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USAID'S COLLECTIVE ACTION TO REDUCE GENDER-BASED VIOLENCE (CARE-GBV)

How to Build, Strengthen, and Maintain Gender-Based Violence Referral Networks

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Overview

Building referral networks, or strengthening existing networks, is crucial to providing survivors of gender-based violence (GBV) with access to timely, safe, and confidential services that can support their immediate and long-term health, healing, and empowerment. Every standalone and integrated GBV program—and ideally, every development program—should link to or build a GBV referral network before implementing programming.[1]

The existence and effectiveness of GBV referral networks varies widely across development contexts. With the acknowledgment that every setting is different, this how-to note guides practitioners working across sectors in how to build, strengthen, and maintain referral networks. It serves as a supplemental resource to USAID's *Foundational Elements for Gender-Based Violence Programming in Development* and covers key terms, approaches, and suggested steps, as well as strategies for addressing challenges and considerations for funders. This how-to note is relevant for USAID and implementing partner (IP) staff who provide guidance to and technical oversight for GBV programs, including staff who will be incorporating GBV referrals into other sectoral programming (see Figure 1: Illustrative Examples of How Different Actors Can Support Building, Strengthening, and Maintaining Referral Networks for more information).

What is a Referral Network?

A referral network is a group of actors[a] that provide forms of support to survivors of GBV, as well as GBV prevention and risk mitigation, and are linked through a formal or informal coordinating mechanism or agreement. Referral networks can include formal sources of support (such as health, justice, legal recourse, and social service providers) and informal sources of support (such as support collectives, activist groups, religious leaders, family and friends, and trusted community members). Referral networks typically cover community, district, or regional geographic areas, and their structures vary significantly across local contexts. Some have multi-sectoral working groups at the regional level that facilitate the referral network with regular meetings of providers to coordinate services. In less-resourced settings, referral networks may consist of loose connections between community leaders, activists, and local civil society organizations (CSOs) that collaborate to respond to GBV disclosures and support survivor needs.

[a.] Actors that make up a referral network include individuals, organizations, and institutions that provide services or sources of support.

Box 1. Essential elements of a GBV referral network

A functional referral system should have at least one provider or organization for each of the following: health (physical and mental health), psychosocial support, and justice and legal recourse resources. It should regularly update referral lists that identify all available services, as well as flow charts that depict service coordination pathways. All formal and informal actors in the network should understand where to refer survivors for additional services and should have a follow-up mechanism to see that referrals have been completed.[2]

Within one local context, there may be different referral networks depending on the community that requires support. For example, survivors of GBV who experience compounding forms of marginalization due to intersecting identities of race; ethnicity; sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC); religious or political affiliation; age; immigration status; or disability may require distinct referral networks, because where and how they feel safe disclosing incidents of GBV and accessing referral networks may be affected by structural barriers.[3,4]

Table 1. Key definitions

Gender-based violence	Any harmful threat or act directed at an individual or group based on actual or perceived biological sex, gender identity and/or expression, sexual orientation, and/or lack of adherence to varying socially constructed norms around masculinity and femininity. It is rooted in structural gender inequalities, patriarchy, and power imbalances. GBV is typically characterized by the use or threat of physical, psychological, sexual, economic, legal, political, social, and other forms of control and/or abuse.[5]
Referrals	The process by which a service provider or community member links a survivor of GBV with services or other forms of support. This can be done by providing survivors with information about the resources that are available to them or connecting them directly to the point of contact of the service or informal support they wish to access and supporting them to overcome any barriers to access (often referred to as a "warm referral").
Referral networks	Groups of formal and informal multi-sectoral actors that connect survivors with support and resources, including health care and psychosocial services, justice, policing, legal recourse,[b] and other social services. Referral networks should be survivor centered, accessible, rights based, voluntary, noncoercive, and gender- and age-sensitive.
Entry point	The first point of access that survivors use to obtain support. Entry points can be physical spaces, such as health clinics, community centers, safe spaces,[c] and shelters. Entry points can also be a person, such as a trusted friend or family member, community or religious leader, midwife, teacher, program facilitator, police officer, or hotline operator.

[b.] While resources and support for justice and legal recourse will overlap, not all legal services will lead to justice, and justice mechanisms in many contexts can fall outside of legal systems.

[c.] Safe spaces are places that promote physical and emotional safety, freedom of expression, and access to knowledge, skills, and resources. In GBV programming, women-and-girl safe spaces often serve as an entry point to a variety of confidential support services.

Key Approaches

Survivor Centered

A survivor-centered approach focuses on the empowerment of survivors by creating a supportive environment for healing. Promoting the dignity, rights, and agency of survivors is a key objective of a survivor-centered approach. It is implemented by prioritizing survivors' safety, protecting confidentiality, demonstrating respect for survivors' needs and wishes, and practicing nondiscrimination. Referral network actors should make services available to all survivors even though some survivors may not want or need to access these services. A survivor-centered approach equips survivors with knowledge and information about the services available and how to access them—ultimately, it is an individual's choice whether and when to use services.

Do No Harm

A do-no-harm approach means that, above all, GBV programming must not jeopardize the physical or emotional well-being of survivors, staff, program participants, and community members. In contexts with legislation and social norms that normalize violence against populations, including women, girls, people with disabilities, and people of diverse SOGIESC, survivors may be at risk of further marginalization or harm by accessing services, including those provided by state-based organizations and informal justice mechanisms. Referral network partners must be sensitized to the potential risks survivors face when engaging with different sources of support so they can clearly communicate these risks to survivors and identify strategies to mitigate risk.

Intersectional

An intersectional approach acknowledges that individuals may face different power imbalances based on multiple interconnected social identities that disadvantage or privilege them. It prioritizes access and safety for diverse populations of survivors seeking support by establishing multiple entry points or separate referral pathways and ensuring that services are accessible for a survivor's diverse needs and priorities.

Coordinated

A coordinated approach is crucial to building and strengthening referral networks and improving the access, quality, and sustainability of GBV prevention and response services. This is done by establishing relationships with referral partners; drawing on the expertise and community reach of multi-sectoral stakeholders; creating standards for survivor-centered referrals and services; building on existing, locally led support networks; and designating service providers to help survivors navigate often disparate systems.

Accessible

Accessible services and support for survivors are characterized by an enabling environment that prioritizes safety, autonomy, and confidentiality in a context free from stigma and discrimination. Providing accessible services can entail offering support in multiple, local languages, securing funding to remove financial barriers to survivors who wish to access services, altering the timing of services, creating alternative ways of reaching populations (such as through home visits) and other modifications to service delivery, as well as staff training and sensitization. It may also entail building survivors' awareness of the services and legal recourse options available to them, through awareness-raising campaigns or legal recourse services.

Box 2. Ensuring referral networks serve diverse communities

GBV referral networks should be inclusive of all groups of survivors, including those who experience multiple, intersecting forms of marginalization due to race, ethnicity, SOGIESC, age, religious affiliation, or disability. However, service and access needs can differ by group. Therefore, services (including entry points) should be tailored to enable safe access and meet the distinct needs of each group. Safety and accessibility must be considered together so that safety measures do not impede accessibility and accessibility measures do not compromise a survivor's safety.[6]

For example, women- and girl-only spaces are often a critical entry point for service delivery, particularly in contexts where patriarchal norms compromise female safety and constrain their mobility in mixed-gender spaces, but this may not be an inclusive or accessible entry point for men and boys, or transgender people and other survivors of diverse SOGIESC. Collaborating with lesbian, gay, bisexual, transgender, queer, and intersex people, and those of other diverse sexual orientations and gender identities (LGBTQI+) support collectives and organizations to create entry points or safe spaces for these individuals is also important to ensure all survivors have access to support that feels safe and inclusive.

Referral network actors can adopt approaches that help diverse communities of survivors feel welcome to access their services, even if this is to identify another provider to best support the needs and wishes of the survivor. This can include providing nonjudgmental services to survivors with diverse SOGIESC by never assuming a survivor's gender or sexual orientation, inquiring into and using survivors' preferred names and pronouns, and adhering to strict confidentiality protocols to safeguard survivor confidentiality.[7] To increase the accessibility of services for survivors with physical disabilities, organizations should address common infrastructure barriers whenever possible by installing wheelchair-accessible ramps, widening passageways, and creating accessible restroom facilities.[8] When infrastructure adjustments are not feasible, organizations can explore the possibility of locating trained staff members at trusted health care facilities or disability support groups so that survivors can discreetly access services in locations they may already frequent.

Steps to Build, Strengthen, and Maintain Referral Networks

STEP 1. ASSESS CONTEXT

Understanding the local context is a crucial first step to building or strengthening referral networks. USAID staff and IPs can incorporate these questions, sources, or data collection strategies into planned assessments that occur at different points in the project life cycle, such as gender equality and social inclusion analysis at the Regional Development Cooperation Strategy/Country Development Cooperation Strategy (RDCS/CDCS) or project level, or gender and inclusive development action plans (GIDAPs) at the activity level.[d]

Establish the scope of your assessment.
Identify the geographic area of interest (national, regional, provincial, or community level); consider the time, funding, and staff capacity available; and determine what information you want to gather. Consider involving the Mission's gender advisor or a local GBV expert. If needed, inquire about additional support available from USAID/Washington or other Missions through the Agency's gender architecture.

- Possible questions[e] to consider on local GBV trends and dynamics, social norms, and help-seeking behavior include:

  - Which types of GBV are the most prevalent? How do they affect different populations?

  - Which risk factors contribute to GBV among different groups at the familial, community, regional, and national level? Which protective factors exist?[f]

  - Are there national- or regional-level regulations related to GBV, such as mandatory reporting requirements?

  - What are typical attitudes, beliefs, and social norms about GBV and toward survivors and perpetrators? Which gender and social norms are drivers of GBV in this context?

  - How could laws, policies, and institutional practices be strengthened to create a more enabling environment for preventing and responding to GBV?

  - Where do survivors of GBV go? Whom do they reach out to for support? Is this different for different groups?

  - Do survivors trust service providers, including state-based service organizations such as law enforcement or social welfare? If not, why?

  - What would help survivors access the services they need? How does access to services differ according to age, class, ethnicity, sexual orientation, gender identity, and other factors?

- **Review existing sources of information.** Useful sources may include:

  - Literature, blogs, and podcasts authored by CSOs, NGOs, activist networks, or other local knowledge holders

  - Academic research such as ethnographic accounts, prevalence studies, and research produced by local scholars

  - Interagency reports, USAID gender equity and social inclusion (GESI) analyses, or gender and inclusive development action plans (GIDAPs)

  - Government-sponsored reports or action plans

  - Demographic and Health Surveys (DHS) Program data

- **Engage local knowledge holders to fill gaps in existing information.**

  - Key informant interviews (KIIs) and focus group discussion (FGDs) are common methods for collecting GBV-related data in an ethical and timely manner. Participants may include:

    - Grassroots and advocacy organizations based in the community, familiar with local context, and willing to share insights into power dynamics and GBV

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[d] USAID and its IPs are required to conduct gender analysis when designing all strategies, programs, and activities, as mandated by the Women's Entrepreneurship and Economic Empowerment Act of 2018 and further defined by ADS 205.

[e] Adapted from USAID's "Foundational Elements for GBV Programming in Development: Process Elements."

[f] Risk factors are conditions or attributes that increase the likelihood of an individual experiencing violence. Protective factors are conditions or attributes that lower the likelihood. These factors occur at the individual, relationship, community, and societal levels.

- Members of local communities—particularly those belonging to marginalized groups—who can act as an advisory on help-seeking behavior, including barriers and facilitators to accessing services

- Community mapping exercises, where participants depict their responses on a map of the community or geographic area of interest, can be integrated into FGDs, and are particularly useful in cultures that have a strong visual tradition.

When conducting FGDs or KIIs, data collection teams should consult with community and survivor-led organizations and diverse groups of people at risk of GBV, recognizing that survivors of GBV will be among these groups. Teams **should not** plan to seek out or speak directly with survivors, because it can be difficult to protect confidentiality and safety; instead, they should recognize that anyone they speak with may be a survivor and be trained on safe and ethical responses to disclosures.[g]

STEP 2. MAP AND ASSESS SERVICES AND RESOURCES

After assessing the broader context, begin mapping GBV-related services and other resources for support. To do this, IPs should link to existing formal or informal actors engaged in work to address GBV to identify referral lists through the following mapping actions:

- Reach out to local GBV organizations, knowledge holders, or community leaders to learn about formal and informal sources of support available for survivors, and whether referral lists exist.

If referral lists do not currently exist:

- Generate a list with the names and information of all formal and informal actors providing support to survivors. Prior to documenting and sharing information about service providers, assess whether there are risks associated with doing so (to service providers or survivors accessing services), and identify strategies to mitigate risks through data protection and information sharing protocols.

For suggested questions and approaches to gathering information for a referral list, please see the Building Referral Lists tool in Annex A.

When existing referral lists are available (or after generating a list using the step above):

- Review existing referral lists and identify gaps in services offered.

- Assess whether the services provided by formal and informal sources of support are survivor centered, trauma informed, safe, and accessible, and which services are provided to which populations. This includes service providers' attitudes, as well as their competency in delivering GBV services while adhering to guiding principles and minimum standards. Sample tools for assessing service quality can be found in the resources at the end of this note. For additional guidance on survivor-centered and trauma-informed care, see How to Implement a Survivor-Centered Approach in GBV Programming and How to Integrate Mental Health and Psychosocial Interventions in Gender-Based Violence Programs in Low-Resources Settings.

- Assess the quality of care provided to survivors at local health clinics; determine whether survivors have free access to care, whether providers are trained in clinical management of sexual assault, including whether post-exposure prophylaxis (PEP) and emergency contraception are available, and whether clinics have private spaces to protect survivor confidentiality.

- Gauge the level of coordination and trust between formal and informal referral network partners. This can be done through informal conversations with formal and informal network actors and integrated into the community mapping exercise in Step 1.

- Assess community awareness of services, as well as perceptions of service accessibility, safety, and quality.

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[g] For additional guidance on safe and ethical data collection, see the *WHO ethical and safety recommendations for researching, documenting, and monitoring sexual violence in emergencies*, which are widely accepted and applied across humanitarian and development contexts for the planning, collection, and use of information on GBV.

STEP 3. DEVELOP OR STRENGTHEN REFERRAL NETWORKS

Strong, effective referral networks require trust and collaboration between formal and informal network partners, trained staff or informal actors with empathetic attitudes toward survivors, and clear guidelines, policies, and standard operating procedures (SOPs).[9]

The steps needed to develop or strengthen referral networks will depend on the state of existing networks. Using the information gathered in Step 2, identify strategic priorities in strengthening referral networks based on identified gaps, as well as available time, funding, and staff capacity within project budgets. Consider gathering network partners in a collaborative, participatory process to establish consensus on guiding principles, agree upon standards of care, and develop referral guidelines and policies.

Suggested actions for developing or strengthening referral networks

- Establish consensus on guiding principles for working with survivors of GBV and overarching standards of care, including measures to reduce the need for survivors to share their experience of GBV multiple times.

- Develop SOPs and information, education, and communication (IEC) materials that guide the coordination of services and referrals and include the following:

  - Roles and responsibilities for the staff and volunteers of all formal and informal referral network members

  - Flow charts (often called referral pathways) that depict when and how referrals should be made and followed up across the referral network to ensure continuity of care

  - Guidelines for informed consent, confidentiality, and mandatory reporting procedures, including when working with children or adolescents under the legal age of consent

  - Guidelines and policies to establish nondiscrimination, protection of survivor information and data, prevention of sexual exploitation and abuse (PSEA), adverse event documentation, anonymous reporting channels, and non-retaliation policies

  - Standards for data collection, management, and information-sharing protocols, including when and how service provider and survivor information will be shared among network partners

  - Network coordination mechanisms (frequency of network meetings, convening body, etc.)

  - Processes for how referrals and follow-up should be documented (verbal, paper-based, or computerized methods) and how standards for management of GBV survivor data should be followed

- Address gaps in service accessibility or quality

  - Review the referral network, and map the strengths, bottlenecks, and areas for improvement

  - Convene network meetings to discuss common challenges to improve referrals

  - Continuously address challenges that prevent the referral system from functioning (e.g., barriers for survivors in accessing services, challenges to coordinated service provision)

- Formalize relationships between referral network partners. When appropriate, sign memoranda of understanding with referral network partners, inclusive of the following information:

  - Agreements that outline coordination protocols, expectations for the staff and volunteers of all network partners, and commitments to implementing monitoring, information-sharing, and quality assurance protocols

  - Agreement on guidelines for interfacing with clinical, legal, and other reporting systems

- **Train formal and informal referral network partners**

  - Provide training on the use of SOPs, guidelines, referral forms, supportive supervision, and service monitoring tools. Non-GBV specialists who come into contact with survivors should be trained on what constitutes GBV and how to respond to disclosures and facilitate referrals (see Box 3).

  - Conduct training and interactive workshops with formal and informal network partners to foster survivor-centered attitudes, knowledge, and skills.

- Implement interactive learning sessions that provide opportunities for individual and group reflection on one's power, biases related to GBV and survivors, and further promoting survivor-centered and inclusive attitudes and practices across network partners.

• **Ensure formal and informal referral network partners have access to self- and collective care resources that promote wellness and resilience**[13]

- Embed self- and collective care into organizational culture, values, and leadership and associated policies and structures.[14]

- Establish policies and mechanisms to mitigate burnout and enhance psychological well-being (such as policies on paid leave, maximum client-to-staff ratios, regular opportunities for debriefing, and trauma-informed protocol for staff exposed to critical incidents and referrals to specialized mental health services).[15]

- Allocate time and resources for contextually relevant self- and collective care activities, such as embodiment practices, exercises to mitigate stress, and having dedicated space for staff to gather.[16]

- For more on embedding self- and collective care in organizations addressing GBV, see CARE-GBV's how-to note: How to Embed Self- and Collective Care in Organizations Addressing Gender-Based Violence.

• **Conduct outreach to relevant communities**

- Design IEC materials to inform the public of referral network services, using local languages and formats that are accessible and relevant for diverse groups of survivors, including those with physical, cognitive, and sensory disabilities.[17]

- Inform diverse communities of survivors and others at risk of GBV of referral network services and engage community leaders and "gatekeepers" to promote awareness of the referral pathway.

Adapted from USAID's Strengthening Linkages between Clinical and Social/Community Services for Children and Adolescents Who Have Experienced Sexual Violence: A Companion Guide.

Box 3. Strengthening linkages between informal and formal systems of support

Survivors often first disclose their experience of GBV to informal sources of support, such as trusted friends, family, or community and religious leaders,[10] and those who receive a supportive, affirming response are more likely to seek help in the future.[11,12] It is, therefore, crucial that informal sources of support are equipped to respond to survivors and connect them with formal services they may wish to access.

See Step 3: Develop or Strengthen Referral Networks and Box 3: Responding to GBV as a non-specialist for more information.

STEP 4. MONITOR AND MAINTAIN REFERRAL NETWORKS

Strong, integrated referral networks are regularly updated and maintained so that services across the network are high quality and respond to the diverse needs of survivors. Depending on the time, funding, and staff capacity available in project budgets, referral network actors should consider building out or strengthening existing monitoring and feedback mechanisms through the following actions in coordination with network partners:

- Monitor and, as needed, update referral lists, SOPs, and IEC materials every 6 months, at minimum. The frequency for review should depend on the stability of the service environment. Updates should be made more regularly if changes occur that would affect services (e.g., onset of natural disasters, COVID lockdowns).

- Communicate changes in referral processes, SOPs, or other guidelines to referral network partners, community members, and survivors.

- Develop and implement systems to periodically evaluate the efficacy, relevance, accessibility, and use of the existing referral networks. Include anonymous and confidential mechanisms for referral network partners, survivors, or other individuals to offer feedback on gaps and areas for improvement for the referral network. Information gathered should be used to inform and modify services as needed.

Box 4. Responding to GBV as a non-specialist: Using the World Health Organization's (WHO's) LIVES approach for first-line support

Providing information in a safe, ethical, and confidential manner that abides by the core principle of "do no harm," WHO's LIVES protocol was developed to guide health providers in compassionate care for survivors. It is also a useful protocol to guide non-GBV specialists, or informal sources of support, to whom survivors may disclose their experiences of GBV. The protocol can be used in community outreach geared toward training community members on administering first-line support. The following steps make up the LIVES protocol:

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Listen	Listen to the survivor using active listening techniques and leaving out judgment of the survivor's actions.
Inquire about needs and concerns	Inquire about the survivor's needs and concerns, asking open-ended questions and repeating back to ensure understanding.
Validate	Validate the survivor's feelings and actions, reiterating that the survivor is not to blame.
Enhance safety	Enhance safety by helping the survivor think through how to be protected from further harm.
Support	Support the survivor by discussing their access to social support and referring them to qualified services.

Source: World Health Organization. 2021. *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health Care Providers*. Geneva, Switzerland: WHO. https://www.who.int/publications/i/item/9789240039803.

Figure 1. Illustrative Examples of How Different Actors Can Support Building, Strengthening, and Maintaining Referral Networks

ILLUSTRATIVE EXAMPLES OF HOW DIFFERENT ACTORS CAN SUPPORT BUILDING, STRENGTHENING, AND MAINTAINING REFERRAL NETWORKS

This graphic provides illustrative examples of how different actors can engage in steps for building, strengthening, and maintaining referral networks. The actors and actions listed are not meant to be exhaustive or prescriptive, and activities should be based on context, available time, funding, and expertise. All actions should be coordinated with network partners to address gaps and avoid duplication.
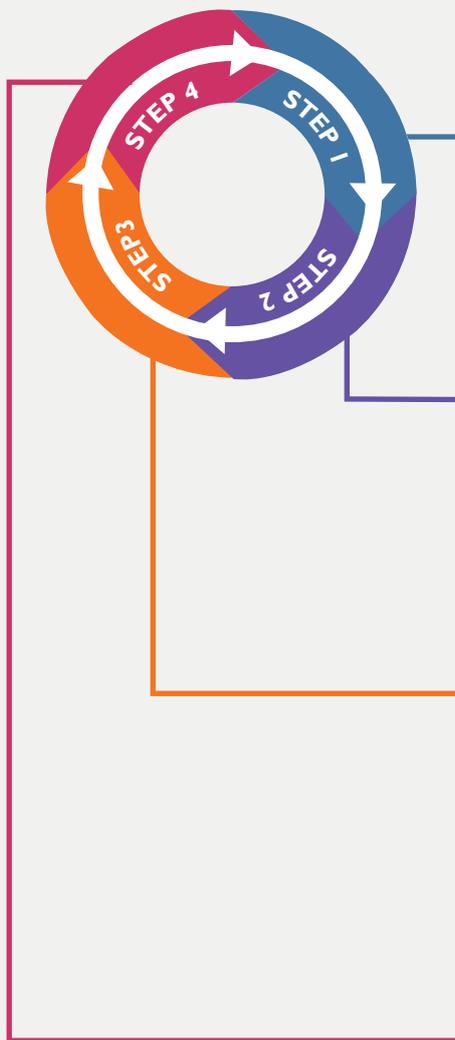
STEP 1: ASSESS CONTEXT

- **USAID mission or regional platform** (or other funders): Synthesize existing information on GBV in the local context and identify which interventions are taking place and what gaps exist.
- **LGBTQI+ network**: In partnership with a GBV specialist, conduct FGDs onGBV trends, dynamics, and help-seeking practices among LGBTQI+ community.

STEP 2: MAP AND ASSESS SERVICES

- **Sector-specific program**: Engage local GBV organizations to learn about sources of support for survivors and whether referral lists exist.
- **Ministry of Health:** Assess the quality of care provided to survivors at local health clinics and determine whether providers are trained in the clinical management of sexual assault.

STEP 3: DEVELOP OR STRENGTHEN REFERRAL NETWORKS

- **Local GBV specialist**: Develop contextualized trainings for referral network partners on survivor-centered approaches.
- **Faith leaders**: In partnership with a GBV specialist, promote community awareness of referral pathways and survivor-centered approaches to first-line support.
- **USAID mission or regional platform** (or other funders): Invest in and advocate for strengthening electronic information management systems that protect data on incidents of GBV.

STEP 4: MONITOR AND MAINTAIN REFERRAL NETWORKS

- **Disability rights advocates**: Develop accessible mechanisms for persons with disabilities to share confidential feedback on access and quality of GBV services and convene with network partners to address areas for improvement.
- **NGO providing shelter and other social services to survivors of GBV**: Lead on updating referral lists, SOPs, and IEC materials every 6 months and disseminating them to referral network partners.

Common Challenges and Suggested Approaches

The following examples suggest approaches to address common challenges when working to strengthen GBV referral networks. Approaches should always be adapted to the local context in collaboration with formal and informal local actors, and where possible, should engage a local GBV expert.

- **In rural areas with limited services or severe resource constraints, or in contexts of displacement, it may not be possible to bring together even basic elements of a referral system.**

  - A percentage of project funding should be allocated for direct cash transfers to survivors to support their needs, including basic food, hygiene, and clothing items; transportation to a health clinic or shelter; or access to PEP or emergency contraception. Mobile services are provided to people where they are residing, displaced, or in transit when they are not easily reached with centralized services, and these services offer unique opportunities to counter the challenges of providing care to survivors.[18] Virtual GBV services, including phone-based support and hotlines, are a flexible and adaptive approach to provide survivors with access to critical support services.[19] Many mobile and virtual service provision models were piloted during the COVID-19 pandemic, and they may be relevant for other resource-constrained development contexts.

- **Survivors of GBV may anticipate or experience stigma and discrimination when accessing GBV-related services within a referral network.**

  - Nondiscrimination is best implemented through active efforts to engage those who typically might not feel welcome by acknowledging that anyone can be a survivor, including people with diverse SOGIESC; people with disabilities; members of indigenous, ethnic, or religious minority communities; and others who are marginalized. Stigma and discrimination can be addressed through staff training and supervision, contextually relevant social behavior change programs at the community level, or IEC campaigns at the national level.

- **Even with a robust referral network in place, referral uptake may remain low.** Factors contributing to low uptake are context specific and may include survivors' fears around the safety of accessing services or fears around the services themselves (such as HIV testing or other medical procedures), lack of understanding of the benefits of accessing care, or access barriers (such as lack of time, transportation, or supportive accompaniment).[20,21]

  - When using a survivor-centered approach, a provider should never aim to persuade survivors to seek certain forms of support. However, providers may help increase uptake of referrals by offering warm referrals or accompaniment to services, integrating a comprehensive package of GBV-response services into key locations (such as health care settings), providing education on the benefits of certain types of care (such as HIV and pregnancy prevention within 72 hours), and addressing survivors' concerns associated with services.

Considerations for Funders

USAID and other funders have a crucial role to play in preventing and responding to GBV across the globe and creating enabling environments so IPs can build or strengthen referral networks in the contexts where they work.

To better support IPs as they assess the underlying context related to GBV and begin to map available services, USAID missions can allocate funding to conduct referral network mapping as part of periodic gender or GESI analyses at the RDCS/CDCS or project level. They can also invest in synthesizing and analyzing research and existing data to build a robust understanding among USAID mission staff of how GBV manifests in their country of service, which communities are most at risk, which prevention and response interventions are taking place, and what gaps exist. In contexts with high GBV burden and weak referral systems, USAID and other funders can consider ways to strengthen networks including funding local GBV organizations or coordination positions at local, regional, and national levels.

USAID and funder coordination bodies can also leverage their role liaising with national governments to advocate for political, legal, and fiscal environments

that better enable practitioners to prevent and respond to GBV. Funders can invest in and advocate for efficient electronic information management systems that protect data and appropriately report on incidents of GBV. This can include strengthening national information management systems. Funders can also advocate for adequate, long-term financial mechanisms that ensure national health systems are able to provide accessible, quality services with no cost to survivors, or for the development of national legislation that dismantles structural-level barriers to safe access of services, such as addressing laws that criminalize certain types of sexual activity (such as sex outside of marriage or sexual activity between individuals of the same sex) that may place survivors at risk of prosecution if they seek support.

Resources

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Annex A: Building Referral Lists

The following tables can be used to generate a list with the names and information of all formal and informal actors providing support to survivors. Prior to documenting and sharing information about service providers, assess whether there are risks associated with doing so (to service providers or survivors accessing services), and identify strategies to mitigate risks through data protection and information sharing protocols.

There are many ways to categorize and group services and support. These tables should be used as a guide and can be adapted to meet the needs of the program and context. For more information on types of GBV response services, see Foundational Elements Section 3.3. Program Elements: Response.

Table 2. Building Referral Lists

	Health care (physical and mental) and psychosocial support			
Name, acronym, address of service provider				
What are the hours of operation?				
Name and contact information of GBV point of contact				
What services, programs, and activities do they provide?				
Which communities does the organization serve? (e.g., women, LGBTQI+ people, adolescents, men and boys, people living with disabilities)				
How do survivors typically access the organization's services? (e.g., is the organization an entry point for services or do they receive referrals?)				
What procedures are in place to safeguard survivors' confidentiality, safety, and anonymity?				
Do survivors need to pay to access their services? If so, what is the cost of services?				
Are there existing or potential barriers to survivor access?[h]				
Last date information was updated				

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h. Barriers can be from the survivor's point of view and the service provider's point of view. Barriers for survivors include entry fees, anticipation of stigma, infrastructure inaccessible for disabled individuals, transportation costs, and fear of confidentiality breach. Barriers for service providers include lack of resources needed to extend their reach to specific communities of survivors, such as funding to hire adequate staff and training existing staff in nondiscrimination and survivor-centered approaches. Other barriers include the need for capacity-building or government authorization to provide services.

Table 2 continued. Building Referral Lists

	Justice, policing, and legal recourse			
Name, acronym, address of service provider				
What are the hours of operation?				
Name and contact information of GBV point of contact				
What services, programs, and activities do they provide?				
Which communities does the organization serve? (e.g., women, LGBTQI+ people, adolescents, men and boys, people living with disabilities)				
How do survivors typically access the organization's services? (e.g., is the organization an entry point for services or do they receive referrals?)				
What procedures are in place to safeguard survivors' confidentiality, safety, and anonymity?				
Do survivors need to pay to access their services? If so, what is the cost of services?				
Are there existing or potential barriers to survivor access?[h]				
Last date information was updated				

Table 2 continued. Building Referral Lists

	Economic empowerment and education			
Name, acronym, address of service provider				
What are the hours of operation?				
Name and contact information of GBV point of contact				
What services, programs, and activities do they provide?				
Which communities does the organization serve? (e.g., women, LGBTQI+ people, adolescents, men and boys, people living with disabilities)				
How do survivors typically access the organization's services? (e.g., is the organization an entry point for services or do they receive referrals?)				
What procedures are in place to safeguard survivors' confidentiality, safety, and anonymity?				
Do survivors need to pay to access their services? If so, what is the cost of services?				
Are there existing or potential barriers to survivor access?[h]				
Last date information was updated				

Table 2 continued. Building Referral Lists

	Other social services			
Name, acronym, address of service provider				
What are the hours of operation?				
Name and contact information of GBV point of contact				
What services, programs, and activities do they provide?				
Which communities does the organization serve? (e.g., women, LGBTQI+ people, adolescents, men and boys, people living with disabilities)				
How do survivors typically access the organization's services? (e.g., is the organization an entry point for services or do they receive referrals?)				
What procedures are in place to safeguard survivors' confidentiality, safety, and anonymity?				
Do survivors need to pay to access their services? If so, what is the cost of services?				
Are there existing or potential barriers to survivor access?[h]				
Last date information was updated				

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The goal of the Collective Action to Reduce Gender-Based Violence (CARE-GBV) activity is to strengthen USAID's collective prevention and response, or "collective action" in gender-based violence (GBV) development programming across USAID. For more information about CARE-GBV, click here.

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