. Inform them that this module covers Gender and Gender based violence which is a critical issue that is often top of the list of cases reported at the police stations. The module calls for active participation of everyone.
4. Explain that Gender- based violence (SGBV) or Sexual and Gender- based violence (SGBV) are interchangeably used for purpose of avoiding any confusion; we shall refer to it as SGBV.
5. Write the phrase SGBV on a flip chart and ask trainees to take minutes to think about what SGBV is. Ask them to brainstorm on what they understand by the phrase.
6. Write all their contributions and have a quick discussion about them.
7. Hang up or write up the UN definition of SGBV as stated below and ask someone to read it loudly to the trainees.
8. Explain that there is usually a tendency to confuse the term SGBV with domestic violence, but they are slightly different terms. Domestic violence is one of the forms of SGBV though SGBV encompasses several other forms as we shall see later.

9. Explain to the trainees that:

   It is important to note that the UN highlights Violence Against Women (VAW) as SGBV and the need to understand VAW within the context of women's and girls' subordinate status in society. While both men and women experience violence, evidence suggests that the risk factors, patterns and consequences of violence against women are different from violence that men experience.

   As argued by Heise et al.

   > *"many cultures have beliefs, norms and social institutions that perpetrate violence against women."*

10. Highlight the following words (or words with similar meanings) from their contributions and explain them in relation to SGBV:

GENDER:

Explain to trainees that there is usually a tendency to use the term gender to interpret SGBV as the way men and women hurt each other. But the word gender here is used to refer to the socially ascribed differences between men and women in regards to differences in roles, expectations, limitations etc. SGBV occurs because society created differences between men and women and considers women to be of a low status and men to be of a higher status.

SEX:

"Sex" refers to the biological and physiological characteristics that define male and female.

Some examples of sex characteristics:

- Women menstruate while men do not
- Men have testicles while women do not
- Women have developed breasts that are usually capable of lactating, while men have not (Source: WHO website)

CAUSES HARM:

When SGBV occurs it inflicts harm to the victim and hurts other people around the victim as well.

POWER:

SGBV is about socially determined power relations and power imbalances between men and women. SGBV occurs because society gives one gender more power than the other. It is about how one gender uses their power over others to control another.

CONTROL:

All acts of SGBV are intended to control the victim's rights: SGBV is an abuse of human rights. It violates the rights of the victim. Gender-based violence is a pervasive public health and human rights problem throughout the world, but the patterns and prevalence of violence vary from place to place. SGBV violates several international and national human rights instruments and laws.

For example

- Article 3 of the Universal Declaration of Human Rights (UDHR) which states that:

> *"Everyone has the right to life, liberty and security of person."*

- Article 21 of the Constitution of The Gambia1997 which states that:

> *"No person shall be subject[ed] to torture or inhuman degrading punishment or other treatment."*

Sessions 2.1: Understanding what is Gender

WHAT IS GENDER

Gender refers to the social differences between female and male throughout the life cycle that are learned and, though deeply rooted in every culture, are changeable over time and have wide variations both within and between cultures. “Gender” determines the roles, power, and resources for females and males in any culture.

WHAT IS SEX?

Sex is a biological description. It refers to the biological and physiological differences between male and female as determined by nature.

Difference between Gender and Sex

1. Sex is Biological and Gender is socially constructed
2. Sex is Born with whilst gender is acquired/not born with
3. Sex roles are Natural whilst gender roles are Learned/nurtured
4. Sex roles cannot be change but gender roles can be changed

BASIC GENDER CONCEPTS

Gender Roles

Gender roles are reflected in activities ascribed to men and women on the basis of perceived differences, which are reinforced through the gender division of labour. This arises from the socialization of individuals from the earliest stages of life through identification with specific characteristics associated with being male or female.

Gender Division of Labour

The gender division of labour relates to the different types of work that men and women do as a consequence of their socialization and accepted patterns of work within a given context. While gender roles vary among cultures and over time, and are cross-cut by a multitude of identities (e.g. ethnicity and class), the gender division of labour usually finds men and women relegated to the public and private spheres, respectively. Women are thought to be ‘natural’ caregivers/weaker to take up some roles and men ‘benevolent dictators’ who adequately supply material needs to their

families. This means that men undertake public activities, e.g. paid work, market activities, membership in formal community organizations, and participation in political institutions. Women's activities, in contrast, are often restricted to household and community management activities (childcare, food preparation, subsistence agriculture).

Women's 'Triple Roles'

In classifying the kind of work women do, Moser (1993) refers to women assuming a triple role: they are responsible for the reproductive, productive, and community managing roles. The way these roles are valued affects the way women and men set priorities in planning programmes or projects.

These roles have a direct impact on women and development. Childcare provision, for example, is not likely to be a priority for men in project planning... but it can make or break women's chances of taking advantage of development opportunities.

Gender Stereotypes

Stereotypes are structured sets of beliefs about the personal attributes, behaviors, and roles of a specific social group. Gender stereotypes are biased and often exaggerated images of women and men which are used repeatedly in everyday life.

Gender Relations

Gender relations are social relationships between men and women within a specified time and place. These social relationships explain the differences in power relations between the sexes. Historically, attention to gender relations has been driven by the need to address women's needs and circumstances, as women are typically more disadvantaged than men. Increasingly, however, the humanitarian community is recognizing the Gender Practical Needs/Interests need to know more about what men and boys face in crisis situations.

These are needs related to the roles of reproduction, production, and community work of men and women that, when met, do not necessarily change their relative position/condition in society (which arise from the gender roles).

Gender Strategic Needs/Interests

These are higher-level needs of women and men that, when met, help to change their status in society. Such needs include decision-making power and access to information.

Gender Awareness is the understanding that there are socially determined differences between men and women, based on learned behavior, which affect their ability to access and control resources.

Gender Sensitivity is the ability to perceive existing gender differences, issues, and equalities, and incorporate these into strategies and actions.

Gender Responsiveness is planning and implementing activities that meet identified gender issues/concerns that promote gender equality.

Gender Lens

Think of a gender lens as putting on spectacles. Out of one lens of the spectacles, you see the participation, needs, and realities of women. Out of the other lens, you see the participation, needs, and realities of men. Using a gender lens, relates to the ability to combine these two views.

Gender Blindness is failure to recognize that gender is an essential determinant of social outcomes. Gender blindness therefore impacts project planning and implementation.

Gender Equality: Gender equality or equality between women and men refers to the equal enjoyment by females and males of all ages, and regardless of sexual orientation, of rights, socially valued goods, opportunities, resources, and rewards.

Equality does not mean that women and men are the same but that their enjoyment of rights, opportunities, and life chances are not governed or limited by whether they were born female or male. Protecting human rights and promoting gender equality must be seen as central to the humanitarian community's responsibility to protect and provide assistance to those affected by emergencies.

Gender Equity

Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a 'level playing field'. Equity leads to equality.

Sessions 3 Myths on Sexual and Gender Based Violence

Introduction

This session provided trainees the understanding of the myths surrounding sexual and gender based violence at community and workplace, provide skills on how to handle the misconceptions and ensure there is always the principles of confidentiality when handling cases of sexual and gender based violence.

Session Objectives

1. To provide better understanding of myths on sexual violence.
2. To identify the barriers to disclosing sexual violence
3. Raise trainees understanding on the principle of confidentiality

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Preparation/ training procedure

Trainees will be presented with statements on sexual violence and asked what they think about those statements. The facilitator will say to the group: Rape and other forms of sexual violence are a form of SSGBV that society suffers heavily from. Lets talk about myths surrounding sexual violence in our communities and you can tell me what you think. I will read to you statements that will be discuss.

Activity 1.1 Agree or disagree

Statements

- Women are raped because they are showing their bodies too much.
- Women who go to clubs and bars are bad women and are asking to be raped.
- If a woman is raped by a rich man then it is not rape because she wanted something from him.
- If a woman drinks or smokes then she deserves to be raped.
- Women who spend too much time with men want to be raped.
- Men are weak and it is their nature to want to have sex that is why they rape women.
- Only children are raped, not adults.
- If you go to your boyfriend's house and he rapes you, it is your fault.
- Wives cannot be raped by their husbands.
- Some men rape for rituals or superstitious beliefs, such as raping a virgin will bring good luck.

Barriers to disclosing sexual violence

Facilitator's notes: The facilitator will continue with this activity by asking trainees what they think the barriers are that people face when they want to talk about sexual violence. The facilitator should bring up certain reasons if the trainees do not. These include:

- Our culture of silence
- Fear of judgment from loved ones
- Fear of judgment from service providers such as police officers
- Possibility of re-traumatization from retelling the story
- Self-blame, shame and guilt

- Inability to define sexual violence
- Not knowing who to report to

The facilitator will then ask the trainees how they feel they should approach someone who has just disclosed sexual assault/violence. The facilitator should bring up certain talking points if the trainees do not. These include:

- Assuring them that everything they say is confidential
- Believing them
- Reassuring them that it wasn't their fault
- Simply being there for them

Sessions 4: Types / Categories of SGBV

Introduction

This session will expose trainees to the understanding of the different types of Sexual and Gender Based Violence (SGBV) and Harmful Traditional Practices (HTP) such as physical, economic, emotional and psychological violenceincluding Sexual Abuse and Exploitation (SAE).

Session Objectives

To provide an understanding of SSGBV-HTP

To identify the different types or categories of SSGBV and HTP

To raise awareness of trainees to understand the difference between physical and psychological violence

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Preparation/ training procedure

According to the United Nations Declaration of Elimination of all forms of Violence against Women (DEVAW), SGBV can be categorized as:

a) Physical and psychological violence occurring within the family.
b) Physical, sexual, economical and psychological violence occurring within the community.
c) Physical, sexual, economical and psychological violence perpetrated or condoned by the state wherever it occurs.

1. Write these three broad categories on a flip chart.
2. Divide the trainees into three groups and assign each group one of the categories of SGBV.
3. Give each group 5 minutes to discuss and give examples of the violence that falls in their categories.
4. After 5 minutes have elapsed, ask the groups to stop!
5. Allow at least minutes of each group to present their work to the plenary and allow other trainees to make contributions to each group's work. At the end of each group's presentation, add more contributions from the list below. Emphasize that this list is not exhaustive and mention that there are very many other examples of SGBV.

a) Physical and psychological violence occurring in the family including but not limited to battering, sexual abuse of female children in the household, dowry related violence, marital rape, Female Genital Mutilation/Cutting (FGM/C/C), traditional harmful practices to women, non-spousal violence and violence related to exploitation.

b) Physical, sexual and psychological violence occurring within the community including but not limited to rape, sexual abuse, sexual harassment, intimidation at work, in education institutions and elsewhere, trafficking in women and forced prostitution.

c) Physical, sexual and psychological violence perpetrated or condoned by the state wherever it occurs. Many state organs tend to perpetrate violence especially in conflict areas. Also, the state condones violence when it does not use its power to condemn or stop it.

Sessions 5: What is Harmful Traditional Practices (HTP)

Introduction

This session will provide trainees the different types of Harmful Traditional Practices perpetuated on women and girls. Look at harmful traditional practices that affects girls and women such as Female Genital Mutilation/Cutting (FGM/C), and Child and forced marriage. FGM/C will be looked at in depth, and the trainer will go through the harms of FGM/C, how it is linked to child marriage, and why both harmful traditional practices continue to persist. Trainees will also identify the different forms of FGM/C.

Session Objectives

To expose participant to types of Harmful Traditional Practices
To share existing measures to eradicate HTP
To raise awareness on the harmful effect of Traditional Practices

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments

- Ice breakers
- Role plays

Preparation

The facilitator to share experience on the definition of Harmful Traditional Practices/Socio-cultural Violence include acts or rituals perceived as, based on, or believed to be based on tradition, and which intentionally or unintentionally affect in a physical, emotional, or psychological way those on whom these rituals are performed. Examples include Female Genital Mutilation/Cutting (FGM/C), Child Marriage, widow inheritance, and honour killings

Trainees will be asked to brainstorm on what they think defines harmful traditional practices. These answers will be written on a flip chart by the facilitator. After the brainstorm session, the facilitator will make a short presentation, clarifying the definition of a harmful traditional practice. The facilitator must remind trainees that FGM/C and child marriage are illegal in The Gambia.

Harmful Traditional Practices of Gender Violence can be defined as any form of violations of women's and girls' rights which are defended on the basis of tradition, culture, religious misconceptions, socio-cultural norms and beliefs or superstition by some community members. These are often known as 'harmful traditional practices. They may be described as harmful practices, but there are also particular forms of violence against women and girls.

It may also be defined as any form of violence which are committed primarily against women and girls in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice. This involves Female Genital Mutilation/Cutting (FGM/C) Female Circumcision (FC) and Child Marriage.

Presentation: Harmful traditional practices

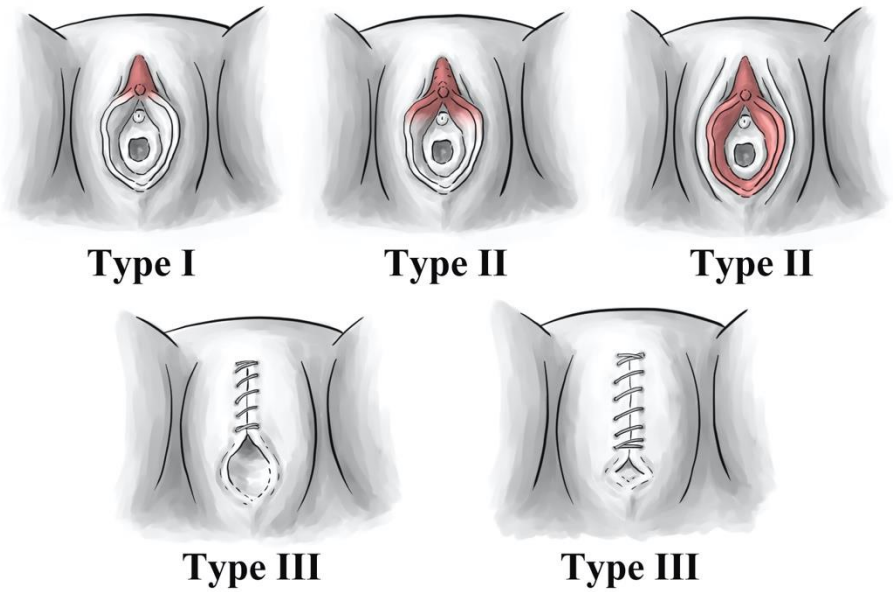
Harmful traditional practices are **accepted** cultural and traditional practices that are **harmful** to all genders. There are many forms of harmful traditional practices within our communities, however, this session, will focus on Female Genital Mutilation/Cutting (FGM/C), Child and Forced Marriage.

What is FGM/C?

A practice in which the female genitalia is partially cut or removed for non-medical purposes. There are 4 types of FGM/C

- Type 1: Clitoridectomy: the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)
- Type 2: Excision: the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina)
- Type 3: Infibulation: the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer labia, with or without removal of the clitoris
- Type 4: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area

Activity 2: An image of the female genital area will be handed out. Trainees will highlight which part of the genitalia are removed depending on what type of FGM/C a girl or woman has undergone. This activity will help trainees visually familiarize themselves with the different types of FGM/C. (10 minutes including discussion time)



Types of FGM/C. This image will be a handout[12]

Presentation and discussion: Are there any health effects of FGM/C that you can think of? Long and Short term /What are they? Why do you think FGM/C continues to be practiced?

Health effects of FGM/C

- Heavy bleeding
- Trauma
- Depression
- Post-Traumatic Stress Disorder
- Anxiety
- Painful and heavy periods
- Infections
- Transmission of diseases e.g. HIV
- Difficulty urinating
- Difficulty during sexual intercourse/lack of sensation

[12] Female Circumcision https://med.virginia.edu/family-medicine/wp-content/uploads/sites/285/2017/01/Jewel-Llamas-Paper-KT3.pdf

- Infertility
- Difficulty giving birth
- Obstetric fistula

In 2015 the national prevalence rate of FGM/C for girls and women in The Gambia was at 76.3%. FGM/C continues to be practiced for many cultural reasons, such as:

- Rite of passage to womanhood for girls and to prepare them for marriage.
- Attachment to certain cultural values
- Limiting premarital sex
- Keeping girls from getting pregnant before marriage
- Belief that FGM/C makes girls more marriageable
- Circumcised vulvas seen as more beautiful, clean and pure
- Associations with religion
- Preserving virginity
- Lack of understanding of the risks and harms associated with FGM/C.

Activity 3: Defining child marriage and exploring its links to FGM/C

Method: Brainstorm and presentation

Facilitator's notes: Trainees will be asked if they know how child marriage is defined under Gambian laws. They will also be asked to think about how it is linked to FGM/C. These answers will be written on a flip chart by the facilitator. After the brainstorm session, the facilitator will make a short presentation to clarify the definition of child marriage in The Gambia and how it can be linked to FGM/C.

Brainstorm questions: What is child marriage? Do you think that FGM/C and child marriage are linked? What are those links?

Presentation: Child Marriage

Child Marriage is defined in The Gambia as anyone who is married **before the age of 18**.

FGM/C and Child Marriage are linked in many ways:

- They both occur because of **gender inequalities** and **inadequate protection for girls and women**
- They both also occur because parents and community members believe that these practices will **protect girls and women from teenage pregnancy and sex outside of marriage**
- Both practices are also driven by **poverty, inadequate education, wrong beliefs, religious misconceptions, socio-cultural norms and values etc.**

Group Work: Identifying the impacts of harmful traditional practices

Method: Case study and role play

Facilitator's notes: Trainees will read a case-study where the scenario highlights Child Marriage and FGM/C. They will be asked to answer questions in groups after reading the case study. When trainees display a clear understanding of the case study, they will then be asked to perform a role play. In this scenario, they will be asked to get into groups of two (2) and create dialogue specific to the case study, keeping certain questions in mind.

Case study:

Sirreh underwent type three (3) of FGM/C when she was one week old. She is now fifteen 15years old and preparing to get married. Sirreh did not know that she was infibulated, so on her wedding night, she and her husband struggled to have sex. Sirreh thinks something is wrong with her because of the amount of pain she feels whenever she and her husband try to have sex.

Instructions for role play:

Get into groups of two and come up with a dialogue for how Sirreh would go about getting help. You can choose who you think Sirreh would go to for help. When creating the dialogue, keep these questions in mind:

- What are the problems Sirreh is facing?
- Who would you speak with? What will you tell them?
- Come up with a short play/script between Sirreh and the person she would speak with.

Group Work: Recap of session 2

Method: Discussion

Facilitator's notes: Trainees will reflect on the previous session. They will have the opportunity to expand on what they learned and what stood out to them. They will also have the opportunity to bring up any other points they want to discuss.

Group Work 2: Teenage pregnancy and child marriage

Method: Brainstorm and presentation

Facilitator's notes: Trainees will be asked to brainstorm on what they believe are the unique problems adolescent girls face. These answers will be written on a flip chart by the facilitator. After the brainstorm session, the facilitator will make a short presentation, paying special attention to teenage pregnancy and child marriage.

Brainstorm question: What are unique sexual and reproductive health problems that adolescent girls face?

Presentation: Child marriage and pregnancy

Harms and complications from teenage pregnancy and child marriage:

Key facts

- Complications in pregnancy and childbirth are the leading causes of death among adolescent girls ages 15-19 in sub-Saharan Africa and other low- and middle-income countries
- Teenage pregnancies are risk to a girl's health regardless of whether she is married or not
- Teenage pregnancies also put newborn babies at risk of death
- Abortion is a common health intervention. It is safe when carried out using a method recommended by WHO, appropriate to the pregnancy duration and by someone with the necessary skills.
- Six out of 10 of all unintended pregnancies end in an induced abortion.

- Around 45% of all abortions are unsafe, of which 97% take place in developing countries[13].
- Unsafe abortion is a leading – but preventable – cause of maternal deaths and morbidities. It can lead to physical and mental health complications and social and financial burdens for women, communities and health systems.
- Lack of access to safe, timely, affordable and respectful abortion care is a critical public health and human rights issue.
- Girls and young women who become pregnant are forced to drop out of school. This limits their future potential and it's detrimental to both the mother and the child's health.

Brainstorm questions: What other harms of teenage pregnancy and child marriage can you think of? What are some sexual and reproductive health risks that are unique to adolescent girls?

Facilitator's notes: During this discussion, the facilitator should make sure to highlight certain points, including:

- Girls and young women 15-24 account to 64% of new HIV infections[14]
- Young people generally engage in riskier health behaviors
- Peer pressure
- Limited Sexual and Reproductive Health Right education

Sessions 6: Definition and key concept

Introduction

This session provided trainees the understanding the definition of key concept and principles of sexual and gender based violence and Harmful Traditional Practices, clarify the differences between sexual and gender based violence and Harmful Rational Practices as well as raised participant understanding of SGBV- HTP definition, concepts, prevention, and response

Session Objectives

- To provide an understanding of SGBV-HTP

[13] WHO Abortion (who.int)

[14] Facts and figures: HIV and AIDS | UN Women – Headquarters

- Clarify the difference between SGBV – HTP
- Raise participant understanding of SGBV- HTP definition, concepts, prevention, and response

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Sexual Gender-Based Violence (SGBV)

United Nations defines human rights as those rights which are inherent in our nature and without which we cannot function as human beings irrespective of our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status (Atsenuwa, Olubamise, Abazie, *et al.* 1999 cited in Nwanna and Ogunniran, 2019[15]). We are all equally entitled to our human rights without discrimination. These rights include the right to life and liberty, freedom of opinion and expression, the right to work and education, freedom from slavery and torture, and many others. Every person in the world is entitled to enjoy these rights without any form of discrimination.

[15] Atsenuwa, Olubamise, Abazie, *et al.* 1999 cited in Nwanna and Ogunniran, 2019

Gender-based Violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of SGBV violate universal human rights protected by international instruments and conventions. Many – but not all – forms of SGBV are illegal and criminal acts in national laws and policies. The term 'gender-based violence' is often used interchangeably with the term 'violence against women'. The term 'gender-based violence' highlights the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence. The nature and extent of specific types of SGBV vary across cultures, countries, and regions (IASC, 2005).
Examples include:

- Sexual violence, including sexual exploitation/abuse and forced prostitution
- Domestic violence
- Trafficking
- Forced/Child Marriage
- Harmful traditional practices such as Female Genital Mutilation/Cutting (FGM/C/C), honour killings, and widow inheritance

Human rights are enshrined in the 1948 UN Universal Declaration of Human Rights, and in a range of international conventions. Human rights of Women are specially emphasized in the following international conventions and instruments, such as the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), CEDAW General Recommendations 12 and 19, and the 1993 UN Declaration on the Elimination of Violence against Women[16].

In 1995, the UN World Conference on Women in Beijing declared that 'violence against women is an obstacle to the achievement of the objectives of equality, development and peace. Violence against women both violates and impairs or nullifies the enjoyment by women of their human rights and fundamental freedoms. SGBV violates fundamental human rights. It violates several women's rights such as the right to life, the right to equal protection under the law, freedom from

[16]CEDAW General Recommendations 12 and 19, and the 1993 UN Declaration on the Elimination of Violence against

torture, degrading and cruel treatment, the right to equality in the family, in the workplace and also the right to the highest standard attainable of physical and mental health (SustainabilityX, 2019). SustainabilityX (2019) also avers that SGBV is a major barrier to achieving gender equality. Violence against women is indeed one of the most significant violations of women's rights across the world.

SGBV is therefore a violation of human rights and it affects physical and mental health, while constituting a critical barrier to the achievement of sustainable development goals, democratic development, economic growth and sustainable peace. Various forms of sexual and gender-based violence such as rape, domestic violence, sexual harassment, forced marriage, child marriage, traditional harmful practices, and so on, – constitute serious violations of women and girls' human rights as well and they are impediments to the attainment of gender equality and the empowerment of women and girls (ECOWAS, 2021).

In order to promote and respect women's human rights obligations, governments across the globe should seek to transform the social and cultural norms regulating power relations between women and men, and other linked aspects of subordination. Recognizing SGBV as a violation of human rights clarifies that governments at all levels have binding obligations to prevent, eradicate and punish such violence. Reiterating that Violence Against Women (VAW) is a Human Rights Issue does not preclude using other approaches to preventing and responding to VAW. Rather, it encourages addressing VAW within a multi-sectoral response framework that integrates human rights dimension across all the sectors, such as in the education, health, criminal justice, humanitarian, security sectors, etc. (United Nations, 2006).

Violence Against Women & Girls (VAWG) consists of the following forms:

• Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, Female Genital Mutilation/Cutting (FGM/C/C) and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

• Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced sex work;

• Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

The Beijing Platform for Action in paragraphs 114-116 [17]identified women who were particularly vulnerable to violence as those belonging to minority groups, indigenous women, refugee women, women migrants including women migrant workers, women in poverty living in rural or remote communities, destitute women, women in institutions or in detention, female children, women with disabilities, elderly women, displaced women, repatriated women and women in situations of armed conflict, foreign occupation, wars of aggression, civil wars and terrorism including hostage taking (Cruz and Klinger, 2011)[18]. Manifestations and Categorizations of SGBV do overlap. World Bank (2018) highlights the manifestations of SGBV[19]as:

Physical violence (such as slapping, kicking, hitting, or the use of weapons); emotional abuse (such as systematic humiliation, controlling behavior, degrading treatment, insults, and threats);

Sexual violence, which includes any form of non-consensual sexual contact, including rape; early/forced marriage, which is the marriage of an individual against her or his will often occurring before the age of 18, also referred to as child marriage.

Others are economic abuse and the denial of resources, services, and opportunities (such as restricting access to financial, health, educational, or other resources with the purpose of controlling or subjugating a person); trafficking and abduction for exploitation; and

[17]The Beijing Platform for Action in paragraphs 114-116
[18]Cruz and Klinger, 2011
[19]World Bank (2018) highlights the manifestations of SGBV

Intimate Partner Violence (IPV) perpetrated by a former or current partner, includes a range of acts of violence, but not exhaustive. It also includes: sexual abuse, forced prostitution; domestic violence; harmful traditional practices such as Female Genital Mutilation/Cutting (FGM/C), honour crimes and widow inheritance.

Arango et al. 2014 cited in the World Bank Group (2019)[20] go further to delineate the forms of SGBV. They include intimate partner violence, non-partner sexual assault, Female Genital Mutilation/Cutting (FGM/C), sexual exploitation and abuse, child abuse, female infanticide, and child marriage. It occurs in both public and private spheres. It encompasses physical, sexual, psychological, emotional and verbal violence. It includes violence in the family such as battering, sexual abuse of girls and young women in the household dowry-related violence, marital rape, Female Genital Mutilation/Cutting (FGM/C) and other harmful traditional practices. Others are non-spousal violence and violence related to exploitation physical, sexual and psychological violence in the community including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere trafficking of women and forced prostitution physical, sexual and psychological violence perpetuated or condoned by a State, wherever it occurs.

Child and Adolescent Sexual Abuse, Exploitation and Violence

Badoe, E. (2017)[21] defines child sexual abuse as forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. These activities may involve physical contact, including penetrative (e.g. rape, defilement, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways (Borg, Snowden, and Hodes, 2014 cited in Badoe, 2017)[22].

[20]Arango et al. 2014 cited in the World Bank Group (2019)
[21]Badoe, E. (2017)
[22]Borg, Snowden, and Hodes, 2014 cited in Badoe, 2017).

Sexual exploitation is any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another (World Bank, 2018 and 2020) while Sexual abuse is further defined as the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions (World Bank, 2018 and 2020).

Sexual Violence

According to Health Policy Project (2014) and World Bank (2018), sexual violence is any sexual act performed on an individual without their consent through intimidation, threats, coercion, or the use of force. Sexual violence can take the form of rape or sexual assault, marital rape, attempted rape, child sexual abuse, online sexual abuse, sexual violence as a weapon of war or torture and genital mutilation.

Other forms include sexual harassment, sexual exploitation (for example at the workplace or school), trafficking, commercial sexual exploitation and sexual violence based on sexual orientation. There are other forms mentioned by Seelinger *et.al.* (2011)[23]unwanted sexual advances, including demanding sex in return for favours; sexual abuse of mentally or physically disabled people; forced marriage or cohabitation, including the marriage of children, denial of the right to use contraception or to adopt other measures to protect against sexually transmitted infections (STIs); forced abortion, violent acts against the sexual integrity of women, including obligatory inspections for virginity; forced prostitution Seelinger *et.al.* (2011) also state that it can happen in a bedroom, alleyway or war zone.

Though the vast majority of victims are women, men and boys can also be victims, and women can be perpetrators. NSVRC (2010) avers that anyone can experience sexual violence irrespective of the person's age. Those who sexually abuse people can be acquaintances, family members, trusted individuals or strangers. Sexual Violence is a violation of women's and girls' human rights and it is a major public health problem across the world in virtually all regions and countries.

[23]Seelinger *et.al.* (2011)

Sexual Harassment

Sexual harassment can be defined as unsolicited, unwelcome sexual advances, demand for sexual favors, which can be physical, verbal or non-verbal or gesture of a sexual nature, or any other behavior of a sexual nature that might reasonably be expected or be perceived to cause offense or humiliation to another, when such conduct interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment (World Bank, 2020).

Sexual Harassment constitutes a form of violence against women who are the main victims and it is gender-based discrimination even though both males and females can be either perpetrators or victims of sexual harassment. However, in many instances, males have often been found to be the perpetrators and females the victims especially within educational institutions. Sexual Harassment has been identified as a major public health issue and it constitutes a major stressor to the individual being victimized and often leads to reduced job performance and\or low academic performance and other socio-psychological problems. Sexual harassment is a form of Sexual and Gender-based Violence in three important ways.

Firstly, in the workplace the victims of sexual harassment who are mostly women are degraded and demeaned by being treated as sex objects whilst non-victims are treated as workers. In educational institutions in which cognitive achievement should be the main criteria of assessment of students some female students are sexually harassed, and are treated as mindless objects whilst, in the main, their male classmates are respected for their cognitive output.

Secondly, female workers and students are unfairly denied a certain amount of autonomy over their lives. In the severe case of sexual harassment, a victim's autonomy is restricted, because he/she is forced to accede to a boss' wishes or risk harm to herself. In subtler forms of harassment a victim's autonomy is still restricted because for the person the work environment cannot remain the same after episodes of sexual harassment; he/she is not free to act as she did previously.

Thirdly, the participation of women in work and in tertiary education in which sexual harassment is particularly rife is decreased through forced resignation and withdrawals as a consequence of sexual harassment. Unfortunately across the globe sexual harassment is rampant in the educational system and it has become part of the school culture and it impacts negatively on the female students school performance, physical and mental health (ECOWAS, 2011).

Sexual violence, gender-based violence and violence against women are terms that are commonly used interchangeably. All these terms refer to violations of fundamental human rights that perpetuate sex-stereotyped roles that deny human dignity and the self-determination of the individual and hamper human development. They refer to physical, sexual and psychological harm that reinforces female subordination and perpetuates male power and control.
While gender-based violence has a devastating impact on the lives of women and girls who are the majority of victims/survivors, it is also hinders the development of men and boys.

Sexual Violence

This term is used to cover all forms of sexual threat, assault, domestic violence, interference, and exploitation, including involuntary prostitution, statutory rape, and molestation without physical harm or penetration. Sexual Assault includes acts of violence not involving anal or vaginal penetration. Examples include forced or coerced oral sex, insertion of objects in the vagina, etc.

Abuse is misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inciting fear of that harm. Abuse prevents persons from making free decisions and forces them to behave against their will.

Rape: This is an act of non-consensual sexual intercourse, where one person forces another to have sex. Any penetration (anal or vaginal), regardless of the level of force used, is considered rape, and may include: statutory

Rape (sex with a person considered a minor by law regardless of the consent of the survivor); gang rape, if there is more than one assailant; and male rape, also known as sodomy.

Attempted Rape: This refers to efforts to rape someone that fall short of penetration.

Domestic Violence: This is the most common form of violence and probably the most difficult to deal with, since it is perpetrated within the confines of home and the family. Such is the extent of this form of violence that many women and girls have come to accept it as a norm in marriage.

A Perpetrator: is a person, group, or institution that directly inflicts, supports, and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision making, and/or authority and can thus exert control over their victims.

Survivors: This is a term used to refer to individuals or groups who have been affected by gender-based violence. While "victims": should be treated with compassion and sensitivity, referring to them as "survivors" recognizes their strength and resilience.

Actors: is a term that is used to refer to individuals, groups, organizations, and institutions involved in preventing and responding to sexual and gender-based violence. Actors may be refugees, local populations, or employees or volunteers of UN agencies, non-governmental organizations, host government institutions, donors, and other members of the international community.

Protection: refers to all actions aimed at ensuring the equal access to and enjoyment of the rights of women, men, girls, and boys in accordance with the relevant bodies of law (international humanitarian, human rights, and refugee law).

Victim

Sessions 7: Role of Public, Private sector, CSOs and relevant organisations working in this field

Introduction

This session will reveal the role of the public, private sector, CSOs and relevant organisations including state and non-state institutions working in this field. One of the critical role is to ensure these institutions have specific sector policies, rules and regulations addressing SGBV and HTP and ensure access to justice for women who have experienced gender-based violence.

Session Objectives

1. To identify the role of Public and Private sector and relevant organisations

2. To ensure state and non-state institution including CSOs identify and understand cases of SGBV-HTP
3. To advocate for specific sector policies, rules and regulations addressing SGBV and HTP

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Preparation

In their efforts to compliment the efforts of governments to reduce Sexual Gender Based Violence (SSGBV), The Public, Private Sector, Civil Society Organizations and all other relevant Institutions have a role to play.

However, their roles and responsibilities are somewhat similar and complimentary. Whilst the public sector is mostly engaged in establishing responsive mechanisms, laws, policies and actions plans, The Private sector, Civil Society Organizations and other stakeholders do compliment these

efforts by engaging in these Multiple interventions at different levels **(individual, community, institutional, legal, and policy**) appear to be necessary.

Ensure access to justice for women who have experienced gender-based violence.

These are: protecting women by improving laws and policies and raising awareness of women's rights; providing redress by strengthening institutional responses to gender-based violence; and raising the cost to men of engaging in gender-based violence by establishing or increasing criminal sanctions and mandating participation in treatment programmes. Findings include the following:

- Efforts to improve laws and policies which focuses on international conventions to provide: an overarching legal framework to support (or in some cases supersede) national legislation; new specialised legislation on gender-based violence; and reform of national civil and criminal codes.

- Initiatives to improve institutional responses to gender-based violence have included training professionals, reorganizing police or courts, and providing a more comprehensive and supportive response to survivors. The most effective appear to be strengthening and reforming the justice sector as a whole and building partnerships between the justice system and other sectors. Support services for survivors, run mainly by NGOs, are inadequate in most countries.

- Development of methodologies for high-quality data collection on gender-based violence.

- Awareness creation using community-wide interventions, bringing into play myriad social and cultural factors.

- Promoting nonviolence behaviors among boys and girls targeting adults and school girls.

- Capacity Building through training of personnel (including officials at the highest levels) and institutional strengthening including policies, procedures, resources, and monitoring and evaluation.

Sessions 8: Sexual Gender Based Violence Culture

Introduction

This session provided trainees the understanding of sexual and gender based violence and Harmful Rational Practices, clarify the differences between sexual and gender based violence and Harmful Rational Practices as well as raised participant understanding of SGBV- HTP definition, concepts, prevention, and response

Session Objectives

To provide an understanding of SGBV-HTP
Clarify the difference between SGBV – HTP
Raise participant understanding of SGBV- HTP definition, concepts, prevention, and response

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Preparation

The facilitator will share experience on how Harmful Traditional Practices are forms of violence which have been committed primarily against women and girls in certain communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted cultural practice.

Female Genital Mutilation/Cutting (FGM/C/C) or cutting (FGM/C, Child, forced and arranged marriages, forced inheritance of wives and even betrothals; are all classified as cultural norms and values that are considered to be harmful

Sessions 9: SSGBV and HTTP: Intersecting identities and key vulnerability group (Adolescent, Boys and Young Men and Adolescent Girls and Young Women, Key Population and persons with disability

Introduction

This session will expose participant to intersecting identities and key and vulnerable groups (Adolescent Boys and Young Men and Adolescent Girls and Young Women, key population groups, People with disabilities. The session will also identify the effect of SGBV and HTP on key population group such as Adolescent Boys and Young Men and Adolescent Girls and Young Women

Session Objectives

1. To enhance knowledge on the intersecting identity of key vulnerable groups to SGBV-HTP guidelines
2. To identify the effect of SGBV and HTP on key population group
3. To enhance knowledge and awareness on SGBV and HTP Vulnerability

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Name Tags

- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Preparation

The facilitator will enumerates the foundational guidelines that should inform the provision of SGBV or SRHR services to women and young persons with disabilities. These guidelines are grounded in international human rights frameworks. Lack of resources is an unfortunate reality for SGBV and SRHR service providers around the world. However, lack of resources is not sufficient justification to exclude women and young persons with disabilities from such services. Service providers and the national and subnational governments responsible for providing services must consider and budget for accessible services for women and young persons with disabilities from the programme development stage.

Moreover, while some of the guidelines in this document may be unaffordable to service providers in low-resource settings, these Guidelines offer a starting point for developing creative solutions and programmes that are guided by and aim to meet the principles laid out below. The essential principle that should guide all quality rights-based services for women and young persons with disabilities is: When in doubt, ask the person with the disability. In fact, the Convention on the Rights of Persons with Disabilities requires such consultation in the development and implementation of legislation and policies to realize women

There is a clear intersection of sexual and reproductive health struggles of adolescent girls, including child marriage, teenage pregnancy and lack of access to contraception. Adolescence is a time of rapid growth, as many physical, social, mental and emotional changes occur. Access to

sexual and reproductive health education and resources is important at this time, because it lays a foundation for healthy sexual practices in later adult life. Studies have shown that adolescent girls face numerous barriers to access these services. Gambia has a youthful population, therefore it is important to understand and respond to the needs of this population

WOMEN AND YOUNG PERSONS WITH DISABILITIES

Young persons with disabilities'/ differently abled full and equal enjoyment of their human rights. Women and young persons with disabilities are the experts on their own needs, the barriers they experience, and the accommodations they require for equal access to services. The following criteria are also essential to all stages of the development and implementation of rights-based services, programmes, and policies generally:

- Participation of women and young persons with disabilities at all stages of programme development and assessment. Inclusive services for people with and without disabilities.
- Respect for a person's legal capacity, informed consent, and privacy, along with mechanisms for supported decision-making and confidentiality safeguards.
- Sufficient funding for accessible services.
- Training and supportive supervision of service providers and support staff about the rights and needs of women and young persons with different types of disabilities and how to provide respectful care. Incorporate disability issues in curricula for service providers and support staff.
- Effective referrals through streamlined inter-agency coordination.
- Accessible services (physical, information, communication, financial, sensory environment). The following Foundational Guidelines are organized into the three stages of developing and administering programmes to meet the needs of women and young persons with disabilities:
- Developing disability- and gender-sensitive laws and policies;
- Programme development, implementation, monitoring and evaluation; and
- Designing facilities and Laws and Policies Creating an enabling legislative environment is essential to providing quality rights-based services for women and young persons with disabilities. The following actions are crucial to creating this environment:

Sessions 10: Peoples in humanitarian crises, increasingly vulnerable segment of group's people affected by disaster and crisis

Introduction

This session provided trainees the understanding of sexual and gender based violence and Harmful Rational Practices in a humanitarian crises, increasingly vulnerable segment of group's people affected by disaster and crises.

Session Objectives

1. To provide an understanding of SGBV-HTP in a humanitarian crises, increasingly vulnerable segment of group's people affected by disaster and crises
2. Raise participant understanding of SGBV- HTP a humanitarian crises, increasingly vulnerable segment of group's people affected by disaster and crises

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Pens
- Note Pads
- Projector

Training approaches/methodology

- Brainstorming,
- Discussion and sharing experience,
- Group Work,
- Presentation,
- Take home Assignments
- Ice breakers
- Role plays

Does Consideration of Gender Equality Matter in Humanitarian Response?

In life and death situations, isn't the question of gender equality a luxury? That is what many people think. But in reality, equality is neither a luxury nor a matter of giving privileges to women over men, or vice versa. Gender equality is about ensuring that the protection and assistance provided in emergencies is planned and implemented in a way that benefits women and men equally, taking into account an analysis of their needs as well as their capacities **(IASC, 2006).**

In many instances, attempting to integrate principles of equality into programmes requires the active involvement and support of men.

For example:

- Women may be faced with the added burden of responsibility and perhaps the risk of backlash from men.
- Critical issues relating to survival and health are marginalized and relegated to "women's issues" (for example, HIV/AIDS awareness and condom use should be promoted among men as well as women).
- Men may not take women's participation seriously, and this can place women in a more difficult situation.
- Threats or risks facing men may not be adequately understood or addressed

Men may lose some of their status and authority as emergencies impact on traditional family and clan structures. Men who have been the traditional leaders and wielders of power may resent the perceived interference of women in the male domains of providing security to the family, bringing food to the household, or in economic activity. Understanding the nuances of masculinity in the context of each situation and gaining the support of men for involvement by women and youth in traditionally male activities will be crucial to the success and sustainability of the humanitarian response (IASC, 2006).

Finally, gender equality is a critical step towards achieving sustainable development. Crisis situations radically affect social and cultural structures, changing women's and men's status. They often provide a window of opportunity for addressing gender-based discrimination and rights violations. If humanitarian interventions are not planned with gender equality in mind, not only do

the chances of doing greater harm increase, but the opportunity to support and promote equality in livelihoods between women and men can be lost

Eliminating gender-based violence and gender inequalities helps to strengthen entire communities.

CORE PRINCIPLES IN RESPONSE

- Flexibility in the implementation of multi-sector SGBV response has enabled its adaptation to a range of different, challenging contexts.
- Action Aid can made significant contributions to the wider sector in the areas of SGBV response for men and boys and Persons of Concern (PoC) which provides a strong foundation for further needed work internally and externally.
- Evidence highlights the importance of community-based interventions.
- A recurrent priority for SGBV survivors is support for their livelihoods which is an area that could be strengthened in programming.
- A recurring challenge is low uptake rates of specialist services but initiatives which build understanding and relationships between service providers and Point of Contact (PoC) show promise.
- Building relationships with national civil society networks and groups including LGBTI and women's rights groups can strengthen UNHCR SGBV interventions.

MODULE 2 PREVENTION AND MITIGATION OF SSGBV AND EFFECT OF HTP

Sessions 2.1: Assessing, designing and implementing SGBV prevention and mitigation measures and programming

Introduction

This session provided trainees the understanding of assessing, designing and implementing SGBV prevention and mitigation measures and programming and also identify challenges related to addressing and integrating SGBV in program implementation.

Session Objectives

1. To provide an understanding on how to assess SGBV program areas for intervention

2.To enhance capacities and develop strategies to implement activities of SGBV prevention and mitigation.

3.Raise participant's understanding of the tools to assess, design, and implement SGBV prevention and mitigation measures into programming.

4.To identify strategies in programming for SGBV prevention and mitigation design measures

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens
- Note pad and pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading
- Role play/scenarios
- Writing

OVERVIEW OF SGBV/HIV PREVENTION AND MITIGATION MEASURES FRAMEWORK PROGRAMMES DESIGN & IMPLEMENTATION

Preparation

The facilitator to share experience on the various situational analysis tools and strategies to prevent and mitigate SGBV/HIV through assessing, design and implementation using different steps to develop methods of program intervention areas**.**



SGBV Assessment - Areas of Inquiry

- General Information & GBV Basic Knowledge
- Demographics (desegregation by age and sex)
- Types of gender-based violence
- Risk factors for different types of GBV/HIV
- Survivor profiles, including mothers of children born as a result of sexual violence and HIV
- Perpetrator profiles
- Survivor needs and preferences for assistance and support

Community Profile

- Community knowledge, attitudes and practices about gender, gender-based violence and HIV/AIDS
- Forms of GBV/HIV that are occurring; how the community perceives each type; words used to describe these acts
- Community attitudes and behaviour toward survivors/suspected survivors and perpetrators/suspected perpetrators and HIV/AIDS Victims
- Traditional/religious beliefs and practices
- Level of women's participation in decision making Norms around age and gender;
- Roles and opportunities for women; status of women; women's empowerment, Roles and opportunities for men
- Status of children; community views about children's participation; school attendance (boys and girls)

Community-based protection systems

- Accessibility and Safety of services and facilities
- Mapping of services: village/settlement/camp services and facilities (locations, organisation, accessibility, etc.)
- Inclusion of women in planning, delivery, and decision making about services

Security Measures

- Types and numbers of police and security staff/volunteers in and around the setting
- Proportion of female security staff /volunteers
- Methods used for identifying security threats and risks
- Involvement of community

Disclosure, Help Seeking, and Appropriate Referral

- Entry points for survivors to seek help
- Presence of referral pathways and systems
- Confidentiality and information sharing

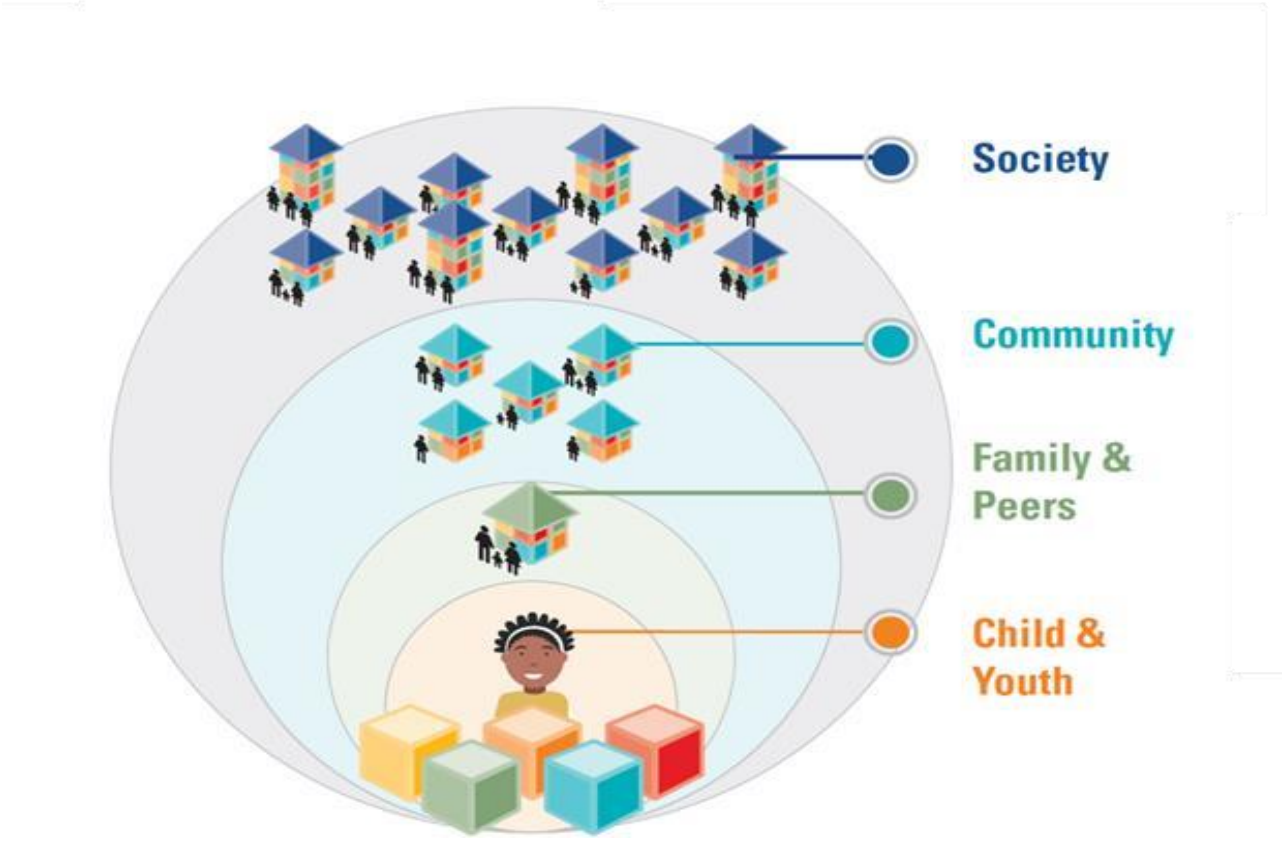
- Service provider knowledge, attitudes, behaviour; application of guiding principles
- Involvement of community in helping survivors and assisting with appropriate referrals

Survivor Support Services

- Availability, accessibility, quality of:
- Health care
- Psychosocial support
- Security
- Legal justice
- Include: traditional practitioners, community-based groups, NGOs, UN's, government
- Sensitivity, awareness, knowledge and attitudes of service provider staff and volunteers
- Involvement of community in supporting survivors and their reintegration into the community

Assessing Risk and Context Analysis (30 Minutes)

The Facilitator will tell the group that this Module will now move more deeply into focusing on understanding the risks that vulnerable people may face. We will be using a Risk Assessment Tool to assess the risk and then an additional tool to begin looking at the strengths.



Through models such as this, we can begin to explore the complete experience of survivors and start to implement protection standards that will address both prevention and intervention**.**

The Facilitator will outline that the Model also provides a framework for identifying signs of risk that helps us to understand:

At the individual level: What are the personal history and risk factors that may increase the likelihood of a child or youth become a victim of SGBV. We can also assess the protective factors and strengths/resilience of the individual**.**

Personal relationships such as family, friends, intimate partners and peers may influence the risks of becoming a victim of SGBV. We can also assess the protective factors and strengths/resilience of the personal relationships.

Community contexts in which social relationships occur, such as schools, neighborhoods and workplaces, also influence SGBV. Risk factors here may include poverty, migration and the existence of a trafficking and exploitation. We can also assess the protective factors and strengths/resilience of the community.

Social and cultural factors influence whether SGBV is encouraged or inhibited. This includes the existence of legislation and laws in regards to SGBV, economic and social policies, as well as social and cultural norms such as those around male dominance over women, parental dominance over children and cultural norms that endorse SGBV.

This Assessment Tool will guide you through the four levels with a series of questions to begin to assess the SGBV risk that is present in your context.

Mapping Their Context

The Facilitator will divide the group into small groups. The composition of the groups will depend on the country or context where they are working. If all members of the group are from the same country, then divide them into groups based on their profession. If they are all from the same profession or organisation, divide them into random small groups.

Handout 2.1 SGBV Preventions: Assessing Risk and Context Analysis and 2.2 GBV Risk Assessment Tool for Survivors, Children and Youth. They will be doing a risk assessment and context analysis of the area where they work. The group will answer all of the questions outlined in the assessment and then complete the SGBV/HIV Risk Analysis handout. As this is a long exercise, the Facilitator will move from group to group, assessing if the groups need any support or have any questions.

When the groups have completed their Analysis, they will present their findings back to the larger group.

Assessing Strengths and Resources (15 Minutes)

As outlined above, we also need to assess strengths and resources as well as risks. After the presentation of the Risks, have the groups return to their small groups and then map out the Strengths and Resources where they are working.

Ask each group to present back some of the Strengths and Resources that they have found.

Group	Strengths	Resources
Individuals		
Relationships		
Community		
Society		

PROGRAMME MEASURES/STRATEGIES

What measures can be applied to prevent and mitigate and how do we achieve them (15 Minutes)

Action Planning

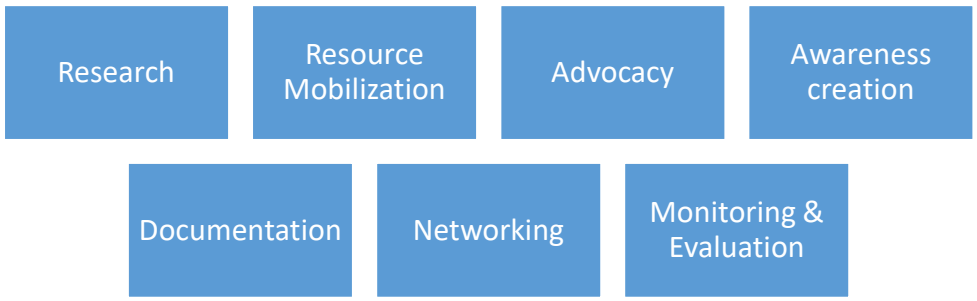
The last section of the day focuses on Action Planning. Have each participant complete the Action Planning section of the handout. They will identify how they will:

Prevent GBV Risk

Implement a Survivor Centred and Strengths Based Approach

Have each person present back and discuss their action plan according to the following strategies.

1. Research
2. Advocacy
3. Capacity Building
4. Awareness Creation (Sensitization, Training, social media
5. Networking
6. Documentation
7. Resource Mobilization



Work for the Facilitator to do in Advance

1. Prepare Handout of SGBV Risks and Mitigation/Prevention

Mitigating Risk

The next Module builds on all of the learning of the day and the focus is on developing a mitigation or prevention plan for stopping SGBV from occurring or ensuring that our services and places of work are both strengths based, and survivor centred.

Have the participants return to their small groups from the previous module and handout 2.6 GBV Risks and Mitigation/Prevention.

The focus of this exercise is for them to:

1. Select one Identified Risk
2. Select a Mitigation Strategy
3. Develop an Implementation Plan
Step 1
Step 2
Step 3

Encourage the groups to be creative in their planning and in their presentation back to the larger group.

Have each group present back and then discuss how they will action this when they return to work.

Session 2.2: Integrating SGBV and HTP Intervention in thematic program activities (eg Health, HIV and AIDS, Education, Food Security, Economic Empowerment etc)

Introduction

This session provides the trainees with the understanding of the integration of SGBV and HTP interventions in thematic programs activities including Health, HIV and AIDS, Education, Food Security and Economic Empowerment, Programming and also identify challenges related to addressing and integrating SGBV in program implementation.

Session Objectives

1. To provide an understanding on how to assess SGBV and HTP Interventions can have direct implication on thematic program activities

2. To enhance capacities and develop strategies to implement activities of SGBV and HTP and it's effect to Health, HIV and AIDS, Education, Food Security and Economic Empowerment.

3. Raise participant's understanding tools to assessing, designing, implementing SGBV prevention and mitigation measures into programming.

4. To identify strategies in programming for SGBV and HTP prevention and mitigation design measures

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens
- Note pads and pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Role play/scenarios
- Writing

HEALTH

A state of physical, mental and social well-being and not merely the absence of disease or infirmity

Consequences of SGBV on HEALTH

SGBV can have severe and long lasting consequences for survivors, their families and societies. At the level of the survivor, immediate health consequences include reproductive health impacts, injury, and a myriad of other negative effects which may even lead to death.

EDUCATION

Education is both the act of teaching knowledge to others and the act of receiving knowledge from someone else. Education also refers to the knowledge received through schooling or instruction

and to the institution of teaching and learning as a whole. Education has a few other senses as a norm.

IMPACT

SGBV also has a serious impact on educational outcomes, with many students avoiding school, achieving below their potential, or dropping out completely. In every country and region of the world where SGBV has been studied, incidents have been reported.

The relation between SGBV and education comes in both sides. Those people which suffered violence's shows negative outcomes for education, SGBV have more prone to show adverse impacts for education.

However the most serious consequence of poor mental health is when a student goes as far as attempting or committing suicide. Suicide, which is considered to be the second-leading cause of death among young people, may be the tragic result or consequence of undetected or untreated mental health problems

FOOD SECURITY

Food security is the measure of an individual's ability to access food that is nutritious and sufficient in quantity. Some definitions of food security specify that food must also meet an individual's food preferences and dietary needs for active and healthy lifestyles.

CONSEQUENCES SGBV is the most extreme manifestation of gender inequality and a fundamental human rights violation. Protracted crises can create and exacerbate many forms of SGBV, having a devastating impact on the agriculture sector and food security by reducing the capacity and productivity of survivors as a result of illness, injury, stigma and discrimination. It includes emotional and economic acts of harm, as well as sexual exploitation, abuse and harassment.

It has far reaching effects for food security by

- Reducing on and off farm capacity
- Increasing household costs
- Restricting access to extension and community support
- Preventing participation in markets, community enterprises, savings and loans groups
- Reducing economic output
- Contributing to decreased productivity.

ECONOMIC EMPOWERMENT

"Economic empowerment" can be defined as the development of the ability of the historically disadvantaged to engage in economic activity that benefits both the individuals in question and the broader society. It is seen as a more productive and less costly way to help those who would otherwise remain dependent

IMPACT

Equipping survivors of SGBV with economic empowerment skills through Village Savings and Loan Association (VISLA) programs yields positive results such as; diminishing poverty and exploitation, access to prescribed medicine, ensuring access to education for their offspring improving nutrition and impacts culture by changing the mind-sets of the refugees.

Violence of this kind included SGBV, property or economic violence, physical violence, and psychological violence. It was evident that this violence impacted negatively on women to attain economic empowerment to the extent of even causing disabilities, living independent life that was expensive and led to reduced incomes of women.

Under these conditions, domestic and workplace SGBV can play a significant role in limiting women's agency and economic empowerment. Additionally, economic participation does not necessarily lead to a reduction in the violence women experience both at home and at work.

Session 2.3: SMART Indicators that track outcomes effectively

Introduction

This session will provide trainees with the understanding of Indicators and also equip them with the skills to measure and track programme performance at all levels. It will also serve as a basis for trainees to be able to develop smart indicators that are in line with National, Regional and Global perspectives with regards to SGBV and HTP Programme monitoring and evaluation.

Session Objectives

1. To enable trainees to understand and apply indicators
2. To enable trainees to develop smart indicators on SGBV and HTP

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens

Training approaches/methodology

- Brainstorming,
- Discussion,

- Group Work,
- Presentation,
- Reading,
- Writing

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing

Preparation

The facilitator will share experience on Smart Indicators and how to track and monitor Sexual Gender Based Violence and Harmful Traditional Practises at all levels of the programme/project cycle.

INDICATORS FOR SGBV AND HTP

1. % SGBV survivors that have access to the medical treatment.
2. % SGBV survivors that have access to psychosocial support.
3. % survivors who choose to report cases
4. Number of survivors that have access to legal advice and support
5. % of survivor's who are at risk and safely relocated to safe house, shelter, or alternative location within the country, or considered for resettlement
6. Number of survivors of rape who have access to services for clinical management of rape.
7. Number of health facility staff trained on SGBV and HTP case management.
8. Number of Health facilities that are equipped with sufficient supplies and equipment for the clinical management of rape.
9. % of eligible rape survivors receive PEP (against HIV) within 72 hours of an incident
10. Number of eligible female rape survivors receive emergency contraception within 120 hours of the incident
11. % of eligible rape survivors receive prophylaxis for sexually transmitted infections within 2 weeks of the incident.
12. No of FGM cases that are reported to the Police
13. Number of FGM/C and Child Marriage cases prosecuted
14. Number of Circumcisers that dropped the knife and abandoned the practice
15. Number of child marriage cases terminated

MODULE 3 HIV/AIDS AND ITS LINK TO SGBV- HTP

Introduction

The human immunodeficiency virus (HIV) targets cells of the immune system, called CD4 cells, which help the body respond to infection. Within the CD4 cells, HIV replicates and in turn, damages and destroys the cell. Without effective treatment of a combination of antiretroviral (ARV) drugs, the immune system will become weakened to the point that it can no longer fight infection and disease.

HIV weakens the immune system by destroying important cells that fight disease and infection. Over time, HIV can destroy so many of your T-cells or CD4 cells, a key part of your immune system, that your body can't fight infections and disease anymore. When this happens, HIV infection can lead to AIDS.

Session 3.1: What is AIDS

Acquired immunodeficiency syndrome (AIDS) is a term that applies to the most advanced stages of HIV infection. It is defined by the occurrence of any of the more than 20 life-threatening cancers or “opportunistic infections”, so named because they take advantage of a weakened immune system.

AIDS, is a complex illness with a wide range of complications and symptoms. AIDS is the final stage of HIV. When individuals reach this stage, they are at high risk for opportunistic infections due to their badly damaged immune system.

AIDS was a defining feature of the earlier years of the HIV epidemic, before antiretroviral therapy (ART) became available. Now, as more and more people access ART, most people living with HIV do not progress to AIDS. However, it is more likely to occur in people with HIV who have not been tested, in people who are diagnosed at a late stage of infection, in people who are not taking ART or people who defaulted from treatment.

Session 3.2: Sign and Symptoms of HIV and AIDS

Many people who are HIV positive do not have symptoms of HIV infection. The virus can sometimes cause people to feel sick, but most of the severe symptoms and illnesses of HIV come from the opportunistic infections that attack the damaged immune system. It is also important to recognize that some symptoms of HIV are similar to common illnesses, such as the flu or respiratory infections.

Signs and symptoms commonly seen in the early stages of HIV include:

- Fever

- Chills
- Rash
- Night sweats
- Muscle aches
- Sore throat
- Fatigue
- Swollen lymph nodes
- Ulcers in the mouth

Infected individuals can have the virus for up to 10 year or more without showing signs or symptoms.

Session 3.3: Mode of Transmission

MODE OF TRANSMISSION

HIV is found in specific human body fluids. You can be infected with HIV if any of the following fluids enter your body:

- Infected Blood and blood products
- Semen (cum)
- Pre-seminal fluid (pre-cum)
- Breast feeding
- Vaginal fluids
- Rectal (anal) mucous

The main routes of HIV transmission are

- Unprotected sexual intercourse with an infected partner (s)
- Blood and other bodily fluids
- Mother to Child/vertical during pregnancy, child birth and breast feeding
- Injecting drug users and sharing of infected needles and sharp objects.

According to HIV.gov, other body fluids and waste products—like faeces, Nasal fluids, Saliva, Sweat, Tears, Urine, or Vomit don't transfer the virus unless they have blood mixed in them and you have significant and direct contact with them.

There are very specific ways that HIV can be transmitted through body fluids.

- During sexual contact. You can contract HIV through anal, oral, or vaginal sex. During sexual contact, you have contact with your partner's body fluids, which can deliver the virus into your bloodstream through microscopic breaks or rips in the linings of the vagina, vulva, penis, rectum, or mouth.
- During pregnancy, childbirth, or breastfeeding. Babies can contract HIV through the contact they have with their mother's body fluids—including amniotic fluids and blood—through pregnancy and childbirth. Infants can also get HIV from drinking infected breast milk.
- ***As a result of injection drug use:*** Needles or drugs that are contaminated with HIV-infected blood can deliver the virus directly into your body.
- ***As a result of occupational exposure***: Healthcare workers have the greatest risk for this type of HIV transmission because they may come in contact with infected blood or other fluids through *needle sticks or cuts.*
- ***As a result of blood transfusion with infected blood or an organ transplant from an infected donor:***

Session 3.1:Vulnerable and Key Population at Risk to HIV

The main routes of HIV transmission include unsafe sex without condoms, receiving blood transfusions or other blood products contaminated with HIV, sharing of needles and syringes and other injecting equipment, being exposed to HIV through contaminated surgical and other skin piercing equipment and vertical transmission from mothers with HIV to their children. HIV is fully preventable; different interventions exist to stop transmission.

However, many people are not accessing necessary information and skills to prevent HIV. In some cases, major legal and social barriers prevent people from accessing effective prevention services and measures. Some populations groups are at higher risk of HIV infection, including men who have sex with men; people who inject drugs; men that are not circumcise, people in prisons and other closed settings; sex workers and their clients; and transgender people. These populations are referred to as ‘key populations’, who are often marginalized in communities and experience major barriers in accessing HIV prevention and treatment and other health services. In some settings, other populations may be particularly vulnerable to HIV infection such as adolescent girls in some African countries.

Session 3.5: HIV Prevention

HIV PREVENTION

Reducing your sexual risk is one way to prevent the transmission of HIV. You can reduce your risk by:

- **Practicing abstinence**: If you have no sexual contact with another individual, you are 100 percent protected from contracting HIV through anal, oral, or vaginal sex—which are the main ways that HIV is transmitted.
- **Practicing safer sex**: Safer sex is being informed on sexual health and healthy relationships. It also includes talking to your partner about your interest, boundaries, and HIV status. Safer sex means you are taking extra precautions to protect yourself and your partner from sexually transmitted infections (STIs), HIV and unplanned pregnancy. To reduce your risk of contracting HIV or other STIs, you should use a barrier method (i.e., male/female condom or dental dam) every time you engage in anal, oral, or vaginal sex. Latex condoms are very effective against HIV. Lambskin condoms will not protect you from HIV, because the virus is small enough to slip through the lambskin. You should always use a water-based lubricant when you use a condom for anal or vaginal sex to help keep the condom from breaking.
- **Getting tested:** You should know your status—both for your health and the health of your partner. It is also imperative that you know your partners status prior to engaging in sexual activity. This conversation can be difficult or uncomfortable for some, but it can be as simple as saying: "When is the last time that you were tested for HIV," or "... you don't know your HIV status? We can go get tested together before we move into a sexual relationship."
- **Being monogamous:** Monogamy means being in a sexual relationship with only one person and you both are having sex only with each other. Having one sexual partner greatly reduces your risk of contracting HIV, assuming neither of you are already infected with HIV.

Session 3.6: Sexual and Gender Based Violence and its relations to HIV

The main drivers of the HIV epidemic are influenced by a wide range of gender inequalities. Child and forced marriage, Female Genital Mutilation/Cutting (FGM/C) (FGM/C) Sexual and gender-based violence (SGBV), unequal access to information, including Sexual Health Knowledge, and a lack of negotiating power and economic autonomy are also among the factors that also place women and adolescent girls at increased risk of HIV infection as well as circumscribe their responses to being infected.

Sexual and Gender-based violence (SGBV) globally considered encompassing both sexual and non-sexual physical violence, emotional abuse, and forms of child sexual abuse do lead and is link to HIV infection.

At the same time, masculine norms that stigmatize homosexuality and promote promiscuity and substance abuse increase the risk of infection among men and boys, particularly survivors of

Sexual and Gender Based Violence. This may be as a result of rape or other forms of Intimate Partner Violence (IPV)

Sexual Gender Based Violence (SGBV) can directly lead to HIV infection as, for example, a rape perpetrator may be HIV positive thus transmitting his/her victim/survivor.

However, victims/survivors of childhood sexual abuse are more likely to be HIV positive, and to have high risk behaviors.

SGBV perpetrators on PLHIV are also at risk of HIV infection since their victims are already HIV positive.

A 2013 WHO systematic global review and analysis of studies across different HIV epidemic settings underscored the association between SGBV and HIV, revealed that intimate partner violence increases the risk for HIV infection among women and girls by more than 50 percent, and in some instances up to four-fold.

Session 3.7: Type of HIV

Types of HIV

HIV 1

HIV 2

It is worth noting some people could be infected with both HIV 1 and HIV 2 but it is not a type of HIV

Misconceptions on HIV and AIDS

Being around people who have HIV eg eating with them, sleeping on the same bed, using the same utensils etc can transmit HIV

Mosquitos can transmit HIV

Oral sex is as risky as vaginal sex

I could if my husband is HIV positive

Consequences of HIV

- Tuberculosis
- Pneumocystic jevoric pneumonia
- STIs
- Cancers

- Mental problems
- Renal problems
- Hepatitis problems
- Neurological problems

Session 3.8: HIV Referral Mechanism and Services

Referral Mechanism and Services

- History taking
- Physical assessment
- Specimen collection
- Counselling and testing on HIV
- if negative give PEP and if positive put on ART
- test for pregnancy if negative give emergency contraceptive and if positive refer for ANC
- Refer for psychosocial support
- Counseling and Testing

Introduction

- Counseling is a helping relationship in which a counselor helps a counselee look into his/her own issues in a realistic way, in order to find solutions.
- HIV voluntary counseling and testing is the process by which an individual undergoes counseling, enabling him or her to make an informed choice about being tested for HIV;
- HIV voluntary counseling: a gateway to HIV prevention, treatment, care and support interventions;

Types off counselling

- 2 types of services as part of the strategy to increase people's knowledge of their HIV status

- Voluntary Counseling and Testing (VCT) or Client Initiated Counseling and Testing (CICT)

- The client voluntarily makes the decision to learn his or her HIV status and seeks for counseling and testing services out of his or her own will

- VCT emphasizes individual risk assessment, counseling that addresses the implications of taking an HIV test and strategies for risk reduction

- Provider Initiated Counseling and Testing (PICT) or HIV Counseling and Testing (HCT);This refers to HCT which is recommended by health care providers to persons attending health care facilities as a standard component of medical care

Guiding principles

All forms of HIV counseling and testing should be voluntary and adhered to the Six Cs:

- Counseling
- Consent
- Confidentiality
- Comfort - testing should be offered in a space that is clean and comfortable for the client
- Correct test results
- Connect to prevention, treatment, care and support services

NOTE Mandatory, coerced or anonymous testing is not accepted and there is a penalty for not seeking a written consent from client/patient and as closely aligned to the HIV prevention and control Act 2015.

Minimum package for CICT/HCT services

- Pretest Counseling
- Testing (test kits)
- Post-test Counseling
- Condom services (promotion and provision)
- Information on disclosure and link to treatment and psychosocial support .

Treatment

Anti-retroviral Drugs

- The current country strategy is "test and treat" but however it should not be seen as a one-time emergency. Your client has to understand what it takes to be on treatment.
- Anti-retroviral (ARV) drugs can reduce the ability of the virus to replicate, and they can thus reduce the damage that the virus does over time to the person's immune system and other vital organs.
- Usually combination of three drugs as two NRTIs + one IIs for both HIV 1 , 2 and dual infection
- Current regimen is

TDF and 3 TC and DTG

- Use of ARVs in Patients with Tuberculosis (TB)
- TB is the most common OI encountered among people with HIV infection in The Gambia. There is therefore, a need to integrate the HIV and TB services, as TB and HIV co-infection is common.
- The regimen for HIV/TB co-infections is the same (TDF/3TC/DTG) as that for those without co-infections.

- However, the dose of DTG needs to be increased in people who are treated for TB with Rifampicin as it lowers the concentration of DTG in the body. The dose of DTG should be increased with an additional 50 mg of DTG taken 12 hourly after the dose of TDF/3TC/DTG (TLD). Similarly, in children an additional dose of DTG (equivalent in strength to the amount in the combination) should be given 12 hourly after the first as for adults.
- Early initiation of ART for patients with HIV-associated TB is critical in reducing morbidity and mortality. Therefore, ART should be started as soon as possible in patients with TB.

MODULE 4 RESPONSE MEASURES: UNDERSTANDING IT, TIPS AND TOOLS TO DESIGN AND IMPLEMENT IT INTO PROGRAMING

Sessions 4.1: Preparedness to respond to SGBV and HTP cases

Introduction

The problem of sexual and gender-based violence (SGBV) has gained attraction in recent years, with increased attention to the risk and severity of violence women, men, boys and girls face in society. Gradually, this has led to recognition of how violence can also weaken social structures and, as a result, increase women and girls' exposure to abuses in the long term. These have also promoted greater understanding of SGBV response priorities and standards.

Session Objectives

1. Understand the purpose of preparedness and the tasks that can enhance readiness
2. How to put in place mechanisms to response to SGBV and HTP Cases

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens
- Projector
- White board,

- Note pads,
- Pens,
- Sticker notes.

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing
- Drama role play
- Case Study

Methodology

The methodology is highly participatory; exercises and activities are intended to prompt questions and reflection, leading to shared learning. Participation is therefore about more than listening and repeating information; you are encouraged to think critically about information that is presented, and share your thoughts and questions with the group as the training progresses.

Response measures: understanding it, tips and tools to design and implement it into programming

Preparedness to respond to SGBV and HTP cases

Emergency Preparedness aims to establish a standing capacity to respond to a range of different situations that may affect a country or region by putting in place a broad set of preparedness measures. This process allows us to be ready to deal with uncertainty and quickly adapt when the situation around us is changing rapidly. It's about being proactive and planning for potential situations that may occur. Being prepared will help ensure that the emergency intervention starts immediately and service delivery is of good quality.

Preparedness for gender-based violence relies on actions from a variety of people who have different levels of association to your work. Because so many different people can contribute in preparedness, the activity can be seems to be overwhelming. It is important to be strategic about how to do preparedness. There are different layers of preparedness to focus your time and energy.

These layers depend on your influence to get specific preparedness tasks done. Think of it like a beam of light from a flashlight – things that are closer to the flashlight beam are easier to see. People who are closer to your project are going to be easier to influence when prioritizing tasks that can help your project be better prepared. In the first layer, your organization, you have the most control on which tasks can be done using the resources and time that you have at hand.

Other tasks are going to have varying degrees of support from other actors. Your ability to get those tasks done will depend on your leverage with those other actors, be it people from other organizations that prioritize SGBV response, senior management, operations and other sectors within your organization, or the greater humanitarian community. Work to build understanding and buy-in from key figures in advance – particularly those with the power and resources to make essential decisions.

Preparedness does not have to be done all at once. Spread out the tasks; do one or two tasks per week over a period of time. It is better to be partially prepared than not prepared at all because you kept pushing off all the little tasks as a "preparedness activity". Since there can rarely enough time to do preparedness tasks, it's best to start with those tasks that you and your team will have the most influence getting done.

PREPAREDNESS TOOLS

A variety of tools exist to support your preparedness planning. Within the *SGBV response and preparedness package* you will find templates for preparedness plans, contingency plans (including scenario development), a communication and responsibilities matrix and a deployment materials checklist.

- ***Preparedness Plan Template*** – The preparedness plan template is designed to support your reflection during the training on the actions that are most likely for you and your organization in a SGBV , according to your current interventions and organizational preparedness and response.

- ***Scenario Development*** – Guidance to identify the most likely scenarios in your context. The questions to guide your scenario development are included in the second tab of the same Preparedness Plan Template spreadsheet.

- ***Communication & Responsibilities Matrix for Advent of an Emergency*** - This is a simple map that outlines who should be contacting who and what their responsibilities are when a crisis occurs. It makes sure that the lines of communications are clear and that people know what to do when the right people doing the right think at the right time.

- Emergency Deployment Tool Kit / Materials Check-List - This is a list of the materials that a response team would need if they have to deploy into a crisis situation. It lists the types and quantity of the materials needed and who is responsible to have them packed and ready.

Session 4.2: Setting up the minimum standard operating procedures to respond to SGBV and HTP Cases (Includes consent, do no harm, protection of the survivors, confidentiality etc)

Introduction

This session will expose participants to establish minimum standard operating procedures (SOPs) to respond to SGBV and HTP reported cases and provides a suitable environment to avoid the survivors being re-victimized during the process of investigation. The session will provide the opportunity for participants to share the existing SOPs under the principles of do no harm, protection and confidentiality

Session Objectives

1. To share experience on the minimum standard operating procedures (SOPs) to respond to SGBV and HTP Cases
2. To ensure the survivors consent is secured and the principles of do no harm, protection and confidentiality is guaranteed.

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing

Response to SGBV – HTP Cases

The term sexual and gender-based violence (SGBV) refers to any act inflicted against a person's will and is based on gender norms and unequal power relations between sexes. SGBV is a serious violation of several human rights and has the potential to inflict different forms of violence such as;

- Sexual
- Physical
- Emotional/psychological
- Economical

In The Gambia, there exists a strong patriarchal social structure contributing to harmful traditional practices of:

- Prevalence of FGM 75.79% (15-49 years)[24]
- Child marriage stands at 34.8%.[25]
- Both the above rates are extremely high considering the small population size of the country
- In addition globally, 1 in 4 women are victims of sexual, physical or emotional violence among the ever-married.

Response Mechanism in The Gambia

The establishment of the one-stop centers enables the provision of comprehensive care to survivors of sexual and gender-based violence, offering medical, legal and psychosocial services either within one location—a hospital or a stand-alone center—or through a referral system that links there services

The main aim of the above coordinated response model is to;

- Increase survivor safety and perpetrator accountability
- Coordinate and link core services
- Provide immediate to longer term health care
- Access to police and legal services
- Culturally and age appropriate counseling services

[24] DHS 2019-2020
[25] MICS2018

SERVICES OFFERED AT THE ONE STOP CENTER

- Health and Medical care
- Ongoing counseling
- Psychosocial and Psychological response
- Safety and security response
- Legal/justice response

GUIDING PRINCIPLES AND RIGHTS FOR WORKING WITH INDIVIDUAL SURVIVORS

- Safety and Security
- Respect
- Best Interest of the Child
- Do No Harm
- Privacy & Confidentiality
- Information
- Informed Consent
- Informed Assent
- Self-Determination and Child Participation
- Non-Discrimination and Impartiality
- Survivor's Comfort

HOW TO SUPPORT SURVIVORS OF SEXUAL GENDER BASED VIOLENCE AND HTP

Remember **The Three *L's*** which is to ***Look, Listen,*** and to ***Link***

1. LOOK

- *Introduce yourself*
- *Address urgent basic needs*
- *Be aware of the different ways that people reach out for support*
- *Recognize what you can and cannot manage*

DO'S AND DONT'S WHEN OBSERVING SURVIVOR'S

DO'S	DONT'S
• DO allow the survivor to approach you. Listen to their needs. • DO ask how you can support with any basic urgent needs first. Some survivors may need immediate medical care or clothing. • DO ask the survivor if s/he feels comfortable talking to you in your current location. If a survivor is accompanied by someone, do not assume it is safe to talk to the survivor about their experience in front of that person. • DO provide practical support like offering water, a private place to sit, a tissue etc. • DO, to the best of your ability, ask the survivor to choose someone s/he feels comfortable with to translate for and/or support them if needed	• DO NOT ignore someone who approaches you and shares that s/he has experienced something bad, something uncomfortable, something wrong and/or violence. • DO NOT force help on people by being intrusive or pushy. • DO NOT overreact. Stay calm. • DO NOT pressure the survivor into sharing more information beyond what s/he feels comfortable sharing. The details of what happened and by whom are not important or relevant to your role in listening and providing information on available services. • DO NOT ask if someone has experienced GBV, has been raped, has been hit etc.

EXAMPLE QUESTIONS OF WHAT YOU CAN ASK

- "You seem to be in a lot of pain right now, would you like to go to the health clinic?"
- "Does this place feel OK for you? Is there another place where you would feel better?
- Do you feel comfortable having a conversation here?"
- "Would you like some water?
- Please feel free to have a seat."

LISTEN

- After ensuring the survivor's basic needs are met, and that s/he is not in immediate danger, ***LISTEN.***
- The survivor may be very upset and/or confused, but as a helper it is important to stay as calm as possible
- Allow the individual to share as much or as little information as s/he would like to

DO'S AND DON'T'S WHEN LISTENING TO SURVIVORS

DO'S	DONT'S
• **DO treat any information shared with confidentiality. If you need to seek advise and guidance on how to best support a survivor, ask for the survivor's permission to talk to a specialist or colleague. Do so without revealing the personal identifiers of the survivor.** • **DO manage any expectations on the limits of your confidentiality, if applicable in your context.** • **DO manage expectations on your role.** • **DO listen more than you speak.** • **DO say some statements of comfort and support; reinforce that what happened to them was not their fault.**	• DO NOT write anything down, take photos of the survivor, record the conversation on your phone or other device, or inform others including the media. • DO NOT ask questions about what happened. Instead, listen and ask what you can do to support. • DO NOT make comparisons between the person's experience and something that happened to another person. Do not communicate that the situation is "not a big deal" or unimportant. What matters is how the survivor feels about their experience. • DO NOT doubt or contradict what someone tells you. Remember your role is to listen without judgment and to provide information on available services.

EXAMPLE QUESTION OF WHAT YOU CAN ASK WHEN LISTENING

- How can I support you?"

- Everything that we talk about together stays between us. I will not share anything without your permission."
- "I will try to support you as much as I can, but I am not a counselor. I can share any information that I have on support available to you."
- "Please share with me whatever you want to share. You do not need to tell me about your experience in order for me to provide you with information on support available to you."
- "I'm sorry this happened to you."
- "What happened was not your fault."

3. LINK – (Referral)

- ***As you support the survivor to make decisions on their next steps, ask the survivor if there is someone s/he trusts to go to for support***
- Encourage the survivor to make the decisions on whom to go to, when and why
- Do not give your own opinion of the situation
- ***If any services do exist, provide accurate information to the survivor on the available services or options for more comfort***
- Preparation is key. Make sure you have accurate, up-to-date information on the services available and how to access them
- If you are not sure a specific service exists, say so
- ***Compassionately end the conversation***
- Maintain confidentiality
- Positively reinforce any decisions that the survivor made
- Keep in mind, your role is to support the survivor in their decisions and choices, even if the survivor does not make any

***EXAMPLE QUESTIONS OF WHAT YOU CAN ASK** WHEN LINKING/REFERRING*

DO'S	DONT'S
• **DO respect the rights of the survivor to make their own decisions.** • **DO share information on all services that may be available, even if not GBV specialized services.** • **DO tell the survivor that s/he does not have to make any decisions now, s/he can change their mind and access these services in the future.** • **DO ask if there is someone, a friend, family member, caregiver or anyone else who the survivor trusts to go to for support.** • **DO offer your phone or communication device, if you feel safe doing so, to the survivor to contact someone s/he trusts.** • **DO ask for permission from the survivor before taking any action.** • **DO end the conversation supportively.**	• DO NOT exaggerate your skills, make false promises or provide false information. • DO NOT offer your own advice or opinion on the best course of action or what to do next.

- "Our conversation will stay between us and those who need to know base on inform consent."
- "I am not a counselor, however, I can provide you with the information that I have. There are some people/organizations that may be able to provide some support to you and/or your family. Would you like to know about them?"
- "Here are the details of the service including the location, times that the service is open, the cost (if applicable), transport options and the person's name for who you can talk to."
- "Is there anyone that you trust that you can go to for support, maybe a family member or a friend? Would you like to use my phone to call anyone that you need at this moment?"

Session 4.3: Creating SGBV and HTP referral pathways

Introduction

This session provides guidance to humanitarian stakeholder on how to refer SGBV survivors after disclosure. Providing information to survivors in an ethical, safe and confidential manner about their rights and options to access care is a cornerstone element of a survivor-centered referral system by which survivors can access the mix of services and support that is appropriate to their needs and wishes. Quality referral pathways are of paramount importance to enable timely interventions in response to survivors' multiple needs. Referral roles and responsibilities are assigned according to an individual's professional position and level of professional responsibility. The referral pathways differ for humanitarian actors who are SGBV specialists and humanitarian actors who are not. All humanitarian actors provide information on the services available, how to access them, and refer survivors to services. SGBV specialists provide additional support and services directly to survivors, including case management. Any humanitarian worker or service provider who is asked for information about SGBV support services should follow the referral guidelines set out in this module.

Session Objectives

1. To provide an understanding of the referral process of SGBV-HTP

Training Material

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colors (vanguards)
- Marker pens
- Pen
- Projector
- Note pad

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing

3.3.1 Types of referrals and processes

Referrals can happen in many different directions amongst different actors.

Table 5 indicates types of possible referrals.

Table : Types of referrals

FROM	TO	TYPE OF REFERRAL
Any humanitarian actor or community members	GBV case management actors	Professional care and GBV case management
GBV case management actors	GBV case management actors	It may be more appropriate for another GBV specialist to provide case management (e.g., in another area).
GBV case management actors	Multi-sectoral response services	To provide timely and quality care to GBV survivors such as medical services. Refer to Chapter 7 for more information about multi-sectoral response services. According to the survivor's needs and initial assessment, care should be provided and comprehensive information about other services and the consequences and benefits of accessing them should be given. At this point, the survivor will be referred to additional services of his/her choice and based on her/his needs.

GBV case management actors	Other services	During or following the period of time when a survivor is receiving care from specialists, they may also be in need of additional services not directly GBV-related (e.g. food assistance, shelter, NFI, education, etc.) as part of their case management action plan. GBV case management actors will refer survivors to the relevant agencies, and follow up if they are acting as case managers for the survivor.

Confidentiality

Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. It promotes safety, trust and empowerment. It is an important part of the survivor-centered approach, and should be given consideration at all times. Confidentiality might need to be broken in certain circumstances. These are:

2. If the survivor is an adult who threatens their own life or who is directly threatening the safety of others, in which case referrals to lifesaving services can be sought.
3. If the survivor is a child, when there are concerns for his/her health or safety.
4. When there are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers. A survivor should be informed about any exception to confidentiality.

Informed consent

Informed consent refers to the giving of approval after careful consideration. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given, and must be able to evaluate and understand the consequences of an action. Informed consent is a crucial step in providing quality care and response to a SGBV survivor. The purpose of documenting the SGBV incident and gaining the survivor's consent to share the information with other organizations and/or services is to facilitate protective measures and the healing process of the survivor through appropriate referrals. Informed consent is an important step in recognizing the fundamental rights of the individual of taking care of their own life. It places the survivor at the center of the healing process. It empowers them to decide what to do

about their life and body. Asking for informed consent means asking the survivor for permission to undertake any action (e.g., a referral, a medical exam) and to share information about them with others (e.g., referral services). Informed consent should be voluntarily and given freely by the survivor based upon their clear appreciation and understanding of the facts, implications and future consequences of any action that will be undertaken.

All humanitarian actors must explain to the survivor any steps involved in the offered service, as well as inform them about additional available services according to their needs. This must include explaining in detail any potential negative aspects (e.g., cost, distance, lack of female staff) or consequences, as well as potential benefits related to accessing the services.

Under no circumstances should the survivor be pressured to consent to any examination, conversation, assessment, interview or other intervention with which they do not feel comfortable. A survivor can also at any time decide to stop an intervention (e.g. during a medical examination).

Table summarizes the steps to ensure informed consent.

STEPS TO ENSURE INFORMED CONSENT	
Step 1: Provide all information	To ensure consent is truly informed consent, a humanitarian actor must provide all possible information and options available to the survivor. They must explain what is going to happen to the survivor after the referral. They must also explain to the survivor that they have the right to decline or refuse any part of any services.
Step 2: Ensure the survivor understands the implications of any referral	Explain the benefits and risks of the service to the survivor. GBV survivors have a right to control how information about their case is shared with other agencies or individuals, and should understand the implications for sharing information so that they can make decisions based on full knowledge before the information is shared.
Step 3: Explain the limitations to confidentiality	Make the survivor aware that their information may need to be shared with others who can provide additional services.

Step 4: **Ask for consent**	Ask the survivor if they give consent for you to contact other services and to pass on their name. For non-specialized providers, this can be done verbally. A written document is not advisable, especially if confidentiality procedures are not known or cannot be followed. During case management, written consent should be obtained as much as possible
Step 5: **Check limitations of consent**	After being made aware of any risks or implications of sharing information about their situation, the survivor has the right to place limitations on the types of information to be shared, and to specify which organizations can and cannot be given the information.

Informed consent form

An 'Informed Consent Form' (Annex VI) should be used by GBV specialists within the framework of case management when referring the survivor to specialized GBV services. When possible and relevant, the survivor should sign the form to indicate they understand and agree to the care they choose. Before a survivor signs a consent form, the GBV actor should confirm the survivor understands how the provider will use, store and disseminate the information. Service providers should also sign the form.

Asking for a signature may not always be appropriate, especially if the existence of such a form signed by the survivor poses risks to their safety. Alternative options are for the provider to sign a form confirming consent was given. For those who cannot sign, a thumbprint or "X" may be appropriate, otherwise verbal consent must be obtained. If an informed consent form is not available for a survivor to sign, verbal informed consent must be obtained.

If the survivor does not consent to sharing information, information cannot be shared with outside organizations. Even if a survivor does not provide their consent to share information with other organizations, they are still entitled to receive appropriate and timely care.

The generally accepted approach to obtaining informed consent is as follows:

- ✓ Read aloud to the survivor the consent statement included in the standard informed consent form, allowing time for the survivor to ask questions and seek clarification of individual points.

- ✓ After explaining the key points, ask the survivor to repeat back in their own words why they think consent is being requested, what they think they will gain from providing consent, what they have agreed to consent to, what the potential consequences of giving consent might be, and what would happen if they refuse to give consent. This will allow the service provider to assess the survivor's understanding of each issue and if necessary, reinforce anything that was not clearly understood and/or correct any misunderstanding.

Informed consent for survivors with disabilities

Persons with disabilities are not a homogenous group. Some may have long-term disabilities, whereas others may have short-term disabilities. Their disabilities might be physical, sensory, intellectual and/or psychosocial. Gaining informed consent from persons with disabilities can sometimes be difficult depending on the type and extent of their disabilities. Perceptions about the capacity of a person with a disability and the level of control the caregiver may have over the person also present barriers to gaining truly informed consent from GBV survivors with disabilities.

The Convention on the Rights of Persons with Disabilities states that an individual cannot lose their legal capacity to make decisions simply because they have a disability.16 It is therefore important to assume initially that all adult GBV survivors with disabilities can provide informed consent, and to follow the same procedures as described above. Some additions17 to these procedures are:

- ✓ Asking the survivor if they want some support to help them give informed consent.
- ✓ Adapting communication methods to match those preferred by and effective for the survivor.
- ✓ Taking more time to ask questions to ensure the survivor understands everything, including possible consequences of accessing services.
- ✓ Checking to ensure they are not being coerced or forced to make decisions. http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf.
- ✓ For more details of how to ensure a GBV survivor with disabilities has the capacity to give informed consent, referral.

Informed consent/assent for child survivors

Generally, children who have experienced GBV do not disclose it directly. Identification is more common.

Identification occurs, for example, when someone witnesses child sexual abuse or when the child contracts a STI or becomes pregnant.

As a general principle, permission to proceed with providing assistance is sought from both the child and their caregiver (e.g., parent) unless it is deemed inappropriate to involve the caregiver. Permission to proceed with case management and other care and treatment actions (e.g., referrals) is sought by obtaining 'informed consent' from caregivers of older children and/or 'informed assent' from younger children.

Informed consent and informed assent are similar, but not exactly the same.

- ✓ Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent.
- ✓ To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.
- ✓ Informed assent is the expressed willingness to participate in services.

Table provides a summary of the guidelines for obtaining informed consent/assent from children

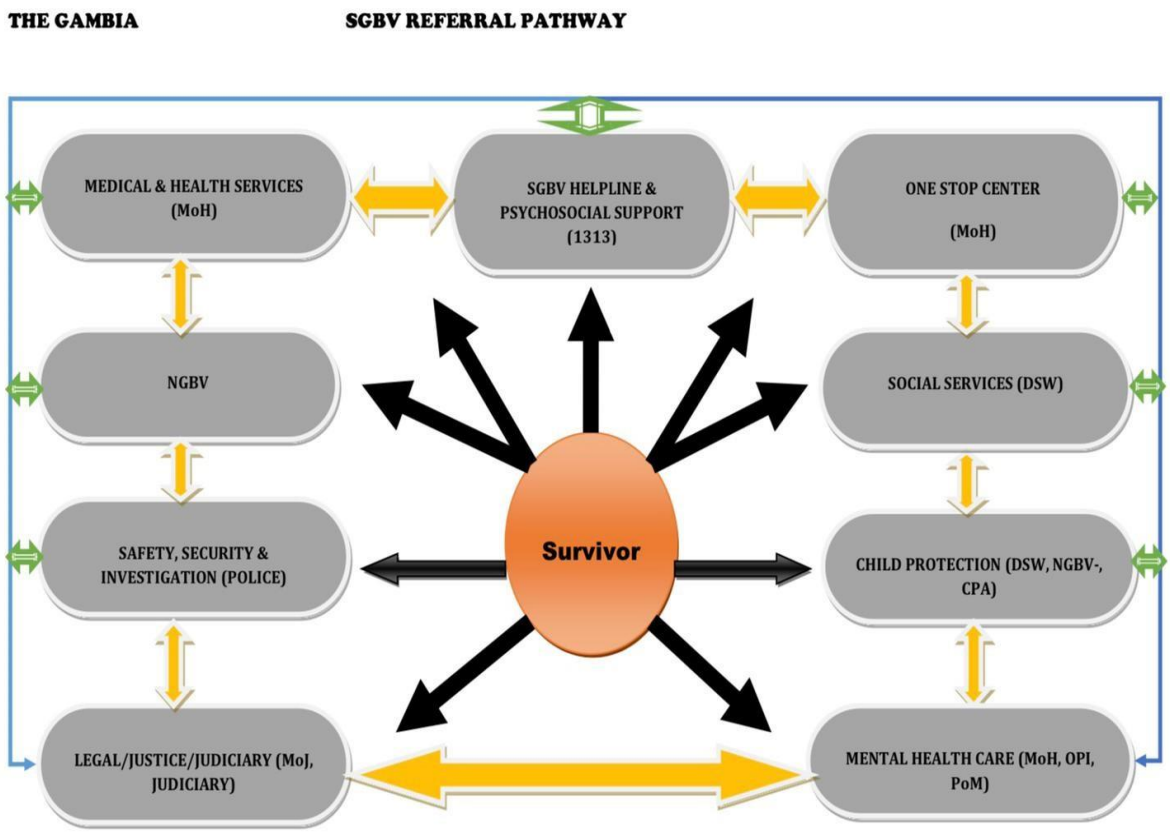
AGE GROUP	CHILD	CAREGIVER	IF NO CAREGIVER OR NOT IN THE CHILD'S BEST INTEREST	MEANS
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, Written consent
15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

SGBV REFERAL PATHWAY

The National Referral Pathway guideline facilitates primary duty bearers and actors with;

- Information on how to respond to SGBV cases
- Guide survivors of SGBV on where to seek assistance and what services are available at different referral points
- The diagram below explains the SGBV referral pathway developed by actors working on protecting the rights of most vulnerable population who are subjected to SGBV
- A service directory is available that provides information of all the necessary actors involve in delivering SGBV services across the country
- However, it is important to note that, the assigned personnel in the directory are subjected to change as they may not be permanent staff at these centers

ROLES AND RESPONSIBILITIES OF MINISTRY OF HEALTH



- The Ministry of Health (MoH) has oversight responsibility for all public hospitals where the One Stop Centers are lodged

- Under MoH, The Reproductive, Maternal, Neonatal, Child and Adolescent Health Program Unit is responsible for advising on all matters affecting the reproductive life of all persons living in the Gambia through the promotion of sexual and reproductive health and prevention and reduction of morbidity and mortality associated with sexual and reproductive ill-health
- The unit is also responsible for the formulation of policies and guidelines for the implementation of Reproductive Health (RH) activities, overall coordination and implementation of RH activities, resource mobilization and distribution of RH tools, equipment and family planning Commodities

ROLES AND RESPONSIBILITIES OF MINISTRY OF HEALTH IN THE OPERATION OF THE ONE-STOP CENTERS:

- Ensure proper coordination within sectors
- Ensure SGBV is integrated in existing service delivery
- Training of health care workers for the effective management of SGBV cases including the clinical management of rape cases
- Provide protocols and guidelines for the management of SGBV cases
- Ensure the availability of personnel and medical supplies for the smooth running of the centers.
- Resource mobilization for the operation of the centers
- Incorporate the SGBV referral pathway into the existing referral system
- Monitor and supervise service delivery
- Provide data on the cases reported at the one stop centers

STANDARD OPERATING PROCEDURES (SOPS) FOR THE HEALTH CARE WORKERS

- Create an enabling environment for service provision, ensure survivor's safety and assure privacy and confidentiality
- Act in a non-discriminatory and non-judgmental manner towards survivors
- Explain the services available to the survivor for informed choice
- Obtain informed consent or assent on the presence of escort and decision on the available services
- Allow the survivor to narrate their story
- Provide services; medical examination, treatment and basic psychosocial support
- Develop a care plan for the management of the survivor

- Collect any forensic evidence that will help subsequent legal action
- Support data entry and reporting of SGBV cases
- Provide a medical report within 72 hours
- Assess the client and ensure provision of appropriate services
- Doctors to serve as witnesses in court

MINISTRY OF GENDR, CHILDREN AND SOCIAL WELFARE (MoGCSW)

- The Ministry of Gender, Children and Social Welfare is responsible for advising the Government on all matters affecting the development and welfare of women, children and other vulnerable groups
- The Ministry serves as a coordinating body in gender mainstreaming efforts to ensure that the perspectives of both men and women are central to policy formulation, legislation and resource allocation
- In this regard, they are the main body responsible for the overall coordination and harmonization of efforts of all stakeholders working on Sexual Gender Based Violence and the empowerment of women

ROLES AND RESPONSIBILITIES OF MINISTRY OF GENDER, CHILDREN AND SOCIAL WELFARE ON THE OPERATION OF THE ONE-STOP CENTERS:

- Lead the agenda on promoting gender equality and equity, protecting the rights of women and children and other vulnerable groups in the Gambia
- Provide policy guidance on SGBV case management
- Coordination and harmonization of inter-agency technical working groups on SGBV response services
- Establish shelters and safe spaces of SGBV survivors
- Ensure survivors are integrated back to their normal life (livelihood skills, re integration)
- Do capacity needs assessment of social workers and conduct regular training on SGBV
- Advocate for budgetary allocation to support survivors and create a survivor's fund.
- Community sensitization on SGBV
- Ensure functional data collection on GMIS

DIRECTORATE OF SOCIAL WELFARE REGIONAL LEVEL

INTRODUCTION

- The Department of Social Welfare is under the Ministry of Women, Children and Social Welfare. They play a key role in assisting survivors, especially child victims
- They ensure proper needs assessment and provide psychosocial support through counselling for survivors and their families. Based on their needs, placements are offered at the shelter for children and re-integration.

ROLES AND RESPONSIBILITIES OF THE DIRECTRAITE OF SOCIAL WELFARE ON THE ONE-STOP CENTERS:

- Complete the referral forms for survivors
- Allocate the case to a social worker
- Conduct home visit for assessment, prepare a report with recommendations and share with partners
- Provide psychosocial support
- Ensure case management and follow up
- Monitoring and supervision to ensure survivors are reintegrated back to their normal lives

ATTORNEY GENERAL'S CHAMBER & MINISTRY OF JUSTICE

- The Attorney General's Chamber and Ministry of Justice seeks to ensure that SGBV cases that are forwarded to the office are effectively investigated and diligently prosecuted within a reasonable time
- The judicial outcomes of these cases are published for the general public to know and to serve as deterrence for future perpetrators of SGBV

ROLES AND RESPONSIBILITIES OF ATTORNEY GENERAL'S CHAMBER AND MINISTRY OF JUSTICE IN THE OPERATION OF THE ONE-STOP CENTERS:

- Provide legal opinions on SGBV cases to the police
- Coordinate with the police to ensure investigation and proper prosecution of SGBV cases.
- Provide reports on SGBV cases that have been prosecute
- The SGBV unit provides legal counselling to the survivors
- Prosecution of rape and other SGBV cases
- Conduct sensitization programs to encourage victims to report cases and witnesses to come forward and testify in court
- Provide training to the SGBV unit of the Ministry, and the Police.

- Facilitate transportation for witnesses
- Coordinate with the Ministry of Women, Children and Social Welfare, and the Police to ensure an effective integrated response to SGBV, including information to survivors at the Shelter for Victims of Domestic Violence.

Non-availability of services

It might be the case that one or more services are not available or not accessible at a given time. It is important not to raise unrealistic expectations for a survivor about what services and support they may be able to receive. It is therefore important all actors maintain up-to-date knowledge about what community and GBV specialized services are operating in their areas.

Session 4.4 Psychological first aid/ psychosocial support to response to SGBV and HTP informant

Introduction

In emergencies, people are affected in different ways and require different kinds of mental health and psychosocial support. The population at large benefits from basic services and a general sense of security. Community and family structures can promote well-being and the protection of women, children and other vulnerable groups. Additionally individuals and groups at risk, such as women and girls, may benefit from focused person-to-person services, such as counselling, case management and emotional and practical support provided by trained community or social workers. Finally, a smaller proportion of the population, who suffer from specific mental health issues, will require specialized services delivered by mental health professionals, such as a psychologist or psychiatrist in a manner which is appropriate to the local social and cultural context.

Session Objectives

1. To provide an understanding of Psychological support in response to SGBV-HTP
2. To understand the PFA and PSS in response to SGBV – HTP cases

Training Materials

- Flip charts
- Markers

- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing

Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental distress. This includes providing PFA and linking survivors with other services, psychosocial interventions (such as groups activities), and, where indicated, specialist mental health care. It also includes engaging the broader community to play a role in protecting dignity, promoting psychosocial wellbeing, and preventing mental health problems associated with GBV and the stigmatization/isolation of the survivor.

All MHPSS activities with survivors and communities must adhere to the GBV guiding principles of confidentiality, safety, respect and non-discrimination. It is never acceptable to share information about a survivor's case without their explicit informed consent. All MHPSS actors who interview or have direct contact with survivors should:

- Be familiar with the guiding principles and be able to put them into practice;
- Be familiar with GBV core concepts and definitions; and,
- Assess immediate safety and security risks of the survivor.

Table provides summary guidance on how MHPSS actors should interact with survivors.

Table: MHPSS interaction

DO	DON'T
Welcome the survivor and make them feel at ease	Do not blame or judge them
Listen to the survivor and ask only non-intrusive, relevant and non-judgmental questions for clarification only.	Do not press the survivor for more information than they are ready to give.
Reassure the survivor that GBV is always the fault of the perpetrator and never the fault of the survivor.	Do not justify the perpetrator's' action or ask the survivor to forgive or forget the perpetrator.
Give honest and complete information about services and facilities available, as well as the potential consequences and benefits in accessing these.	Do not use technical jargon or medical language.
Empower the survivor by helping them make informed decisions.	Do not tell the survivor what to do. Do not provide examples of other cases that might influence their choice.

Figure 2 shows the four levels of MHPSS care for GBV survivors linked to the survivor's mental state and the care provider.

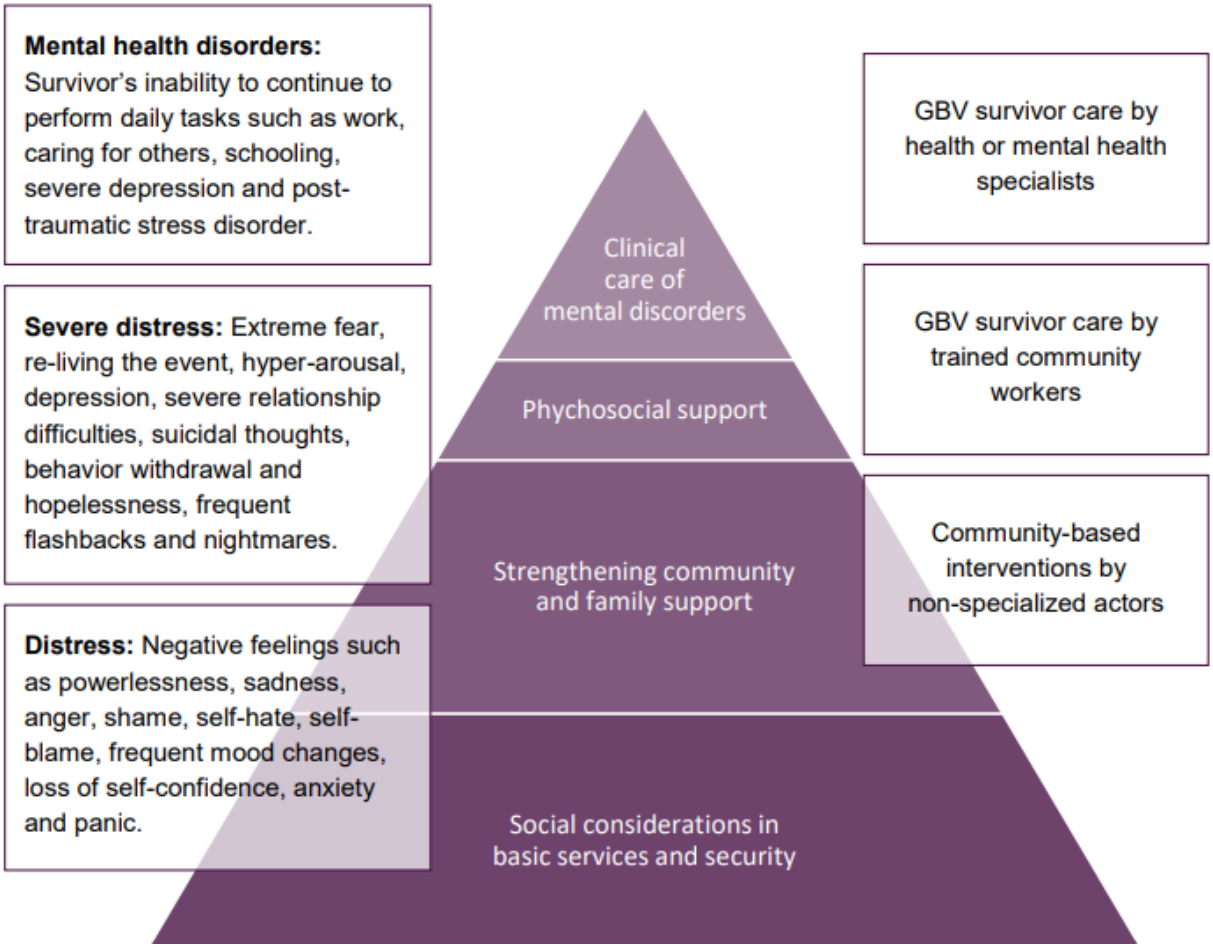


Figure shows the importance of ensuring, firstly, that the basic services and security needs of GBV

Level 1 : survivors are addressed. Then, from the perspective of MHPSS, the most appropriate support for GBV survivors is generally family and community-based interventions by non-specialized actors to support survivors when they are distressed. Some GBV survivors require more specialized psychosocial support, and some may need clinical care.

Response services for GBV survivors focus primarily on the top three levels.

Level 2: Strengthening community and family support. Provided by service providers and community members, the support is intended for community members who are able to maintain their mental health and psychosocial wellbeing through receiving help from their community and family. It seeks to respond to immediate, non-complex psychological distress, and to prevent further severe forms of distress and mental health disorders. It can include working with community leaders, setting up safe spaces for those at risk of GBV and their family members

(especially women and adolescent girls), GBV awareness-raising activities, promoting women and girls groups and age-tailored activities including self-help and resilience initiatives, livelihoods activities, and facilitating community-mobilization activities (including women's and men's support groups, dialogue groups and community education and advocacy). Typically, GBV survivors are referred to or join community activities without other participants or facilitators knowing about GBV incidents. This confidentiality provides some protection to survivors against stigmatization.

Level 3: Psychosocial support by trained workers. Provided by psychosocial workers and trained GBV staff who are able to give PFA to the survivors as part of their care, and who know how to protect and promote survivors' rights to dignity through informed consent, confidentiality and privacy. The support seeks to respond to survivor's emotional issues and psychological distress. It can include providing basic emotional support, providing opportunities for survivors to discuss their experiences, discouraging negative coping mechanisms, providing one to one or group PSS sessions and encouraging participation in everyday activities In the application of these SOPs, this service is usually provided together with and in the framework of case management.

Level 4: Clinical care of mental disorders. Provided by trained local health workers, and international medical organizations. This support is intended for survivors with mental disorders such as post-traumatic stress disorders. 34 It seeks to respond to severe behavioral and emotional disorders, including psychoses. It can include the prescription of psychiatric drugs, as well as a combination of biological, social and psychological interventions.

Session 4. 5: Psychological/ psychosocial support to victims, staff and partners

Introduction

Mental health and psychosocial support (MHPSS) is located between the protection and health sectors and describes support that seeks to protect or promote psychosocial well-being and mental health. The word 'psychosocial' captures how psychological well-being is directly linked to one's social surroundings, including community, family and cultural networks. MHPSS includes four layers of service provision that become more specialized as they progress

Session Objectives

1. To learn from the field point to the ongoing need for GBV

2. To provide survivor-centered approach and on making safe referrals
3. Working in PSS and/or GBV response is emotionally difficulty, and ongoing staff care

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing

Trainings on GBV core principles for all protection staff Using the GBV sub-cluster and WHO resources, World Vision trained its local implementing partner on PM+ and case management, including GBV core concepts, disclosure and safe referrals. In order to increase capacity across the board, World Vision targeted both specialized and non-specialized protection staff working on the front line with local communities. Importantly, the trainings were not only about acquiring technical skills but also about learning the essential skills and traits to work with GBV survivors, such as building trust, normalizing the client's reaction, eliminating judgment, confidentiality, compassionate, active listening and openness.

The trainings resonated with many participants, especially women staff members who were personally aware of GBV seen in their communities in Syria, before and after the war.

In fact, many women shared stories of family and domestic violence, underlying the importance of creating a safe space in trainings.

The staff in the training engaged in breathing exercises and grounding techniques, and individual staff case sessions and ongoing follow-up were provided. Overall, there is a lack of psychosocial support and protection services, including shelters for GBV survivors and legal services, as well as ongoing complex displacement.

There is an ongoing need for GBV response which includes PSS interventions. Protection staff do not need to be GBV experts, particularly to work in PSS interventions at Layer 1 and Layer 2 of the MHPSS intervention pyramid, which includes psychological first aid and community and family supports. Rather, it is important for an understanding of GBV core principles to be mainstreamed across PSS interventions. This can include training protection and health staff in understanding the survivor-centered approach and making safe and confidential referrals. Working in PSS and/or in GBV response is emotionally challenging for staff.

Ongoing staff care for humanitarians and development practitioners is essential in providing sustainable interventions. The Inter-Agency Minimum Standards on GBViE Programming include guidance notes, indicators and examples of key actions for each of the 16 Standards. This resource should be used for developing a common understanding of the minimum requirements for GBV prevention and response in emergencies

MODULE 5 IN-COUNTRY AND INTERNATIONAL ADVOCACY

Session 5.1: Multi stakeholder approach and collaboration with actors to address SGBV and HTP and to exchange information

Introduction

A case study is a detailed study of a specific subject, such as that of a person, group, place, event, organization or a phenomenon. Case studies are commonly used in social, education, clinical or Business Research. This session will provide trainees with the understanding of Case studies and also broaden their horizon the linkages between SGBV and HTP

Session Objectives

1. Understand the concept and meaning of case study
2. To enable trainees to understand the effect of Child marriage
3. To know the linkage between Child Marriage and HIV/AIDS
4. Understand the role of culture in compounding SGBV

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,
- Reading,
- Writing
- Role play

CASE STUDY OF A SURVIVOR OF CHILD MARRIAGE

Nyonkoling was in her last month of pregnancy but was very worried because she had been under pressure from her in-laws and husband to have a boy. Expectations were very high, and everyone said: "The first child has to be a boy." Nyonkoling was terrified to inquire from the doctor if she was expecting a boy or a girl because of the fear that the baby could be female. On her day of birth, her mother-in-law followed her to the clinic. She had a girl. When her in-laws and husband found out, they were sad and blamed her. Even so, Nyokonling warmly welcomed the baby, who was named Nyakonding after Nyonkolings mother-in-law, and therefore, received some love and acceptance. At home, the child was called Nyako. When she was seven months old, doctors

discovered that Nyako had an impairment in her leg. The family blamed Nyonkoling for the defect; they thought Nyonkoling was jinxed. When Nyako was two years old, Nyokoling gave birth to a boy who received all the family's attention. He was named Bamba and was the pride of the family. Nyokonling had a total of five children: three boys and two girls. All the children were enrolled in school, but only the boys were allowed to complete primary school. After being withdrawn from school, Nyako and her sister were given the tasks of helping with domestic work and taking care of their brothers. The boys played while the girls performed chores. When Nyako was 16, her father delivered her for marriage to Mr. Janko, who worked as a Fisherman in the Gambia. His work often kept him away from home for long periods of time. Nyako became Mr. Janko's third wife and was mistreated by his other wives for being the youngest and having a disability. She also suffered psychologically and physically because her child marriage meant that she started sexual activity as an adolescent. When she first married, she didn't know about condoms or how to negotiate safe sex practices with her husband. She once asked her husband to use a condom and he yelled, what? And beat her severely. "You don't trust me?" At age 17 she became pregnant and miscarried at six months. Shortly thereafter, Mr. Janko learned that he was living with HIV/AIDS, within a few years, all the wives, including Nyako, were too. Five years later, Nyakos husband and his first wife died due to complications related to HIV/AIDS. Nyako was 22 years old, the mother of one child, and a widow without the means to survive. She returned to her village, but not to her parents' house as she felt hurt by her father's behavior. She went to live with an aunt and uncle and worked on their small plot of land to help provide for her child. Nyako aunt encouraged her to visit the health clinic to receive counseling on living with HIV/AIDS. Now, Nyako visits her health clinic regularly to monitor her HIV/AIDS status. She's learned that by taking care of her health, she can lead a long and fulfilling life. Nyako also recently enrolled in a microcredit program. She plans to start her own business so she can improve her life and take care of her son

Session 5.2: Multi-sectorial Prevention and Response to SGBV and HTP

Introduction

This session will provide trainees with the understanding of a comprehensive multi-sectoral approach to the prevention and response to Sexual and Gender Based Violence and Harmful Traditional Practices (SGBV and HTP)

Session Objective:

By the end of the session, the participants will be able to:

1. Identify the characteristics of a comprehensive multisectoral approach
2. Response to SGBV and HTP
3. Identify concrete actions to strengthen the multisectoral response to SGBV and HTP

Training Materials

- Flip charts
- Flip chart stand
- Markers

- Glue Tag/Stickers
- Manila cards or small papers of different colors (vanguards)

Methodology/Approach

- Brainstorming,
- Discussion,
- Group Work
- Presentation

Stakeholder Identification process

The procedures or guidelines for a realistic Multi-Sectoral Approach mechanism

1. Identify and engage key stakeholders/actors

2. in sector-specific response and prevention action

4. Establish reporting/referral procedures (inter-organizational)

5. Establish documentation system; train relevant actors

6. Establish systems for coordination and information sharing, and staff well-being.

7. Conduct a range of awareness raising with the community

8. Monitor and evaluate activities, training, etc. Revise as needed

9.Explain that the activities for Response and for Prevention must be developed simultaneously.
10.Summarize the training and discussions from this module

11.Prevention and Response Plan addresses: − Outcomes/consequences − Causes/contributing factors Module

The requirement of the above Multi-Sectoral Approach Mechanism Guideline

- It should involve all sectors and actors to agree and abide by a set of Guiding Principles
- It encourages team spirit
- It should be well coordinated
- It requires training and capacity building with an array of actors and stakeholders
- It supports full survivors' involvement in the process of planning and implementation
- Prevention involves community awareness raising in the community and in humanitarian aid organizations

- Increased awareness will hopefully lead to behavior change leading to more survivors coming forward for redress.
- Response services must be in place and responsive to the need of survivors.
- If services are poor or uncoordinated it will cause more harm than good because survivors will not come forward for help.

Session 5.3: Coordination, Communication and Collaboration

Introduction

The common and old model of addressing SGBV and HTP use to be fragmented with different stakeholders and partners working in isolation. However, this session intends to equip participants to understand the significance of collaboration in preventing and responding to SGBV and HTP issues

Session Objectives:

1. To understand the need for good interagency, multisectoral coordination.
2. To understand the importance of coordination and Collaboration in SGBV and HTP
3. Identify strategies and methods for maximizing interagency, multisectoral coordination, communication, and collaboration.
4. To enable trainees to understand the steps needed to develop a well-coordinated and effective interagency, multisectoral GBV prevention and response programmes

Training Materials

- Flip charts
- Flip chart stands
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colors (vanguards)

Methodology/Approach

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,

Coordination, Communication and Collaboration are crucial if we want to assist survivors and prevent further acts of SGBV and HTP in the communities we serve. It is a good idea to have a

coordinator—or leader—until the system works more smoothly. Establish regular interagency coordination meetings. Agree on agenda items, keep the meetings on-task, time limited, and carefully facilitate discussions to ensure discussion of problems and successes, maximize communication and avoid members becoming passive and disengaging.

Coordination involves sharing information about gender-based violence incident data, discussion and problem-solving among actors and stakeholders about prevention and response activities, and collaborative monitoring, evaluation, and ongoing programmed planning and development.

Session 5.4: Coordination Components

Coordination and interagency, multispectral SGBV prevention and response programmes

Introduction

There are specific minimum standards and components that should be in place in any setting to provide services to survivors and prevent gender-based violence. Effectives prevention and response to SGBV is an interagency, multisectoral, interdisciplinary, collaborative effort placing (involvement) the community at the center

Session Objectives:

1. To enable participants to understand the steps needed to develop a well-coordinated and effective interagency, multisectoral SGBV prevention and response programmes

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)

Methodology/Approach

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,

Requirements for a well-coordinated Multi-sectoral Approach Mechanism

- Establish and continuously review methods for reporting and referrals among and between different actors. Referral networks should be free of bureaucratic delays and "red tape," focusing on providing prompt and appropriate services to survivors.
- Agree on an Incident Report Form, to be used by all actors receiving referrals of cases of sexual/gender-based violence. Use the form consistently.
- Share written reports, especially monitoring and evaluation reports and incident data among actors and stakeholders.
- Convene regular meetings of key actors and stakeholders: - Monthly camp level meetings to discuss camp specific information, data, and activities - Monthly regional (e.g., field office, sub-office, district level) meetings to discuss information, data, and activities occurring in that region. Monthly country level meetings to discuss information, data, and activities country wide.

5. Coordination meetings should serve a number of purposes:

- Share information within and between sectors

Critically analyze activities by identifying gaps in services and strategies for improvement and strengthening current activities. Also, oversee the implementation of the strategies identified.

- Provide a supportive forum for actors to seek guidance and assistance from colleagues. Also, provide an opportunity for constructive feedback, problem

-Solving complex or difficult cases and report to the committee.

- Clarify the roles and responsibilities of all those involved with the planning, implementation and monitoring of prevention and response activities.

- Plan, schedule, and co-ordinate activities, such as staff training, community education and awareness raising.

- Continuously build shared ownership of gender-based violence programmers and effective partnerships between all involved.

The designated "Lead Agency" is responsible for encouraging participation and facilitating meetings and other methods for coordination and information sharing.

Coordination involves sharing information about gender-based violence incident data, discussion and problem-solving among actors and stakeholders about prevention and response activities, and collaborative monitoring, evaluation, and ongoing programmed planning and development.

Session 5.5 Information gathering, case studies, and research on SGBV and HTP

Introduction

This session intends to expose participants to scientific method of information gathering case studies and research on Sexual and Gender Based Violence, Harmful Traditional Practices including use of SGBV assessment tools at workplace.

Assessment tool that is most recommended for a humanitarian setting may need some adjustment for a Refugee setting. Rather, SGBV and HTP Programme Managers are expected to draw from existing and tested materials to develop assessment tools that are appropriate and relevant for use in a specific setting.

It aims to show the various ways and methods of Sexual Gender Based Violence (SGBV) And Harmful Traditional Practices Information (HTP) Gathering Tools and Tips

Session Objectives

- To share knowledge on information gathering, case studies and research on SGBV and HTP with participants
- Participants are skillful on SGBV and HTP assessment tools administration

Training Materials

- Flip charts
- Flip chart stand
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)

Training approaches/methodology

- Brainstorming,
- Discussion,
- Group Work,
- Presentation,

SEXUAL GENDER BASED VIOLENCE (SGBV) and HARMFUL TRADITIONAL PRACTICES INFORMATION (HTP) GATHERING TOOLS AND TIPS

Types of Assessment Tools

- SGBV Assessment – Areas of Inquiry
- Sexual Violence Assessment – Short Interview Form

- Camp/Settlement SGBV Safety Audit
- Laws, Policies, and Policing: Information Gathering Checklist
- Key Informant Interview Guides
- Female Genital Mutilation Registers
- Police Gender Based and Sexual Violence Registers
- GMIS on SGBV
- MISP Checklist Example (from International Medical Corps)
- Situation Analysis Form (GBV)
- Focus Group Discussion Guide Sample
- Focus Group Discussion Questions – More Ideas
- Assessment Toolkit Sample (from International Rescue Committee)

GBV Assessment - Areas of Inquiry

General Information & GBV Basics

Demographics (desegregation by age and sex)

Types of gender-based violence

Risk factors for different types of GBV

Survivor profiles, including mothers of children born as a result of sexual violence

Perpetrator profiles

Survivor needs and preferences for assistance and support

Community Profile

Community knowledge, attitudes and practices about gender and gender-based violence

Forms of SGBV that are occurring; how the community perceives each type; words used to describe these acts

Community attitudes and behavior toward survivors/suspected survivors and

Perpetrators/suspected perpetrators

Traditional/religious beliefs and practices

Level of women's participation in decision making

Norms around age and gender, e.g.

Roles and opportunities for women; status of women; women's empowerment

Roles and opportunities for men

Status of children; community views about children's participation; school attendance (boys and girls)

Community-based protection systems

Accessibility and Safety of services and facilities

Mapping of services: village/settlement/camp services and facilities (locations,

organization, accessibility, etc.)

Inclusion of women in planning, delivery, and decision making about services

Security Measures

Types and numbers of police and security staff/volunteers in and around the setting

Proportion of female security staff

Methods used for identifying security threats and risks

Involvement of community

Disclosure, Help Seeking, and Referral

Entry points for survivors to seek help

Presence of referral pathways and systems

Confidentiality and information sharing

Service provider knowledge, attitudes, behavior; application of guiding principles

Involvement of community in helping survivors and assisting with referrals

Survivor Support Services

Availability, accessibility, quality of:

Health care

Psychosocial support

Security

Legal justice

Include: traditional practitioners, community-based groups, NGOs, UN's, government

Sensitivity, awareness, knowledge and attitudes of service provider staff and volunteers

Involvement of community in supporting survivors and their reintegration into the community

MODULE 6: LAWS OF THE GAMBIA PROHOBITING SGBV&HTP

Sessions 6.1: List of National Legislations on SGBV and HTP

Introduction

This session intends to expose participants to the existing national legislations on Sexual Gender Based Violence and Harmful Traditional Practices in The Gambia. The session will focus on the punitive provisions of the Constitution of the Gambia (1997), The Criminal Code, Women's Act 2010 (Women Amendment Act 2015), Sexual Offences Act 2013, Domestic Violence Act 2013, Children's Act 2005 amended in 2016 to prohibit child marriage, Tourism Offences Act and Trafficking In Persons Act.

Session Objectives

1. Understand national legislation on SGBV and HTP
2. Explore on the content of the laws and punitive provision

Training Materials

- Flip charts
- Markers
- Glue Tag/Stickers
- Manila cards or small papers of different colours (vanguards)
- Marker pens
- Projector
- White board,
- Note pads,
- Pens,
- Sticker notes.

Training approaches/methodology

- Brainstorming,
- Discussion,

- Group Work,
- Presentation,
- Reading,
- Writing

LIST OF NATIONAL LEGISLATIONS ON SGBV and HTP

1. The Constitution of the Gambia (1997)
2. The Criminal Code
3. Women's Act 2010 (Women Amendment Act 2015)
4. Sexual Offences Act 2013
5. Domestic Violence Act 2013
6. Children's Act 2016
7. Tourism Offences Act
8. Trafficking In Persons Act

Sessions 6.2: Punitive provisions of the Women's Act 2010

PUNITIVE PROVISIONS OF THE WOMENS ACT

- **Section 4:** Right to dignity – according to this section all women should be treated with dignity.
- **Section 5:** Right to life, integrity and security of the person - in accordance with this provision women have the right to life, be treated with integrity and security and that pregnant and nursing women shall not be subject to the death penalty.
- **Section 6:** Protection from violence - this section protects all women from all forms of violence be it sexual, physical, psychological or economic violence.
- **Section 10:** Prohibition of discrimination - this section criminalize all forms of discrimination against women.
- **Section 11:** Right to movable and immovable property – the section make it a right for women to own properties be it movable or unmovable properties like land that is inherited or bought by them. Moreover, it implies women have the right to make decision regarding their properties without any hindrance from their husbands or any other person.
- **Section 20:** Right to maternity leave - according to this section of the act every woman is entitled to a period of six months maternity leave with pay without loss of employment or other benefits. In the same vein fathers are also entitled to a reasonable period of time not exceeding ten working days as paternity leave with pay, for every child delivered by their wives.
- **Section 26:** Right to education and training – according to this provision every woman and girl child has the right to education and training for development of their potentials and anybody who discriminates against girls in education is offending the law.

- **Section 27:** Prohibition of expulsion on the ground of pregnancy – this section of the act which state: "Where a girl-child student becomes pregnant she shall- (a) not be expelled from school but be allowed to be absent during the period of her pregnancy; and (b) be afforded the opportunity to return to the school on delivery of her baby". Prohibit any person or body to dismiss/expel a female student from school because she is pregnant.
- **Section 28:** Prohibition of withdrawal from school for the purpose of marriage – the act states in section 28 that "A girl-child shall not be withdrawn from school by any parent or guardian for the purpose of marriage, thus, prohibiting the withdrawal of girls from school for marriage.
- **Section 29:** right to health and health care – this section grantees women the right to reproductive health care and to make decisions regarding their reproductive health and welfare. He said before the enactment of the Women's Act 2010 women could not make some decisions on their own concerning their reproductive health and welfare which exposed them to lot of risk.
- **Section 34:** Right to marriage – this section provide the right for both men and women to enjoy equal rights as equal partners in marriage
- **Section 35:** consent of both parties to marriage – this section grantees both men and women the right to give free and full consent to marry before any marriage can be contacted.
- **Section 44:** Widow's rights – according to this section no widow shall be subjected to inhuman, humiliating or degrading treatment. Widows have the right of guardianship and custody over their children after the death of their husband unless if it is not in the best interest of the children. Also widows have the right to remarry to a man of their choice and not to be forcefully inherited.
- **Section 53:** Special protection of elderly women – the section make obligatory on government to protect and take special measures to cater for the needs of elderly women, ensure their right to freedom from violence and be treated with dignity.
- **Section 54:** Special protection of women with disabilities – the section obliged government to take appropriate measures to ensure the protection of women with disabilities, their access to employment, professional and vocational training, and participation in decision- making and ensure their right to freedom from violence, abuse and discrimination based on disability and the right to be treated with dignity.
- **Section 74:** General Penal Provision for Offences under this Act – Fine not exceeding fifty thousand dalasi or imprisonment for a term not exceeding six months or both.

Sessions 6.3: Women's (Amendment Act 2015)

Women's (Amendment) Act- contents

The amendment seeks to amend the 2010 Women's Act prohibiting female circumcision and for connected matters

To reflect this, **section 32A (3) of the Women's (Amendment) Act 2015** replicates the various ways in which the act may be carried out.

Section 32A (2) sets out the punishment for anyone found to be engaging in female circumcision with the punishment ranging from imprisonment for a term of three years or a fine of fifty thousand dalasis or both. However where the act causes death, punishment is life imprisonment.

- **Section 32B (1)** prohibits persons from being accomplices in the carrying out of female circumcision. It provides that any person who requests, incites or promotes female circumcision by providing tools or any other means meant to carry out the circumcision is punishable to three years imprisonment or a fine of fifty thousand dalasi or both.
- **Subsection 2** provides that a person who without good cause fails to warn or inform the proper authorities promptly that female circumcision is about to take place or has taken place is punishable to a fine of ten thousand dalasi.

Sessions 6.4: Punitive Provision of the Domestic Violence Act 2013

Introduction

The Domestic Violence Act was enacted at the end of 2013 to combat domestic violence, to provide protection for the victims of domestic violence; particularly women and children and for connected matters**.**

- **Section 15** of the Domestic Violence Act defines 'Domestic Violence' as engaging in the following within the context of a previous or existing domestic relationship:

(a) An act under the **Criminal Code Cap 10:01** which constitutes a threat or harm to a person under that Act.

(b) Specific acts, threats to commit, or acts to result in:

i)physical abuse, namely physical assault or use of physical force against another person including the forcible confinement or detention of another person and the deprivation of another person of access to adequate food, water, clothing, shelter, rest , or subjecting another person to torture or other cruel, inhuman or degrading treatment or punishment;
ii) Sexual abuse, including rape, incest and defilement,
iii) Economic abuse, and
iv) emotional, verbal or psychological abuse namely any conduct that makes another person feel constantly unhappy, miserable, humiliated, ridiculed, afraid, jittery or depressed or to feel inadequate or worthless.

- If any of the above happens in a domestic set up or among people who have domestic relationship, it would be regarded as a domestic violence act.

- According to the act domestic relationship means family relationship, a relationship akin to a family relationship or a relationship in a domestic situation that exists or has existed between a complainant and an offender.
- If any of the above happens in a domestic set up or among people who have domestic relationship, it would be regarded as a domestic violence act.
-
- According to the act domestic relationship means family relationship, a relationship akin to a family relationship or a relationship in a domestic situation that exists or has existed between a complainant and an offender.

Sessions 6.5: Punitive Provisions of the Sexual Offence Act 2013

Definition of Sexual Act:

Sexual Act" is defined under S.2 of the Sexual Offences Act as –

the insertion (to even the slightest degree) of the penis of a person into the vagina or anus or mouth of another person,

the insertion of any other part of the body of an animal or of any object into the vagina or anus of another person, except where such insertion is consistent with sound medical practices, carried out for proper medical purposes, or

Cunnilingus or any form of genital stimulation.
Definition of Rape:

Section.3 (1) A person who intentionally, under coercive circumstances –

(a) engages in a sexual act with another person; or
(b) causes another person to engage in a sexual act with the perpetrator or with a third person, commits the offence of rape
Section.3 (2) For the purposes of sub-section (1), "coercive circumstances" includes –
(a) the application of physical force to the complainant or to a person other than the complainant;
(b) threats (whether verbally or through conduct) of the application of physical force to the complainant or to a person other than the complainant;
c) threats (whether verbally or through conduct) to cause harm (other than bodily harm) to the complainant or to a person other than the complainant, under circumstances where it is not reasonable for the complainant to disregard the threats;
d) circumstances where the complainant is under the age of sixteen years;
(e) circumstances where the complainant is unlawfully detained;
f)circumstances where the complainant is affected by –
(i) Physical disability or helplessness, mental incapacity or other instability (whether permanent or temporary),

(ii) Intoxicating liquor or any drug or other substance which mentally incapacities the complainant, or

(iii) Sleep, to such an extent that the complainant is rendered incapable of understanding the nature of the sexual act or is deprived of the opportunity to communicate unwillingness to submit to or to commit the sexual act;

(g)circumstances where the complainant submits to or commits the sexual act by reason of having been induced (whether verbally or through conduct) by the perpetrator, or by some other person to the knowledge of the perpetrator, to believe that the perpetrator or the person with whom the sexual act is being committed, is some other person;

(h) circumstances where as a result of the fraudulent misrepresentation of some fact by, or any fraudulent conduct on the part of, the perpetrator, or by or on the part of some other person to the knowledge of perpetrator, the complainant is unaware that a sexual act is being committed with him or her

(i) Circumstances where the presence of more than one person is used to intimidate the complainant.

Section3 (3) for the purposes of this section, rape shall not apply to married couples.

A person who is convicted of rape under this act, subject to sub-sections **(2), (3) and (4)**, is liable –

(a) In the case of a first conviction –

(i) where the rape is committed under circumstances other than the circumstances contemplated in subparagraphs (ii) and (iii), **to imprisonment for not less than ten years;**

(ii) Where the rape is committed under any of the coercive circumstances referred to in paragraphs (a), (b) or (e) of section 3(2), **to imprisonment for not less than fifteen years;**

iii) Where –

the complainant has suffered grievous bodily or mental harm as a result of the rape,

the complainant is under the age of thirteen years or is by reason of age exceptionally vulnerable,

the complainant is under the age of eighteen years and the perpetrator is the complainant's parent, guardian or caretaker or is otherwise in a position of trust or authority over the complainant,

the convicted person is infected with any serious sexually transmitted disease and at the time of the commission of the rape knows that he or she is so infected,

the convicted person uses a firearm or any other weapon for the purpose of or in connection with the commission of the rape, **to mandatory imprisonment for life;**

(b) In the case of a second or subsequent conviction where the rape is committed under circumstances described in sub-section (1)(a)(i), to imprisonment for a period of not less than twenty years.

(2) If the court is satisfied that substantial and compelling circumstances exists which justify the imposition of a lesser sentence than the applicable sentence prescribed in sub-section (a) it shall enter those circumstances on the record of the proceedings and may thereupon impose such lesser sentence,

(3) The minimum sentences prescribed in sub-section (1) shall not be applicable in respect of a convicted person who was under the age of eighteen years at the time of the commission of the rape and the court may in such circumstances, impose an appropriate sentence.

Section 5-DEFILEMENT OF GIRL BETWEEN THE AGES OF 16 AND 18 YEARS:

Section5 (1) A person who unlawfully has carnal knowledge of a girl between the ages of sixteen and eighteen commits and offence and is liable on conviction to imprisonment not exceeding seven years.

Section 5 (2) It is a sufficient defiance to a charge under this section if it is proved before the court that the accused person had reasonable cause to believe and did in fact believe that the girl was of or above the age of eighteen.

Section 6 -INCAPACITY OF BOY UNDER 14 YEARS:

(1) If in any legal proceedings, the question arises as to whether a male person under 14 years has had sexual intercourse or has performed –

(a) An act of sexual nature with another person or is the father of any child, such question shall be determined as a question of fact; and

(b) No presumption or rule of law to the effect that a boy under the age of fourteen years is incapable of sexual intercourse, shall be application.

(2) The criminal capacity of an accused under the age of fourteen years who is charged with an offence of a sexual nature shall be determined in the same manner as the criminal capacity of an accused under the age of fourteen years who is charged with any other offence.

SECTION 11: SPECIAL DUTIES OF PROSECUTORS:

Section 11 of the Act provides for special duties that prosecutors have in criminal proceedings of sexual offences cases. The Act provides:

In criminal proceedings at which an accused is charged with an offence of a sexual nature, the prosecutor shall consult with the Complainant in such proceedings in order-

To ensure that all information relevant to the trail has been obtained from the complainant, including information relevant to the question whether the accused maybe released on bail and the imposition of any condition of bail; and

To provide all such information to the complainant as will be necessary to lessen the impact of the trail on the complainant.

SECTION 12: SPECIAL DUTIES OF THE POLICE IN RESPECT TO BAIL APPLICATION:

Section 12 provides:

In criminal proceedings at which an accused is charged with an investigation shall:

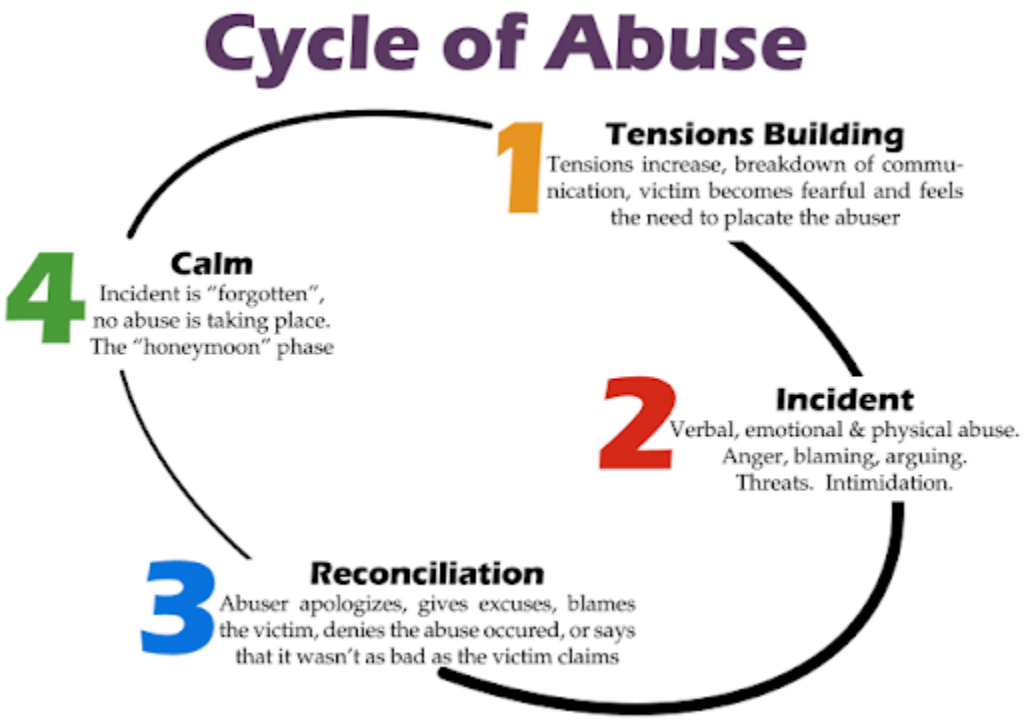
Forthwith inform the prosecutor in such proceedings of any reason to believe that the complainant would be at risk if the accused is released on bail and of any other investigations involving the accused and

If bail has been granted to the accused, inform the prosecutor of any failure by the accused to comply with his or her conditions of bail as soon as he or she becomes aware of such.

Section 14 Prohibition of contact with complainant

If an accused who is in custody on a charge of rape is released on bail, the court shall add such further conditions of bail as will in the opinion of the court, ensure that the accused does not make contact with the complainant concerned.

Annexes1: Cycle of Abuse



Annexes2: Sexual Violence Assessment- Short Interview Form

Person Interviewed: _____ Position/Title: _____

County: _____ City/ Town: _____

Name of Settlement/ Village: _____

Date: _____

1. Do you know of women or children in this community who have been raped or forced to

have sex? Yes / No

2. Do you know who has forced them?

3. How many cases have you heard about?

4. What problems do they have as a result?

5. Do women or children look for help when this happens to them? Yes / No

a. If yes, where do they go?

b. What is done for them?

6. Have you heard about other types of violence being perpetrated against women or girls in this community? Yes / No

If yes, what are the other types of violence?

8. Have you heard of girls or women who have been forced to stay with the fighting forces?

Yes / No

What do you know about them, their needs, and their problems?

9. Do you have anything more to say about sexual violence in this community?

2. Key Informant Interview Guide Samples

(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.)

Date of interview: _____

Name of the institution/agency: _____

Name of person interviewed and contact details if they will provide it:

_____

Their position in the institution/agency: _____

1. What do the words gender-based violence mean to you? (If the respondent does not seem to know what GBV is, ask what about sexual violence or domestic violence? to see if they encounter these things.)

2. What types of cases of gender-based violence do you handle? (If the respondent lists something other than sexual violence, ask him/her what the most frequent type of violence against women and girls is that he/she handles?)

3. How often do you handle sexual violence cases? How many per week or month?

4. How often do you handle domestic violence cases? How many per week or month?

5. From what individuals or organizations do you typically receive reports of sexual violence?

(PROBE: victims/survivors, family members, health professionals, etc.)

Who are the main victims/survivors of sexual violence? (PROBE: who are the main perpetrators, survivors, what are their ages, sex…?)

6. What legal facilities or personnel exist for victims/survivors of sexual violence or other forms of gender-based violence and punish perpetrators? (e.g., court, local/traditional, or civil authorities)

7. Has anyone in your institution received training on sexual violence or other forms of gender-based violence? If so, what was the training about, who received it, who provided it, and how many days did it last? Are the individuals who were trained still in their post?

8. What services do you provide to victims/survivors of sexual violence or other forms of gender-based violence? (Try to get the respondent to be as specific as possible, e.g., provision of information on court process, roles and responsibilities of different actors, time frames, etc.)

9. What kind of documentation is required to facilitate legal proceedings and investigations? What are the major challenges experienced? What is the time that it takes to finalize a case, and why?

10. Does anyone from this institution accompany, advocate for, and support the victim/survivor during any meetings with the police or court officials? (If yes, ask the respondent to describe how this process works and who is responsible for doing this.)

11. Who is responsible for providing support to the victim/survivor during the legal proceedings? (PROBE: Liaison with the police? Legal or trial proceedings? Psychosocial support? Logistical support/accommodation and food?)

12. Which laws are used in addressing gender-based violence and how are they enforced, and by whom?

13. How do you ensure the survivor's confidentiality and protection (during pre-trial, trial, and post-trial)?

14. Do you ever refer survivors to other services such as counselling or healthcare? If yes, where are these services located? How do they provide the referral? How do you ensure that the service is provided?

15. How do you work with other service providers (NGOs, government departments, health facilities legal, law enforcement, psychosocial (social welfare)) on the issue of gender-based violence?

16. What other structures, activities, and forums (or other coordination system) is your institution involved in to address the needs of victims/survivors of sexual violence or other types of gender-based violence?

17. What are some of the challenges that you face in responding to sexual violence or other form of gender-based violence?

18. How do you think these challenges could be addressed?

3. District Authorities Structured Interview Guide

(As the interviewer, introduce yourself, explain the objectives of the interview and request the respondent's consent to be interviewed. Note the respondent's name, position, and job title; describe his or her duties; and enter the institution's name and location and the date of the interview.)

Date of interview: _____

Name of the institution/agency: _____

Name of person interviewed and contact details if they will provide it:

_____

Their position in the institution/agency: _____

1. What does gender-based violence mean to you?

(If the respondent does not seem to know ask: What kinds of incidents of sexual violence, or domestic violence between intimate partners do you hear about?)

2. What types of GBV do you think are most prevalent in this community?

What types of cases of gender-based violence are you involved in as a DA? (If they list something other than sexual violence, ask them, what is the most frequent type of violence against women and girls that they handle.)

How often (if ever) do you see sexual violence cases or other forms of gender-based violence?

How many per week or month?

How often (if ever) do you see domestic violence cases? How many per week or month?

3. What are the commonly used channels for reporting gender-based violence? From what individuals or organizations do you typically receive reports of sexual violence? (PROBE: victims/survivors, family members, health professionals, etc.)

4. Have you been trained on sexual violence or other forms of gender-based violence? How long did the training last and who provided it?

5. How do you respond to cases of sexual violence or other forms of sexual violence? For what services do you refer (psychosocial, medical, legal)?

6. Are there places for victims/survivors of gender-based violence (or specifically sexual or domestic violence) to go to when their life is in danger? Where can you refer such clients (shelters, etc.)?

7. Can your police station transport or accompany victims/survivors for further services? If no, how do victims/survivors access the services? (PROBE: sexual violence survivors)

8. What kind of documentation is required to initiate legal proceedings and investigations (rape kit, medical affidavit)?

How many rape kits do you keep in stock at this station?

9.How would you describe the relationship between this police station and NGOs over rape cases?

10. What policies or laws (national, county-level) are in place for cases of sexual violence or other forms of gender-based violence? How do you use these policies? Are cases of sexual violence ever handled by village heads/leaders? How do they intervene in these cases?

11. What other structures, activities, and forums (or other coordination system) is your institution involved in to address the needs of victims/survivors of sexual violence or other types of gender-based violence?

12. What other challenges are there related to ensuring that survivors of gender-based violence have access to services and in preventing gender-based violence? How do you think some of these challenges could be addressed?

CONCLUSION

Summarize the session by emphasizing the following:

- ✓ SGBV and HTP in all its forms is a crime as stated in the UDHR, Constitution of the Republic of The Gambia, the Criminal Code, Women's Act 2010, Sexual Offences Act 2012, Domestic Violence Act 2013, and Children's Act 2005.

- ✓ Sexual Gender-based violence and Harmful Traditional Practices is a pervasive public health concern. It is an abuse of human rights i.e., it is a form of discrimination, torture, and degrading treatment that is prohibited in all international legal frameworks

- ✓ While both men and women experience violence, evidence indicates that women experience it in far greater patterns than men.

- ✓ VAW is SGBV which should be understood from the context of women's and girls' subordinate status in society.

- ✓ SGBV happens throughout a woman's lifecycle.

- ✓ The most common form of SGBV in our communities is Domestic Violence and Sexual Violence.

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