

UNICEF Key Considerations for GBV Risk Mitigation in Humanitarian Cash Transfers (HCT)



TABLE OF CONTENTS

<i>Glossary</i>	3
<i>Introduction</i>	4
Target Audience	4
Gender and Social Dynamics	4
Identifying GBV Risks and Mitigation Measures	5
GBV Risks and Mitigation Measures by HCT Phase	7
Summary Checklist – GBV Risk Mitigation in HCT Programming	15
Annex 1: GBV Risk Analysis for HCT	16
Annex 2: Decision Tree for Adapting HCT based on GBV Risks	18
Annex 3: UNICEF Tip Sheet for Consulting with Women and Girls	19
Annex 4: Safety-oriented Focus Group Discussion Guide for HCT	21
Annex 5: Key Resources	23

This UNICEF key considerations document was written in January 2020 by Joanna Friedman and revised by Lara Quarterman in May 2021 after field testing in Bangladesh, Sierra Leone and Yemen.

Please contact Christine Heckman (heckman@unicef.org), Kariane Peek Cabrera (kpeekcabrera@unicef.org) or Ruth Graham Goulder (rugoulder@unicef.org) for more information.

GLOSSARY

All HCT-related definitions, including definitions for Financial Service Provider, Beneficiary Communication and Accountability Mechanisms, can be found in the [Sharepoint HCT Glossary](#). Below are the key GBV definitions with which HCT actors should be familiar. It is applicable for UNICEF staff and partners delivering cash transfers through emergency programming or through existing social protection systems.

Gender-Based Violence (GBV) constitutes any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual, mental and economic harm or suffering; threats of such acts; coercion; and deprivations of liberty whether occurring in public or private life. Source: [IASC GBV Guidelines](#). For related definitions, see the [GBV Coordination Handbook, Annex 1](#).

GBV Referral Pathways are flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security, and justice and legal aid. Source: [IASC GBV Guidelines](#)

GBV Risk Mitigation or Integration is the process of ensuring that a program (1) does not cause or increase the likelihood of GBV; (2) proactively seeks to identify and takes action to mitigate GBV risks in the environment and in program design and implementation; and (3) proactively facilitates and monitors vulnerable groups' safe access to services. GBV risk mitigation is the responsibility of everyone working in humanitarian response, cutting across all programmatic sectors. It is distinct from, but complementary to, GBV-specialized programming. Source: [IASC GBV Guidelines](#)

GBV Specialized Programming is dedicated GBV programming that involve GBV specialists and have specific objectives, activities and indicators for the purposes of advancing GBV prevention or response outcomes. Source: [IASC GBV Guidelines](#)

Prevention of Sexual Exploitation and Abuse (PSEA): Sexual exploitation means 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. Sexual abuse means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. Source: [PSEA Task Force](#). While sexual exploitation and abuse can be perpetrated by anyone in a position of power, the term 'SEA' particularly has been used in reference to sexual exploitation and abuse perpetrated by staff of humanitarian organizations, including both civilians and uniformed peacekeepers. Source: [UNICEF Gender-Based Violence in Emergencies Operational Guide](#)

A **Safety Audit** is a simple observation exercise used to identify potential safety risks in a particular setting or location (such as lack of lighting, overcrowded shelters, lack of privacy at WASH facilities, etc.). Sample safety audit tools are available in the [UNICEF GBViE Resource Pack](#) and the [IASC GBV Guidelines Knowledge Hub](#). Source: [UNICEF GBViE Operational Guide](#)

INTRODUCTION

This key considerations document for UNICEF staff and partners is a companion to the [EMOPS Humanitarian Cash Transfers \(HCT\) Guidance](#).

UNICEF uses HCT in order to contribute to better results across all sectors of programming, where relevant and appropriate. Integrating gender-based violence (GBV) risk mitigation across all humanitarian programming in all sectors improves UNICEF's performance and contributes to better results for children and women. HCT are better able to achieve their results when they integrate protection and GBV risk mitigation.

As with any other programming tool or modality, it is important to recognize that HCT interventions can create new GBV risks and exacerbate existing risks. Women and girls may face increased risk of intimate partner violence, sexual exploitation, denial of resources or other forms of GBV if new resources—whether cash, voucher or kits/other in-kind—are introduced into humanitarian contexts without adequate GBV risk analysis, mitigation mechanisms, and ongoing monitoring of safety considerations throughout the project cycle.



Key message: “All humanitarian actors must be aware of the risks of GBV and—acting collectively to ensure a comprehensive response—prevent and mitigate these risks as quickly as possible within their areas of operation. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations.” - [IASC GBV Guidelines](#)

In all humanitarian programming, there is also an inherent power differential between humanitarian actors and beneficiaries. Potential [sexual exploitation and abuse](#) (SEA) by UNICEF staff and partners, including the private sector and government, is one type of GBV risk that is addressed in this document. Please note: the content related to SEA focuses on recommendations for mitigating SEA risks, not the broader requirements around reporting, investigations, etc

TARGET AUDIENCE

The target audience for this guidance is UNICEF staff and partners working to design and deliver HCT programmes, regardless of the type of implementation model used (e.g. government social protection system fully or partially or a parallel system).

UNICEF staff and partners working on social protection programming will also find the guidance useful, especially when aiming to make social protection systems more shock-responsive and resilient in crises or when delivering HCT through existing social protection systems.

This approach is aligned with wider efforts to link the use of HCT with social protection government programmes, wherever feasible at country level.

GENDER AND SOCIAL DYNAMICS

Gender, along with age, sexual orientation, gender identity and ability, determines the access to and control of resources that women, girls, men and boys have. Although international legal frameworks guarantee equal rights for women and men, the lived experiences of women, girls, men and boys are different and unequal.

Social norms, which are the beliefs and attitudes on expected behaviours of members of a society, underpin gender roles. Men and boys typically hold gender roles that allow them more social, economic and political power than women and girls. Consequently, they are able to exercise more decision-making power and autonomy over their own lives and over the decisions in their communities and families. Conversely, women and girls' agency and power are restricted and they are often prevented from making decisions over their own bodies and marital status and have limited access to social, economic or political resources.

Similarly, the empowerment of women and girls to enjoy their equal rights involves shifts in social norms, including on accepted attitudes and beliefs on gendered roles and women and girls' access to resources, social support networks and access to justice. HCT, particularly when based on a strong gender analysis and designed/implemented in collaboration with women and girls themselves, is one of many factors that may enhance women's empowerment and promote gender equality.

IDENTIFYING GBV RISKS AND MITIGATION MEASURES

How can UNICEF staff and partners mitigate GBV risks in HCT programming? This document highlights entry points throughout the program cycle, and the inclusion of a few key safety questions in existing exercises such as market assessments that can help to identify and mitigate potential GBV risks.

The delivery of humanitarian aid involves risks of GBV, which must be identified and mitigated to avoid creating new risks or exacerbating existing risks of GBV. This "Do No Harm" responsibility includes HCT programming.¹

Evidence is emerging that demonstrates the potential for cash-based interventions to reduce risks of GBV in non-humanitarian contexts in low- and middle-income contexts, particularly intimate partner violence.² However, there is a gap in evidence on the relationship between HCT and all forms of GBV in crisis-affected contexts and mixed findings in studies that have been conducted.³ As such, the available tools on GBV risk mitigation in humanitarian interventions as well as the expertise of GBV specialists and consultation with women and girls should be relied on to accurately identify risks of GBV and design effective mitigating measures. Special attention should be paid to the potential risks of GBV within the processes of targeting and registration of HCT recipients, distribution and delivery of cash, and monitoring of HCT.

Key questions that UNICEF staff and partners should consider during all phases of the program cycle for HCT include: Are GBV risks increased by the way that UNICEF delivers HCT? How can we mitigate the risk by making changes to the design and delivery of HCT? Is there a heightened GBV risk for specific groups, such as women, adolescent girls or children with disabilities?

A number of recommendations for risk mitigation are cross-cutting throughout the program cycle.

1. Conduct a **GBV risk analysis for HCT**

Use existing GBV and protection information from colleagues and partners, sub-cluster or working group and consult with women and girls, to identify GBV risks associated with HCT. Include government partners in GBV risk analysis process, where appropriate.

Use **Annex 1: GBV Risk Analysis for HCT** and **Annex 2: Decision Tree for Adapting HCT based on GBV Risks** to develop a GBV Risk Matrix that lists the risks, their likelihood of occurring and their potential impact as well as mitigating actions that can be taken to lessen their likelihood and/or impact.

¹ For a socio-ecological model of potential GBV risk factors, see <http://www.endvawnow.org/en/articles/1509-the-ecological-framework.html>

² For an overview of the link between cash-based interventions and intimate partner violence in low- and middle-income countries, see Buller, A M, A Peterman, M Ranganathan, A Bleile & M Hidrobo (2018) 'A Mixed-Method Review of Cash Transfers and Intimate Partner Violence in Low- and Middle-Income Countries' *The World Bank Research Observer*, 33(2):218-258 [<https://doi.org/10.1093/wbro/lky002>]

³ See GBV AoR Helpdesk (2020) Evidence Digest: GBV in Emergencies and Livelihoods <https://www.sddirect.org.uk/media/2118/evidence-digest-livelihoods-and-gbv-01112020-update.pdf>

2. Consult with women and girls

In collaboration with GBV or protection specialists, conduct early and regular [consultations](#) with women and girls to develop the GBV Risk Matrix and to solicit their feedback on HCT.

Ensure that consultations are done in groups disaggregated by age and gender to ensure that participants are safe and comfortable to share their experiences and opinions. Ensure that those living with disabilities are included in consultations and have the opportunity to participate.

The goal is to identify risks, mitigation measures and adaptations to make HCT safer for all beneficiaries.⁴ Use **Annex 3: UNICEF Tip Sheet for Consulting Women** and **Girls and Annex 4: Safety-oriented Focus Group Discussion Guide for HCT** to plan and facilitate consultations.

3. Establish accountability mechanisms

Accountability mechanisms that are safe, confidential and accessible to HCT beneficiaries and community members should be in place. Accountability mechanisms should be equipped to receive complaints, especially of sexual exploitation and abuse (SEA) and other forms of GBV.

Information on accountability mechanisms, including how reports can be made, should be shared with HCT beneficiaries and communities.

Procedures on how to receive and respond to reports of SEA by UNICEF staff or partners should be incorporated into accountability mechanism protocols and this information should be shared with communities.

Accountability mechanisms staff should be trained on how to receive disclosures and reports of GBV and provided with information on available referral pathways and services and how to make safe and voluntary referrals.⁵

4. Disseminate information on GBV referral pathways and available services

Share information on local GBV referral pathways with HCT beneficiaries, communities, partners and staff and conduct training sessions on the GBV referral pathway so HCT staff and partners know how to appropriately respond in case of GBV disclosure or reports.

Plan regular coordination meetings with GBV colleagues to obtain the latest version of the referral pathway and to understand GBV risks, as they may change over time.

For situations where there are no GBV response services available, disseminate the [GBV Pocket Guide](#) and share details of the accompanying smartphone app and ensure all HCT frontline workers are trained on its content, which includes helpful guidance on what to do and not to do when directly interacting with survivors of GBV. If a survivor chooses to disclose an experience of GBV and there are no referral procedures in place, consult with GBV or protection colleagues on next steps.

5. Take action to prevent SEA

Deliver trainings to UNICEF partners on SEA, including expected conduct, reporting mechanisms, investigation and disciplinary processes, and data protection. Require all UNICEF staff and partners to sign a PSEA protocol and/or Code of Conduct, with consequences that would nullify their contract.

NOTE: Throughout this guidance '**⚠️ with GBV staff**' appears throughout this document whenever it is critical to engage a GBV specialist in carrying out the recommended action. This may be a UNICEF Child Protection, Protection or Gender specialist, GBV specialist organisations, or government Ministries with the mandate for gender or GBV, if appropriate.

⁴ To incorporate safety-related questions into assessments/community discussions, refer to the [IASC GBV Guidelines](#) "Do's and Don'ts for conducting assessments that include GBV-related components," page 35.

⁵ A useful tool to support the receipt of disclosures of GBV is the IASC 'Pocket Guide' and related guidance, which can be found [here](#).

GBV RISKS AND MITIGATION MEASURES BY HCT PHASE

HCT Phase	Potential GBV Risks	Possible mitigation measures
PREPAREDNESS		
<p>Use with EPP MPS 5 Data collection tool, Tab 2 (Preparedness):</p> <p>Coordination platforms – Other – Complaints mechanism</p> <p>Potential partners – Capacity</p> <p>Financial service providers (FSP) – Existing FSP and Mobile technology penetration</p>	<p><i>See further details on each of these points in their respective sections below.</i></p> <p>Complaint mechanism</p> <ul style="list-style-type: none"> • risk of unequal awareness of or access to the complaint mechanism for women and girls • risk that complaint mechanism staff do not respond appropriate to reports and disclosures of GBV <p>Partners and FSPs</p> <ul style="list-style-type: none"> • risk of abuse or exploitation by partners and FSPs in face-to-face engagement • inadequate data protection by partners and FSPs lead to backlash in the form of violence • risks of violence and harassment in travel to and from the delivery points or agents 	<p><i>See further details on each of these points in their respective sections below. Summarized here for purposes of EPP MPS 5 Data collection tool.</i></p> <p>Use different awareness campaigns and materials; ensure that women and men are reached through facilitation mechanisms; ensure that complaint mechanisms are safe and accessible for all. ⚠️ with GBV staff</p> <p>Deliver trainings to partners on GBV risk mitigation, expected conduct, PSEA, referral procedures to connect survivors with response services, and institutional requirements for reporting SEA allegations.</p> <p>In alignment with UNICEF's existing policies, ensure that all staff and partners to sign a PSEA protocol and/or Code of Conduct, with consequences that would nullify their contract.</p> <p>Conduct consultations with women and girls to determine which HCT delivery mechanism and modality is safest and most appropriate to meet their needs. Using information provided by women and girls in consultations, consider the pros and cons of different mechanisms (e.g. cash in envelopes vs mobile money) and ask women and girls if they would have equal access to these mechanisms at household or community level. Use this information when selecting delivery mechanism(s). ⚠️ with GBV staff</p> <p>Consider whether adequate data protection is feasible with each partner and if not, consider alternative partnerships. Ensure that UNICEF data protection protocol for data sharing and storage from partners is agreed to/signed.⁶</p>

⁶ The [UNICEF data protection policy](#).

HCT Phase	Potential GBV Risks	Possible mitigation measures
RESPONSE ANALYSIS		
Risk assessment	Process-related risks, related to safety throughout the design, targeting and delivery phases (detailed in each phase below).	<p>A GBV Risk Analysis for HCT (Annex 1) should serve as the framework to identify GBV risks and mitigation measures for HCT, across the entire program cycle. It should be conducted as a part of wider assessment and analysis efforts. Many risks can be identified through the GBV risk analysis and mitigated by adapting the HCT to reflect consultations with women and girls, and followed up with strong accountability mechanisms.</p> <p>Request a briefing from a GBV specialist (if present or protection/gender specialist) or refer to GBV, gender and/or protection analysis carried out by (sub-) cluster or working group. Consider what has changed since the crisis with respect to pre-crisis social norms and GBV risk factors. ⚠️ with GBV staff</p> <p>Conduct consultations with women and girls along with a GBV specialist (if present or protection/gender specialist) and develop risk mitigation measures. This should be fully integrated into a broader strategy for consulting with women and girls throughout the program cycle. See Annex 3 for a UNICEF Tip Sheet for Consulting with Women and Girls. Consultation could be through a focus group discussion (see Annex 4 for an example) or other tools that are included in “safety audits,” such as a participatory safety walk through the market area. See the UNICEF GBViE Resource Pack, Kit M, Rapid Assessment Tool 9, Participatory Safety Walk, for example. ⚠️ with GBV staff</p> <p>Use the Availability, Accessibility, Acceptability and Quality Framework (AAAQ)⁷ to identify potential barriers to accessing HCT, especially for women and girls. For example, the lack of civil registration or identity documentation might be a barrier to accessing HCT and appropriate actions should be planned to remove such barriers.</p> <p>Integrate information collected in the process of developing a GBV Risk Analysis into the HCT design (e.g. targeting and registration, delivery mechanism, payment schedule, accountability mechanisms)</p>

⁷ The AAAQ framework was developed for the healthcare sector, but has been developed by UNICEF for identifying barriers to humanitarian aid that can have an impact on the risk of GBV.

HCT Phase	Potential GBV Risks	Possible mitigation measures
<i>Risk assessment cont.</i>	Sexual exploitation and abuse by UNIEF staff and HCT partners (including NGOs, Government and private sector including but not limited to financial service providers (FSPs), shopkeepers, mobile agents).	<p>Deliver trainings to staff and partners on GBV risk mitigation, expected conduct, PSEA, and data protection.</p> <p>In alignment with UNICEF's existing policies, ensure that all staff and partners sign a PSEA protocol and/or Code of Conduct, with consequences that would nullify their contract.</p> <p>Include safety-oriented questions in post-distribution monitoring (interviews or focus group discussions). Note: The questions should not focus on personal experience of GBV. Instead more general questions are recommended, such as <i>are there any groups of people within this community who feel afraid or uncomfortable when accessing this service?</i></p>
	Increased household tensions after women in the household receive HCT, which can lead to increased domestic violence in severity or frequency.	<p>Discuss this risk with GBV and protection specialists and seek their guidance on if and how this risk should be mitigated.</p> <p>GBV specialists may advise that consultations with women and girls, men and boys, and local women's organisations, are required to determine the appropriate and safest targeting approaches. ⚠️ with GBV staff</p> <p>Include safety-oriented questions in post-distribution monitoring that is not personal but generalized, for example, <i>have you heard about any women who experienced increased tensions in their household after receiving the HCT? What do women in this community think should be done to mitigate this risk?</i> Share findings with GBV and protection specialists for follow-up with risk mitigation measures or HCT program adaptations if possible. ⚠️ with GBV staff</p>
Market assessment	Violence and harassment while traveling to markets and while in markets/shops using their HCT to purchase goods and services.	<p>During market assessments, include key safety questions such as, <i>Can women and children safely access markets, during any season and at any time of day? Do they need additional cash for safe transport to markets? Do they require alternative care provisions to avoid leaving adolescent girls at home to care for young children or older persons, and are there community-based mechanisms that could support this? Are certain groups e.g. minority ethnic women or gender non-conforming persons at risk in markets/shops?</i> This should help identify potential GBV risks that require mitigation measures.</p> <p>Identify options to provide safe market access for women and girls, for example by working with women traders or by ensuring that cash delivery occurs on days/seasons when women have safe access to markets.</p> <p>Disseminate information about market safety to beneficiaries.</p> <p>If safe and appropriate, consider displaying information about available GBV response services in/around the market. ⚠️ with GBV staff</p>

HCT Phase	Potential GBV Risks	Possible mitigation measures
<p>Selection of delivery mechanism</p> <p>Also consider when drafting EPP MPS 5 Data collection tool, Tab 2 (Preparedness), Financial service providers (FSP) – Existing FSP and Mobile technology penetration</p>	<p>Violence and harassment on the way to pick up cash</p> <p>Violence and harassment at the point of cash delivery.</p> <p>Unequal access to cash delivery mechanism between men and women.</p>	<p>Conduct consultations with women and girls to determine which HCT delivery mechanism is safest and most appropriate to meet their needs, including their preferred locations/times for cash distribution.</p> <p>Assess available cash delivery mechanisms (e.g. cash in envelopes, mobile money) for their accessibility and determine if there are barriers for women and girls to access the delivery mechanism. Where possible, consult with women on their preferred delivery mechanism.</p> <p>Women often have less access than men to mobile phones, for example when mobile money is used. Similarly, women may not have equal access to men with regards to bank accounts, debit cards, or the amount of cash they are allowed to carry.</p>
PROGRAM DESIGN		
Targeting and registration	Selection criteria may exacerbate stigma or GBV risks for women and girls and/or GBV survivors.	<p>GBV survivors should not be singled out for targeting, but GBV survivors should not have any barriers to accessing available HCT for which they qualify. Specific referrals for HCT or other in-kind aid may take place particularly in contexts with established HCT systems, but these are the exception and should only be considered in consultation with GBV specialists and in close coordination with GBV coordination mechanisms and GBV case managers. ⚠ with GBV staff</p> <p>If GBV survivors are referred to HCT, confidentiality and data protection measures must be put in place to ensure that their experiences with GBV are not disclosed or shared [see section on data protection below], and GBV specialists must be involved in designing data sharing protocols and referrals to HCT from GBV service providers. UNICEF typically uses multiple vulnerability categories for HCT and these do not explicitly include 'GBV survivors' in order to ensure safety and confidentiality. ⚠ with GBV staff</p> <p>As part of the community validation process for targeting, consult with women and men in sex and age disaggregated groups to solicit feedback on their preferences and any concerns they have on targeting methodology, including concerns around violence, exploitation, and abuse.</p> <p>Disseminate information on the targeting approach and rationale for decisions made on recipients and criteria for inclusion in the HCT, especially if women are to be the recipients targeted and registered in HCT.</p> <p>Where there is a risk of exclusion of wives and children from polygamous households will not be registered, consider registering women independently of their husbands or partners for HCT, but only if it will not contribute to household conflict.</p>

HCT Phase	Potential GBV Risks	Possible mitigation measures
<i>Targeting and registration cont.</i>	Women and girls may face barriers to registering for HCT, such as lack of civil documentation.	Use the AAAQ framework to identify barriers for women and girls face to registering for HCT. Where barriers are identified, such as lack of civil documentation, consult with HCT recipients and UNICEF partners and government agencies, where appropriate, to identify alternatives to registration requirements to ensure those most vulnerable to GBV are not excluded from HCT.
Determining amount and frequency of cash transfer	<p>Women and girls' needs may not be included in the calculation of the cash transfer amount.</p> <p>Carrying or storing large amount of cash might increase risk of violence and theft of cash.</p> <p>Changes in payment amounts or schedules can lead to GBV if not communicated to recipients and their families and communities.</p>	<p>Consult with women to ensure their needs are included in the cash transfer amount (e.g., the cost of menstruation management materials or contraception).</p> <p>Consult with women and girls of different ages and abilities about their perceptions of safety and security around payment amounts and schedules, including if they would experience heightened risk of GBV through one-off payments or infrequency of HCT delivery.</p> <p>Disseminate information using appropriate awareness raising methodology (e.g. radio messages, community leaders) on safe storage and transport of cash. This could be done by HCT implementing partners or financial service providers (FSP) and could be combined with training on managing bank accounts, mobile money platforms, or other digital tools.</p> <p>If changes to payment schedules or amounts will be required, this should be communicated to HCT recipients and their families in advance.</p>
<p>Implementation model</p> <p>Also consider when drafting EPP MPS 5 Data collection tool, Tab 2 (Preparedness), Potential partners – Capacity</p>	Sexual exploitation and abuse or stigma due to face-to-face engagement with cash recipients and communities of HCT staff or partners.	<p>Deliver trainings to HCT staff and partners on GBV risk mitigation, expected conduct, PSEA, referral procedures to connect survivors with response services,⁸ and institutional requirements for reporting SEA allegations.</p> <p>In alignment with UNICEF's existing policies, ensure that all staff and partners to sign a PSEA protocol and/or Code of Conduct, with consequences that would nullify their contract.</p> <p>Consult with women and girls on their preferences and perceptions of safety and appropriateness of interacting with male HCT partners, FSPs, HCT monitors and if this could put them at risk of SEA, repercussions or stigma.</p>

⁸ Where referral pathways are available. Plan to regularly consult with GBV colleagues to obtain the latest version of the referral pathway and available GBV services. For situations where there are no GBV response services available, disseminate the GBV Pocket Guide and ensure all frontline workers are trained on its content. If a survivor chooses to disclose an experience of GBV and there are no referral procedures in place, consult with GBV or protection colleagues.

HCT Phase	Potential GBV Risks	Possible mitigation measures
PROGRAMMATIC IMPLEMENTATION		
<p>Data protection</p> <p>Also consider when drafting EPP MPS 5 Data collection tool, Tab 2 (Preparedness), Potential partners – Capacity</p>	<p>Inadequate data protections of confidential information (recipients' name, address, phone number or biometric data) leading to violence, exploitation, harassment or stigmatisation, (especially for GBV survivors).</p>	<p>Anonymize identifying recipient information on registration and distribution lists when they need to be shared among HCT partners and contractors. Establish information and data sharing protocols when information must be shared with appropriate access levels for HCT staff and partners.</p> <p>Establish whether referral organisations also adhere to data protection standards before they are included in any referral pathway. ⚠ with GBV staff</p> <p>Information on HCT recipients' status of GBV survivors should not be recorded or shared. If GBV survivors will be referred to HCT, management of related data and information requires advice from GBV specialists. ⚠ with GBV staff</p> <p>Assess feasibility of adequate data protection with HCT partners and contractors and if not, consider alternative partnerships. Ensure that UNICEF data protection protocol for data sharing and storage from partners is agreed to/signed.⁹</p>
<p>Complaint and feedback mechanism;</p> <p>Beneficiary communication (including facilitation mechanism)</p>	<p>Information about HCT may not reach women and girls, resulting in their exclusion.</p> <p>Information about the complaint mechanism, including how to access it and action that will be taken, may not be available to women and girls.</p>	<p>Design and carry out awareness campaigns or trainings on HCT to reach groups that often excluded (e.g. older women, widows, adolescent girls, those with limited literacy or visual impairments, or those who speak minority languages) using the most appropriate communications methods (e.g. radio messages, visual materials, community leaders delivering messages).</p> <p>Communicate information on the complaint mechanism, including how to access it, what will be done upon a report, what types of concerns can be reported, and measures of confidentiality and safety of using the complaints mechanism. Information and communication methods should be tailored to the audience and multiple channels may be required to reach women and girls who are often excluded from communication efforts.</p> <p>Disseminate information about GBV referral pathways and available GBV services among HCT staff and partners as well as expected and appropriate conduct regarding SEA and SEA reporting mechanisms.</p> <p>Communicate information on the effectiveness and responses of the complaint mechanisms with HCT recipients and communities, especially women and girls.</p> <p>Ensure that complaint mechanisms are safe and accessible for women and girls, for instance establishing multiple methods of making reports (e.g. text messaging, hotlines, reporting desks or kiosks)</p>

⁹ The [UNICEF data protection policy](#).

HCT Phase	Potential GBV Risks	Possible mitigation measures
<i>Complaint and feedback mechanism; cont.</i>	Reports and disclosures of GBV to HCT staff and partners or complaint mechanism are not handled appropriately.	<p>Ensure that all HCT staff, partners and contractors are aware of how to respond to reports and disclosures of GBV (e.g. through training on receiving disclosures of GBV or psychological first aid).</p> <p>Disseminate the local GBV referral pathway (if one exists) among HCT recipients and communities and HCT staff and partners.</p> <p>Conduct training on the GBV referral pathway for HCT staff and partners, including entry points and contact details of focal points for their use in the case of GBV disclosure. Establish regular coordination meetings with GBV colleagues to obtain the latest version of the GBV referral pathway.</p> <p>For situations where there are no GBV response services available, disseminate the GBV Pocket Guide and ensure all frontline workers are trained on its content and use. If a survivor chooses to disclose an experience of GBV and there are no referral procedures in place, consult with GBV or protection colleagues on next steps. ⚠️ with GBV staff</p> <p>Do not independently monitor the number of GBV reports or incidents among HCT recipients or in communities or record details of GBV incidents. This can cause more harm and is not aligned with ethical practices. Instead, notify GBV or protection specialists. ⚠️ with GBV staff</p>
	[Opportunity] – integrate GBV awareness and information, including preventative interventions into HCT recipient information and communication efforts	<p>HCT can be an important entry point for information dissemination on GBV awareness and risk mitigation. For instance, GBV information can be shared at in-person information sessions, registration points, cash delivery points or through text messages. If women have access to their own phones, a women's safety-oriented phone tree could be established.¹⁰ ⚠️ with GBV staff</p> <p>Contact information for GBV referral pathways and services can be shared as part of HCT information campaigns.</p> <p>Dissemination of GBV-related awareness raising information within HCT communications efforts should only occur where GBV services exist and are of adequate quality and in collaboration with GBV specialists. ⚠️ with GBV staff</p> <p>Where possible, 'cash plus' interventions can be paired with HCT, including social norm change programming that can reduce domestic violence through shifting attitudes, beliefs, and actions on gender roles, power, and the use of violence. ⚠️ with GBV staff</p>

¹⁰ A method by which women might alert each other to risks at a certain site by one woman calling her neighbor, who calls her neighbor, and so on, in a planned manner so that each woman knows whom to call and each woman only needs to call one other woman.

HCT Phase	Potential GBV Risks	Possible mitigation measures
MONITORING AND EVALUATION		
	<p>Omitting GBV risks in HCT risk analyses and matrices will leave risks of GBV unaddressed and women and girls may remain at risk of GBV or their risk may become higher.</p>	<p>Incorporate safety questions and consultations with women and girls into HCT monitoring plans and implementation.</p> <p>Monitor risks of GBV alongside other risks within HCT and identify emerging risks of GBV and/or other unintended consequences of HCT. Questions should address the safe access of the process such as: <i>were you able to safely register and collect cash?</i></p> <p>Address sensitive questions and outcomes in a generalized, not personal manner, such as: <i>Have you heard about any beneficiaries who had to do something that made them feel uncomfortable in order to receive cash? Have you heard about HCT recipients experiencing increased conflict with family or community members due to receiving cash? Have you heard about any negative consequences for women/girls/others as a result of receiving cash?</i></p> <p>⚠️ with GBV staff</p> <p>Identify if there is a gendered power dynamic for expenditure on particular items for women's and girls' needs (e.g. menstrual hygiene management materials) by asking: <i>Who within the household decides about spending on women's and girls' needs?</i></p> <p>GBV risks that are identified in monitoring activities should be communicated safely and confidentially to GBV specialists and consider changes to HCT design and delivery to prevent GBV from occurring. ⚠️ with GBV staff</p> <p>Include GBV specialists in Cash coordination structures to ensure that information is shared on the trends and patterns of GBV and emerging and changing risks of GBV that should be taken into account in design and delivery of HCT. ⚠️ with GBV staff</p>
	<p>Risk of SEA by those involved in monitoring of HCT.</p>	<p>Ensure that women are included in monitoring team, especially during monitoring visits that will engage with women and girls who have received HCT.</p> <p>Include GBV specialists in monitoring teams, if possible. ⚠️ with GBV staff</p> <p>Build GBV risks into HCT monitoring processes, such as baseline surveys, post-distribution monitoring, and end line surveys, in a safe and ethical manner. ⚠️ with GBV staff</p> <p>Communicate to HCT recipients and communities on monitoring initiatives, including who will be visiting and when, what activities will be undertaken, expected conduct of monitoring teams, and information on the reporting mechanism in case of misconduct and SEA.</p> <p>Ensure that PSEA protocols and training are carried out and Codes of Conduct are signed with those involved in monitoring.</p> <p>Do not attempt to collect information on or ask direct questions about HCT recipients' or community members' experiences GBV.</p>

SUMMARY CHECKLIST

GBV Risk Mitigation in HCT Programming

1. Conduct GBV Risk Analysis using available information
2. Conduct regular consultations with women and girls*
3. Establish safe, confidential, and accessible accountability mechanisms for complaints with feedback channels to recipients and effective referral protocols for reports of GBV*
4. Disseminate information on the GBV referral pathway among recipients of cash, implementing partners, and staff
5. Conduct training sessions on the GBV referral pathway with HCT staff and partners so they can share information on available GBV services if they receive disclosures of GBV *
6. Distribute the IASC GBV Pocket Guide to be used when GBV services do not exist
7. Deliver trainings to all partners on expected conduct and SEA*
8. Require all partners to sign a Code of Conduct and take action when SEA is reported

*To be carried out alongside GBV specialists

ANNEX 1:

GBV RISK ANALYSIS FOR HCT

GBV RISK	LIKELIHOOD OF OCCURRING (low/med/high)	IMPACT (low/med/high)	MITIGATING ACTIONS

Using participatory methodology and through consultation with women and girls and GBV specialists as well as UNICEF partners and government, where appropriate, map the risks of GBV throughout the program cycle.

Assess whether the likelihood of each risk of GBV is low, medium, or high relative to one another. Assess the impact of the risk of GBV if it were to occur. For each GBV risk, identify actions that be taken to mitigate its likelihood of occurring or severity of impact if it does.

This information will form a GBV Risk Matrix, which should be part of a wider risk matrix for HCT. This can be used to develop into an Action Plan or other tools to assign GBV risk mitigation measures to individuals to oversee or be responsible for as well as timelines for when the mitigating actions should be completed by or if they are continuous throughout the program cycle.

A GBV Risk Matrix should be revisited throughout the HCT program cycle and updated as risks of GBV change or emerge and if their likelihood and impact changes over time. Similarly, mitigating actions should be reviewed and updated as necessary.

If a GBV risk has a high likelihood and high impact and no identifiable mitigating actions that would bring it to an acceptable level of risk, changes to the HCT design and delivery should be made, such as alternative cash distribution points or cash delivery mechanisms, adjusted payment schedules or changes to the targeting and registration of recipients or eligibility criteria.

If changes cannot be made to HCT, consider replacing or supplementing HCT with in-kind assistance or direct service delivery. Delivery of humanitarian assistance inherently involves risks of GBV so similar processes of identifying and mitigating risks of GBV should be undertaken regardless of aid modality.

Below is a summarised list of examples of GBV risks that can be used to populate a GBV risk matrix, but this should not replace contextual analysis and consultation with HCT recipients, particularly women and girls.

EXAMPLES OF GBV RISKS

Response Analysis

Abuse of power by Government officials, UNICEF staff and partners, financial service providers, shopkeepers etc.

Increased household tensions and violence after women in the household receive cash.

Violence, exploitation, abuse, and harassment while travelling to markets to spend cash.

Violence, exploitation, abuse, and harassment during journeys to and from cash distribution points.

Programme Design

Backlash and stigma against survivors of GBV targeted for cash distributions.

Women and girls' needs not met because they are not calculated in the cash transfer amount.

Recipients of cash targeted for violence and theft because they are storing large amounts of cash.

Government officials, NGOs, financial service providers, shopkeepers, and mobile agents sexually exploit and abuse women receiving cash.

Programme Implementation

Recipients' names, addresses, phone numbers, and biometric data is not protected and they are targeted with violence and theft.

Information about cash transfer does not reach women and they do not know who is eligible for cash distributions and where and when they will happen.

GBV survivors do not know about the complaint mechanism.

GBV survivors do not trust the safety, confidentiality or effectiveness of the complaint mechanism.

GBV survivors cannot access the complaint mechanism.

Reports of GBV to complaint mechanism are not handled appropriately, causing additional harm to survivors.

Monitoring and Evaluation

Monitors from the cash distribution team or third-party monitors sexually exploit and abuse women, men, girls, or boys.

Women monitoring the cash distribution experience sexual harassment or other forms of violence from community members.

Monitoring does not incorporate GBV risks and they remain unidentified and unaddressed.

Cross-cutting throughout the Programme Cycle

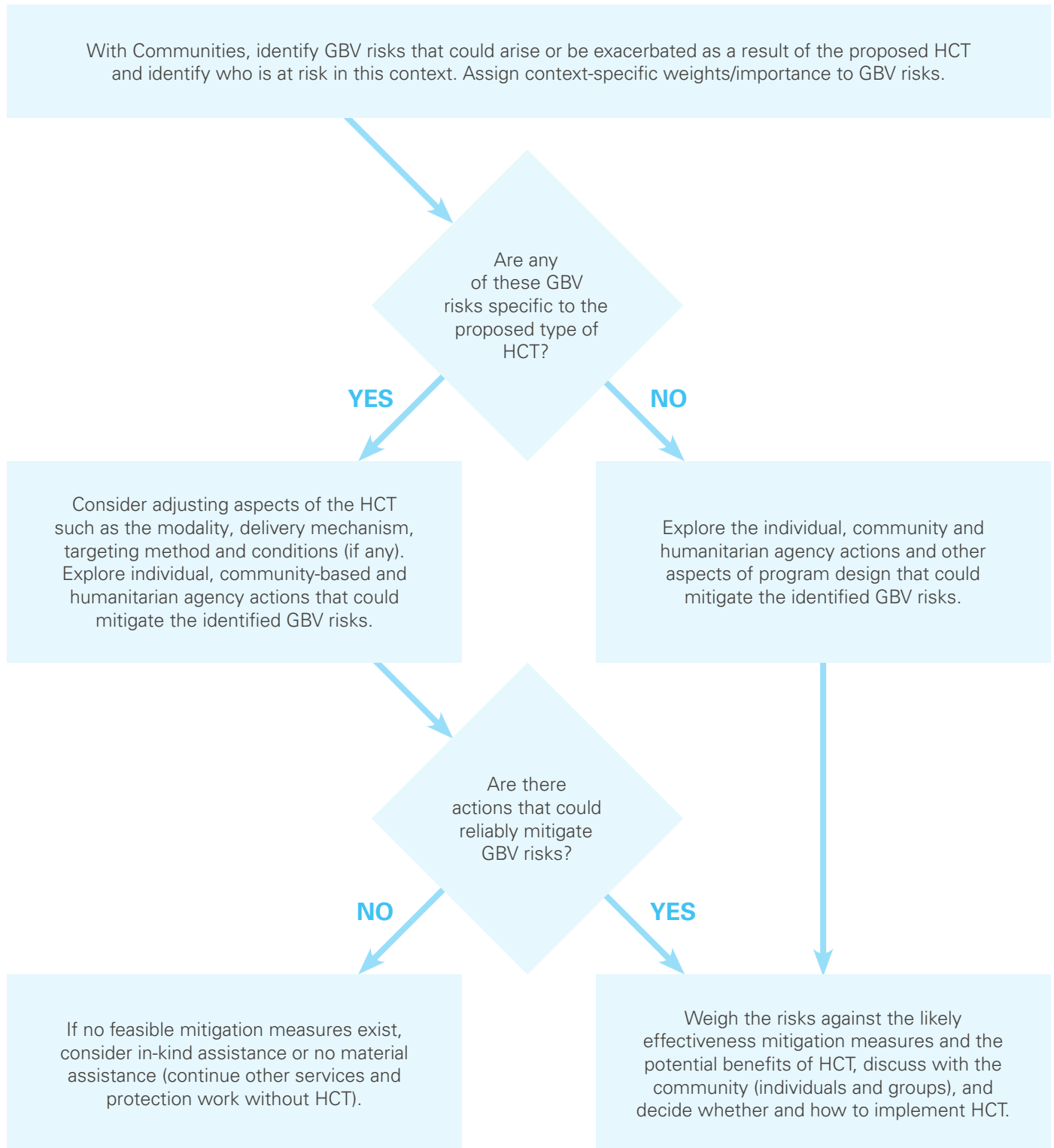
GBV risks are not identified in a risk analysis of the programme and are not identified and mitigated.

Concerns about violence, exploitation, and abuse are not raised during community consultations and are not identified or addressed.

ANNEX 2:

DECISION TREE FOR ADAPTING HCT BASED ON GBV RISKS

The decision tree below has been adapted from the [CVA and GBV Compendium: Practical Guidance for Practitioners](#)



ANNEX 3:

UNICEF TIP SHEET FOR CONSULTING WITH WOMEN AND GIRLS

This Tip Sheet can be found on [Sharepoint](#). It has been adapted slightly here to refer to HCT.

Effective GBV risk mitigation measurement a) integrates regular and routine consultations with women and girls; and b) measures, analyses and documents changes over time related to the GBV risk mitigation measure(s) in the project. This tip sheet provides supplementary guidance on how to engage women and girls to assess if your GBV risk mitigation measures are reducing barriers to HCT or markets or helping women and girls feel safer.

Basic information:

In general, engaging women and girls during consultations happens at three critical moments:

1. Before a project begins: women and girls are best placed to identify GBV risks in the environment and/or barriers to accessing services, along with their priorities for which risks and/or barriers are most critical to address;
2. During the project: women and girls provide feedback as to if/how your GBV risk mitigation efforts have affected their access to services and/or perceptions of safety. This feedback allows you to assess the effectiveness of your risk mitigation measure(s), identify any unanticipated or unintentional consequences; and, if necessary, make changes in your programming;
3. When the project is nearing completion or after it has ended: consultations help identify what worked and what did not work to generate lessons learned and next steps and which risks and/or barriers require the most urgent attention.

For your program, consultations can follow this model to assess perceptions of safety and if your GBV risk mitigation strategy is addressing the needs of women and girls.

Remember: Consultations can take multiple modalities such as focus group discussions, key informant interviews, community mapping exercises, ranking methods or other participatory approaches.

Preparation:

- If there is a GBV sub-cluster/working group or an organization implementing GBV programming, connect with them to request support on planning and carrying out the consultations.
- Consider the restrictions or sensitivities that may prevent a woman or girl from participating in a consultation or lead to more harm for her. GBV specialists, even if in a different location or at national level can provide support in thinking through how to engage women and girls in the safest possible way.
- Find out what GBV services are in place in the location where the consultations will be conducted. Ensure staff who will be facilitating the consultations are equipped to respond if someone discloses that they have experienced GBV. Staff conducting safety consultations should be (a) familiar with the GBV Pocket Guide on how to support GBV survivors and (b) familiar with how to appropriately refer survivors in a timely manner based on the GBV referral pathway in their area.
- It may be necessary to speak with community leaders prior to the consultations. In some situations, guardians, husbands, male relatives, or mothers-in-law may need to be consulted and/or give their permission in order for women and girls to participate in consultation. Carefully frame the purpose and scope of the consultation with communities and/or relevant stakeholders. Focus on the goal to improve HCT for the community, especially with regards to making them safer and more accessible.
- Take into consideration what locations and times of day are safest and most appropriate for women and girls to participate in the consultation, based on school, caring responsibilities, travel requirements, etc. Ensure consultations take place in a secure setting where all participants feel safe to contribute.

- Remember that participants may answer the same question differently depending on who is involved in the conversation (for instance, international or local staff of UNICEF or partner organisations), what they think the data collection team wants to hear, and what action or benefit they believe may result from responding in a certain way.
- Be aware of the composition of a group during consultations and how to make sure everyone feels safe to express their voice and opinions without creating additional harm for them. For example, including unmarried girls with married girls or women can create different power dynamics. Similarly having young women and older women in the same group may prevent younger women from voicing their opinions or experiences. Groups that can be particularly difficult to access include:
 - Married girls
 - Unmarried women
 - People with disabilities
 - Woman heads of household
 - Widows
- Work with a GBV specialist to determine what questions are appropriate. Questions should be worded in a way that explicitly links perceptions of safety to a specific intervention, facility, etc. and should include a time-bound component. Some examples specific to safety perceptions could be:
 - “Do women and girls feel safer going to the HCT delivery point since the location was changed to align with their preferences?”
 - “Do women and girls in your community feel their access to markets/banks/mobile agents has improved with the increased number of women agents (as compared to when the agents were mostly men)?”

DO'S

- Have trained women staff facilitate the consultations with women and girls.
- Be conscious of the fact that the women who are most visible/accessible for consultations may not be representative of the population as a whole (in terms of access to services, etc.). Consider if you need to make alternative arrangements to connect with other groups of women and girls in a safe, non-stigmatizing way.
- Explain the purpose of the consultation and how the information will be used.
- Obtain informed consent before beginning the consultation.
- Manage expectations about participating in the consultation and what participants can expect to receive. Be honest and upfront in explaining that there will be no compensation.
- Keep questions simple, relevant to program objectives and straightforward.
- If relevant, consider options for consulting with women and girls who are using the service (i.e. visiting the market to speak to them).

IMPORTANT DON'TS

- DON'T ask questions about individuals' experiences of GBV.
- DON'T collect or attempt to collect GBV incident data/numbers of cases.
- DON'T attempt to convene a consultation group comprised only of GBV survivors or to find GBV survivors to take part in the consultations.
- DON'T make questions too general. A question like “Do you feel safe?” can be interpreted in multiple ways and does not focus participants on the specific purpose of your consultation.

ANNEX 4:

SAFETY-ORIENTED FOCUS GROUP DISCUSSION GUIDE FOR HCT

Adapted from [UNICEF GBViE Resource Pack](#), Kit M, Rapid Assessment Tool 6, GBV Risk and Safety Focus Group Discussion Guide, and a GBV AoR workshop for HCT and GBV practitioners in Burundi, October 2019.

Purpose: To use semi-structured in-depth discussions with different groups of females and other community members to learn about GBV risks and responses. This tool will help UNICEF and partners to learn more about perceptions of GBV risk and mitigation measures in the community and by UNICEF/its partners, particularly related to the potential introduction of cash assistance. It will inform a [GBV Risk Analysis for HCT](#) and safety questions for post-distribution monitoring of the HCT.

Sources of information (separately by gender and, if possible, by age):

- Older adolescent girls and women of different ages and backgrounds
- Older adolescent boys and men of different ages and backgrounds
- Community leaders (separate from the other groups)

Additional information: Focus group discussions (FGDs) can help to identify places where girls and women feel unsafe and/or experience different forms of violence. The information can be further explored in safety mapping and/or safety walks, if appropriate. See the GBViE Guidance for examples.

Each focus group should include 6–8 volunteers of the same cultural background. Consideration should be given to the profile of group members to reduce the risk of power inequalities in the group based on status or role in the community, which can inhibit some women from speaking freely. Consideration should also be given to ensuring the discussions take place in private and safe spaces.

There should be 2 women facilitators to lead the women's FGD with the following roles:

- Lead facilitator – This person is responsible for asking the questions and guiding the discussion. The lead facilitator should have experience in facilitating FGDs, should be able to probe and draw out discussions, and should have experience observing group dynamics.
- Process facilitator – This person is responsible for taking notes and recording the discussion. This person should be fluent in local languages and should be directly involved in the translation of recordings and notes after the session.
- Remember to make sure that one of the facilitators is trained to respond appropriately to any disclosures made during or after the focus group and to ensure appropriate follow-up as needed. ⚠️ **with GBV staff**

There are examples of questions listed in the menu below which can be chosen as appropriate based on context and available time. They can be followed up with questions relating to the responses of participants, to arrive at a more detailed and contextualized understanding of risks and mitigation.

MENU OF POTENTIAL QUESTIONS

Social relations

- How are the relationships between community members and neighbors/ host community [after the crisis], how are the relationships between new arrivals and other IDPs/refugees? How are relationships between husbands and wives, co-wives, women and their in-laws, and others in the home?
- Are there generally more tensions in the home after the crisis /displacement or in recent days/weeks?
- Are there certain people or groups who are most at risk of violence?

Safe access to markets, shops, banks

- How safe is the market(s)? How safe is it getting to shops/traders, banks and transport? Can women, girls and boys

safely go to market(s) / shops/ banks/ mobile agents, and if so during which seasons, days and hours? Do you have to pay for transport to markets and shops or can you safely walk there?

- Do women need additional cash for safe transport to markets? Do they require dependent care to avoid leaving adolescent girls at home to care for young children or older persons, and are there community-based mechanisms that could support this?
- Are certain groups e.g. minority ethnic women or gender non-conforming persons at risk in markets/shops or carrying money?
- Are there taboos surrounding the purchase of certain products, such as menstrual hygiene management items such as pads or contraception? Are these products available in the market?

Household earning and decision-making

- How do you ensure that your family is able to eat and survive in this context?
- Who manages money and spending within households in your community?
- Who within the household decides about spending on women's and girls' needs (e.g. menstrual hygiene management items)?
- Does the family make-up affect decision making, for instance the presence of multiple wives or in-laws?
- If women in the community receive assistance from humanitarian agencies, what are the risks related to that, within the family, the community or with older arrivals or host community? Would they be different if the woman receives cash instead of a kit?
- If there are risks around women receiving in-kind assistance or cash, what measures could be put in place to reduce those risks?

ANNEX 5:

KEY RESOURCES

[UNICEF Availability, Accessibility, Acceptability and Quality framework:
Identifying potential barriers to accessing services in humanitarian settings](#)

[UNICEF Case Study: Yemen](#)

[UNICEF Gender-Based Violence in Emergencies Operational Guide. Kit 3.6: Programming. Kit M:
Minimum GBViE Response Package](#)

[IASC Guidelines for Integrating Gender-Based violence Interventions in Humanitarian Action](#)

[IASC Cash & Voucher Assistance and GBV Compendium:
Practical Guidance for Humanitarian Practitioners](#)

[Save the Children:
Child Safeguarding in Cash Transfer Programming: A Practical Tool](#)

[Women's Refugee Commission, International Rescue Committee and Mercy Corps:
Assessing and Mitigating Risks of Gender-based Violence: Guidance for Cash Providers](#)