Lessons from Over a Decade of Data

Responding to GBV in a New Era of Humanitarian Aid

INTERNATIONAL RESCUE COMMITTEE

December 2025

Executive Summary

2025 has been a year of system shock for humanitarians. Huge cuts to humanitarian funding have occurred at the same time that crises across multiple regions have not only maintained but gotten worse. Increasing crises at a time of diminishing resources to respond has required all humanitarians to make deeply challenging decisions about prioritization, from the Humanitarian Reset and changes to the cluster system to individual programmatic and staffing choices.

In the realm of gender-based violence (GBV) prevention and response, challenging choices are not new given that GBV prevention and response have been historically and disproportionately underfunded. Before 2025's cuts, millions of people in need of GBV services already went without. The cuts to funding push GBV responders and all humanitarian leadership even harder to ensure that those most in need are able to access services and to invest only in what works and helps us reach scale. To move forward with these decisions, we need to look back at data that tells us what we know about GBV survivors and research that tells us what works to reach them.

To do this, the IRC analyzed over 220,000 incidents of GBV reported to Women's Protection and Empowerment (WPE) programming by women and girls over the last 12 years to gain insights into who is accessing GBV response services, offering one of the largest longitudinal insights into violence patterns in displacement settings available. The incidents were reported across 38 countries in which IRC's WPE programs utilize the GBV Information Management System (GBVIMS) and for which women and girls agreed for their aggregate data to be used for further analysis.

While these cases do not represent the totality of IRC's work to prevent and respond to GBV[1], the data and analysis below tell us many things, including who we are serving – mainly adult women – and who we are not reaching enough – girls, older women, and those living with disabilities. It also reconfirms findings of past research and analysis, such as that intimate partner violence (IPV) continues to be the most pervasive form of GBV, even in emergencies.

Importantly, the analysis also reconfirms that neither home nor other places of supposed refuge, such as shelters, are not safe places for women and girls. Violence stalks women and girls throughout their displacement journey and safety cannot be assumed because a person has reached a camp or host community. This finding in particular highlights that there is a systemic gap in services, one that will not be closed without deliberate investment in social services, protection systems, and gender-sensitive governance. Only when these are all intentionally designed around survivor safety can refuge through humanitarian action become truly protective.

Altogether, the findings beg of us to take a new look with fresh eyes at if the ecosystem of services that women and girls want and need exists, if and how women and girls can access that ecosystem, and guides us towards ensuring that limited resources are geared towards programming that women and girls want and can use. The analysis asks us to recognize that safety is not a series of locations women and girls can go to, nor a list of services, but a system that still needs to be built.

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[1] For more information on WPE's programming across the spectrum of GBV prevention and response, please visit GBV Responders' Network.

Cover Photo Credit: Yolande Longang, WPE Technical Advisor. The cover photo was taken in Mali and shows of a group of young women wearing colorful clothing. Many of them look at the camera and smile; all have their hands together in the center of the photo, creating a circle of their hands.

Unfortunately, this system needs to be built at a time when women and girls are facing unprecedented risks as the world grapples with the highest number of armed conflicts since 1946. Armed conflict consistently fuels gender-based violence (GBV), and the current surge in number and severity of violence is expected to drive GBV rates even higher. In fragile and conflict-affected states (FCAS), progress for women and girls has regressed or barely advanced. The status quo – both in terms of services and funding environment – is broken. We know what is at stake if we do not respond with urgency and through evidence-based programs: millions of women and girls who face violence with little to no recourse, marginalized groups unable to access services, and a generation of girls who are worse off than their mothers and grandmothers, while hastening the erosion of basic rights and protections. By looking at the data we have, taking lessons from it, and being bold in building systems that work for women and girls, we can build a new status quo that works to prevent and respond to GBV.

Photo Credit: Taremwa for IRC

Acronyms

CBO	Community-Based Organization
CRSV	Conflict Related Sexual Violence
CPIMS	Child Protection Information Management System
GBV	Gender Based Violence
GBVIMS	Gender Based Violence Information Management System
IPV	Intimate Partner Violence
IRC	International Rescue Committee
LGBTIAQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Asexual, Questioning/Queer
SRHR	Sexual and Reproductive Health and Rights
SOGIESC	Sexual Orientation, Gender Identity, Gender Expression, and Sex Characteristics
TFGBV	Technology Facilitated Gender Based Violence
VAC	Violence against Children
VAWG	Violence against Women and Girls
WPE	Women's Protection and Empowerment

Acknowledgements

This report is based on the work of hundreds of WPE colleagues over not only the twelve years during which the data in this report was collected, but throughout the more than two decades IRC has been providing GBV prevention and response services to women and girls living in emergencies. There are literally too many individuals to name across dozens of countries. Everyone who has held a WPE title – including Technical Advisors, Senior Technical Advisors, Coordinators, Officers, Managers, and more – had a hand in creating this report. We particularly want to acknowledge the participants of the WPE Learning Forum of 2024, who reviewed early analysis and provided important insights on learning.

From its inception, the Women's Protection and Empowerment Team at the IRC has been a leader in working to ensure that GBV prevention and response is considered a part of humanitarian response, that it is lifesaving, and that it needs to work on not only immediate remedy but also towards the achievement of gender equality. The dedication of the team is not only felt in direct service provision to millions of women and girls, but across the entire humanitarian sector from efforts such as leading the development of the GBV Minimum Standards. Thank you for your dedication, your passion, and for bringing your whole selves to this work.

We would also like to thank the over 220,000 individuals who reached out to IRC for care over the past 12 years and agreed for their information to be used for further analysis. We are honored by the trust you put in the IRC.

This report was written by Mercy Lwambi and Helena Minchew, based on the original analysis and writing of Kristy Crabtree and Megan O'Brian. Many thanks for additional analysis go to Vicky Samara and Cornelia Aton.

Methodology

Research Design

This study employed a retrospective, quantitative research design to analyze twelve years of incident monitoring data collected through IRC's Women's Protection and Empowerment's and local partners' GBV case management services. The objective was to identify trends in reported incidents of GBV and service utilization across humanitarian settings where the IRC operated between 2012 and 2024. The use of standardized data enabled an exploratory analysis of patterns and key indicators across diverse contexts and time periods.

Sampling

The dataset includes 220,718 individual reports of GBV collected in 38 countries affected by conflict, disaster, or displacement. 218,117 (99%) of these were reports by women and girls; given that the vast majority of clients in this dataset identified as women and girls, the figures throughout this document do not include men and boys (unless otherwise stated). The sample is not representative of all survivors but rather reflects those who chose to and were able to disclose incidents of GBV and sought case management services from IRC and its partners. Inclusion was limited to survivors who gave informed consent to have their anonymized data used for aggregated reporting. While the data provides rich insights, the reliance on service-seeking populations introduces potential selection bias.

Data Collection

Data were collected through the Gender-Based Violence Information Management System (GBVIMS) using the Incident Recorder tool. This system standardizes data collection on reported GBV incidents, including survivor demographics, perpetrator characteristics, type and timing of violence, and service referrals. Caseworkers entered data at the point of service delivery, and information was managed in secure, localized databases.

Data Analysis

Incident monitoring data from 2012–2024 were compiled, harmonized, and cleaned to address inconsistencies and ensure uniformity in variable definitions and coding across countries and years. Descriptive statistics were calculated to identify trends in incident characteristics, service access, and survivor profiles. Preliminary findings were presented to IRC Violence Prevention and Response Unit Technical Advisors and field staff during virtual workshops and an in-person learning forum for review and validation. Their feedback informed the contextual interpretation of the results.

Ethical Considerations

All data used in this analysis were provided by survivors who consented to have their information included in aggregate, anonymized reports. The GBVIMS is designed to uphold confidentiality, data protection, and survivor safety. Access to data was restricted to trained personnel, and analysis was conducted in line with ethical guidelines for research involving sensitive information.

Limitations

The analysis is based on incidents reported through GBV case management services and therefore does not capture unreported violence nor prevalence data. Variations in service coverage, program maturity, and contextual factors across countries may affect survivors' ability to seek services and report incidents of GBV. While efforts were made to clean and standardize the dataset, limitations related to data quality, changes in programming over time, and potential reporting bias remain.

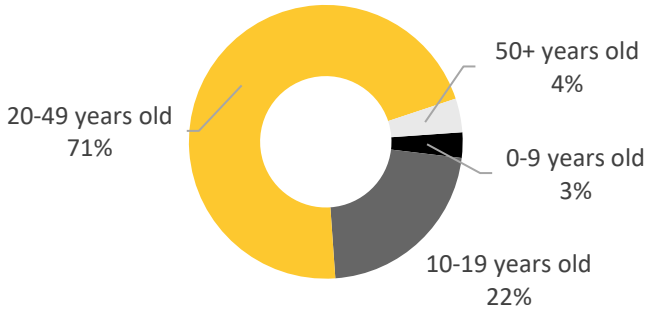
Over a Decade of Data – Who are Our Clients?

Twelve years of consistently collecting quality GBVIMS data across 38 countries allows the IRC to evaluate the profile of whom we serve most frequently. The below data points are based on an analysis of 218,117 incidents of GBV reported by women and girls, reflecting 98.8% of all incidents reported to IRC from 2012-2024 and reported here (see below a note on incidents reported by men or boys).

Client Profile:

Most women who reported GBV incidents were aged between 20 and 49, while girls aged 10-19 accounted for 22% of all reports. Certain regional differences emerged - in West Africa, adolescents of 10-19 years made up 33% of reported cases, whereas in Europe, 32% of reports came from women over the age of 50.

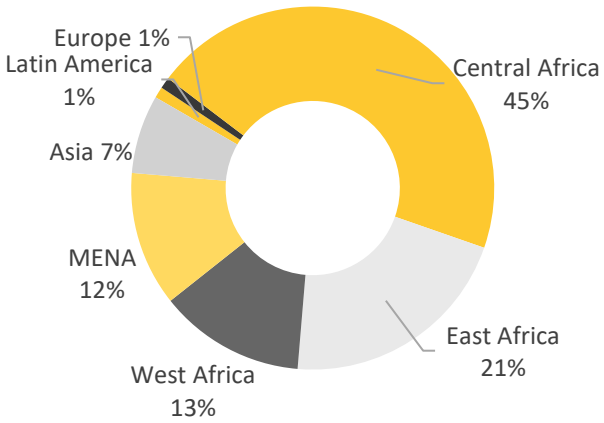
Chart 1: Percentage of GBV clients represented in this report by age



Clients Across Regions:

Almost half of clients that reported GBV incidents were in Central Africa, with DRC and CAR together accounting for 25% of the global GBV incidents reported[2]. Half of the cases in East Africa have been recorded in South Sudan, while more than half of the cases in Asia have been recorded in Bangladesh.

Chart 2: Percentage of GBV clients represented in this report by region



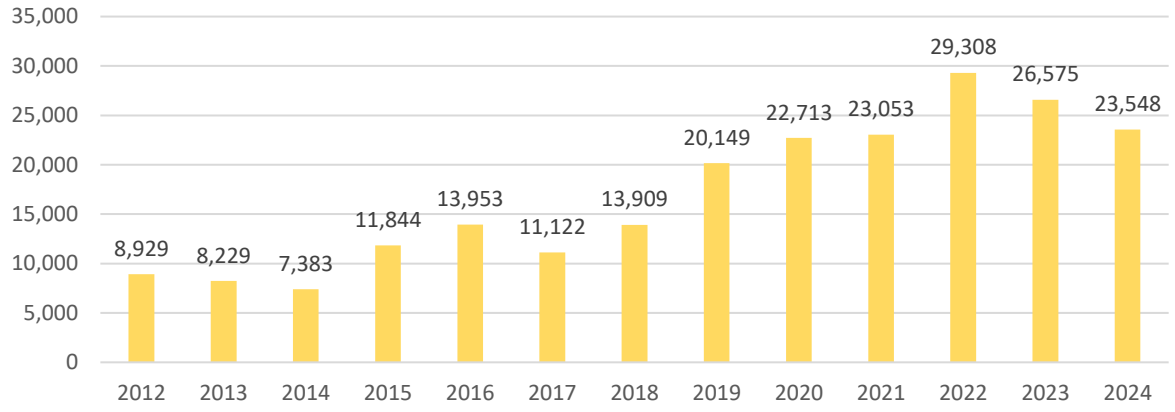
[2] Central Africa is the region where IRC has the strongest GBV Case Management presence, followed by East Africa. The prevalence of GBV Case Management in these regions should be noted when reflecting on the number of incidents per region; this data point should not be read as that Central Africa has a higher prevalence of GBV than other regions, but a reflection of where services are available.

Sights of Insecurity

Almost 80% of survivors reported violence occurred in their home community or in the community in which they sought refuge. Along the path of displacement, there is no true safe place for women and girls. They are at high risk of violence both in their home communities and in supposed places of refuge.

Clients Across Time:

Chart 3: Number of GBV incidents reported by year



Over half of all GBV incidents reported between 2012 and 2024 occurred in just the last five years, from 2020 to 2024. Notably, the number of reports more than tripled over the 12-year period. Experts suggest that this reflects a number of factors, including that more countries are aware of and utilizing reporting mechanisms, increased service reach, and an increase in the number of trained staff as the IRC has invested in building the capacity of staff to use the GBV IMS (both WPE and government staff, though use of the GBVIMS outside of IRC centers is not reflected in this data). Furthermore, experts also suggest that COVID may have played a role in the number of cases presenting as there was a reduction in physical access to services in 2020-2021 given COVID restrictions, with a correlated spike in cases once restrictions were lifted; the data could also reflect increased risk of GBV during COVID itself.

What does the data tell us about men and boys?

Only 2,547 of the incidents captures within the 12-year data set were reported by men and boys, representing 1.17% of clients. Despite this relatively small number of incidents, it is possible to glean several important insights about the violence that men and boys who report to WPE service sights experience:

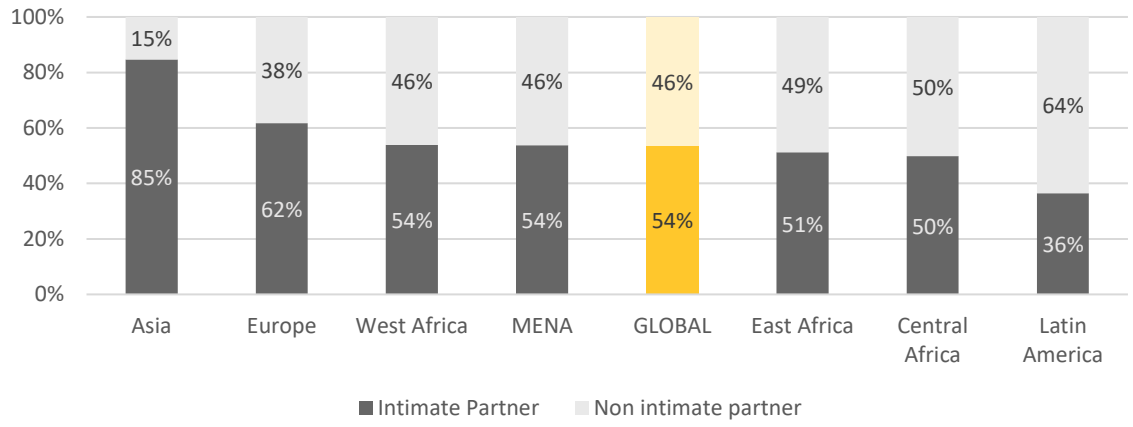
- For men and boys, the most commonly reported form of violence was **psychological and emotional abuse**, which represented 33% of cases for men (women and girls most commonly reported physical assault).
- While current and intimate partners were the most commonly reported perpetrator of violence against all populations, perpetrator profiles did vary. For women and girls, intimate partners were 56% of perpetrators; for men and boys, this figure fell to 38%. Also noteworthy is that family friends or neighbors were over twice as likely to be the perpetrator of violence against men and boys as against women and girls (12% vs 5%).
- Men and boys of all ages reported violence; for boys under the age of 17, 31% of incidents reported were sexual violence.

1. **Intimate Partner Violence (IPV)** is the most common form of violence experienced by women and girls.

Physical assault was the most commonly reported form of violence by women and girls across the 12 years. 54% of women and girls reported that the perpetrator of violence against them was a current or former intimate partner. This finding remains stable over time and across contexts and is higher than the often-cited global statistic of 1 in 3 women experiencing violence at the hands of a domestic partner within their lifetimes. This highlights that domestic violence remains a humanitarian issue that is both destructive and common.

Previous reports have consistently identified that intimate partners are the most common perpetrators of violence against women[3] and global estimates indicate that violence against children (VAC) is perpetrated by those known to the child over 50% of the time.[4] When perpetrator profiles are analyzed beyond intimate partners, it becomes even clearer that the majority of survivors know those who perpetrate violence against them, whether that be IPV or other types of violence. Only 13% of alleged perpetrators had no relationship with the survivor at all.

Chart 4: Percentage of GBV incidents by alleged perpetrator profile



[5]

[3] https://www.rescue.org/report/no-safe-place

[4] https://bmjpaedsopen.bmj.com/content/2/1/e000180

[5] Contextualization of all findings are critical, especially when making programmatic or local policy decisions. Regional experts analyzed the differences shown within this chart and found the following:
For Latin America, high levels of generalized violence, organized crime, and public insecurity that characterize many parts of the region ensure that GBV is not confined within the home but is a pervasive public safety issue. Specifically for Northern Central America (e.g., El Salvador, Honduras, Guatemala) and Mexico, gangs and other non-state armed groups use GBV as a tool of power. Sexual violence is used to control territory, punish, extort, and force recruitment. These perpetrators are "non-intimate partners" (gang members, criminals) targeting community members (including those who are internally displaced), women and girls on the move, and those who have been confined by the armed actors. During transit and in temporary settlements, women and girls are exceptionally vulnerable to sexual violence from non-partners, including smugglers (*"coyotes"*), other migrants, and sometimes state officials.

For Asia, experts posited that the higher-than-expected intimate partner perpetrator statistic can be attributed to a number of factors reflecting both the realities of women's and girls' lives and access to services: 1. Cultural norms reinforcing male authority: In many parts of Asia, traditional gender roles expect women to be obedient and to keep the family peaceful, even when they are treated unfairly,

LESSONS FOR POLICY MAKERS AND PROGRAMMERS

Lesson for Policy Makers: Much of the public and policy discourse around GBV in emergency contexts has centered in recent years on two topics: conflict-related sexual violence (CRSV) and sexual exploitation and abuse (SEA). Survivors of these forms of violence and abuse have the right to services, but if policy makers and those who make funding decisions (in donor governments or humanitarian organizations) focus attention on preventing and responding predominantly to CRSV and SEA, the vast majority of GBV survivors will not receive response services they need. Policies which ensure that survivors of *all* forms of GBV can receive care are needed to tackle CRSV and SEA, as well as the more commonly experienced IPV.

Lesson for Policy and Programming: To reflect the reality that IPV is so common, policies, programs, and funding must focus on preventing GBV within households and communities, including through working with men and boys to address harmful masculinities, and on ensuring that GBV responders are available to identify those who have experienced GBV and to provide long-term support.

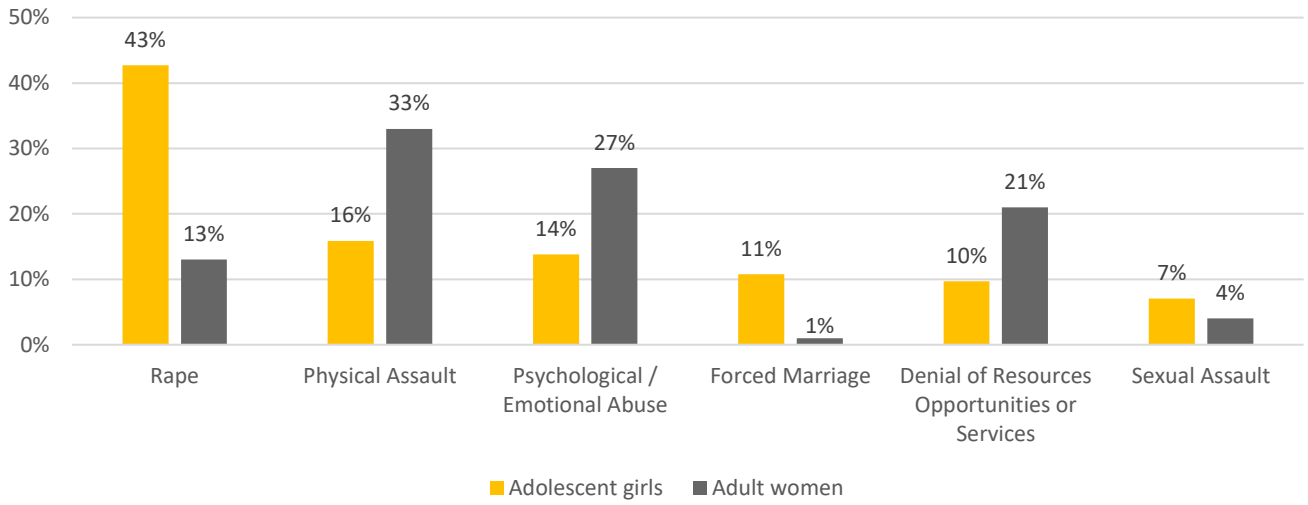
Photo Credit: Esther Sweeney for IRC

allowing for husbands to feel they can or should have control over their wives. In some places, dowry expectations create extra stress, and when these demands aren't met, it can lead to harassment or even violence. Other practices, like women moving into their husband's family home, can leave them isolated or pressured by in-laws. These cultural norms don't directly cause intimate partner violence, but they strongly affect how women experience it and whether they feel able to speak up or seek help; 2. Improved trust in Service Providers: As experts report across contexts, reporting figures do not always reflect prevalence of violence, but can reflect the trust women and girls have in support systems. IRC, across all country programs in Asia, has been investing in strengthening the capacity of service providers, enhancing service provision, and establishing safe referral pathways. Integrated health-GBV facilities, WGSS, MPCC, and various entry points have been expanded, connecting women with safe and confidential GBV response services. IRC has also been working to strengthen service integration across Protection sub-sectors (child protection, rule of law, and WPE) across Asia countries, which can strengthen holistic support, thereby increasing help-seeking behavior and reporting; 3. Influence of Strong Local Women's Organizations; WPE Asia works strongly with local women's organizations and local GBV actors in both formal and informal partnerships who play a critical role as first responders, entry points, and leading awareness of IPV and services available in the communities. These groups conduct outreach, provide psychosocial support, accompany survivors in legal processes, and follow through. As women's groups become more active and visible, more survivors feel empowered to seek assistance, contributing to higher reporting rates; 4. Asia has strong individual legal assistance (and integrated protection services); there is growing access to individual legal assistance, including services specifically for IPV cases. More women have access to legal counseling and community paralegals who help them understand their rights and navigate the justice system. When survivors know they can get free or affordable legal help, they feel more confident taking action, which can also contribute to higher reporting rates.

2. **Adolescent Girls experiences of violence vary from adult women.**

Over 22% of survivors reporting incidents of gender-based violence to IRC case management programs are adolescent girls (aged 10-19 inclusive). 43% of those girls sought services after surviving rape, making it the most prevalent form of violence reported for this population.

Chart 5: Types of GBV experienced by adolescent girls vs. adult women



The analysis also found that less than half of girls who have experienced rape are reporting within 72 hours of the incident, when preventative health services are most effective; experts suggest that further analysis is needed to identify the specific reasons that girls delay reporting. These findings are consistent over the years of analysis.

While the type of violence most commonly perpetrated against adolescent girls is different from adult women, some of their experiences are the same:

- Those closest to girls were found to be the most common perpetrators of violence against them (30% of girls reported that they experienced GBV at the hands of a current or former intimate partner, with primary caregivers or parents, family members other than their spouse or caregiver, and family friends or neighbors representing 29% of perpetrators. Only 17% of girls reported that they had no relationship with the perpetrator.
- "Home" is one of the most unsafe places for children across all types of violence. 45% of girls reported that their experience of violence was within their home.

Photo Credit: Cunningham for IRC

LESSONS FOR PROGRAMMING AND POLICY MAKERS

Lesson for Programming: To make sure that adolescent girls find programming accessible to them, GBV practitioners must involve adolescent girls in program design and research about the impact of programming for them. Child and Adolescent Advisory Boards (AABs) are one modality to ensure this.

The successes of programming that addresses the co-occurrent of violence against children and violence against women must be built upon and supported as one way to meet girls where they are and where they experience violence: at home. IRC's Safe at Home program – which has been shown hugely impactful in preventing both violence against children and violence against women in the home – is one example that can be built upon. Further collaboration between Child Protection and GBV actors and investments in parenting and caregiver support are also ways to ensure that girls' needs are understood and met.

Another way to reach girls "where they are" is to enhance efforts to create linkages between the Education and Protection sectors. Cross-sectoral efforts between Protection and Education have shown dividends in the past, such as to prevent child, early, and forced marriage.

Lesson for Policy Makers: Similar to ensuring that IPV is addressed in humanitarian contexts, policy makers must ensure that social work systems are built, strengthened, and brought to bear for girls living in conflict or crisis. Humanitarians and governments must enhance and centralize protective environments and social work, with its holistic, rights-based, and community-centered approach, and build the social service workforce, even in conflict and crisis settings.

3. **We do not see everyone in the data.**

Globally, only 4.1% of incidents (or just over 8,900) were reported by women over the age of 49. Only 1.8% of women and girls who reported incidents of GBV reported living with a disability. Given the percentage of people over the age of 49 (nearly 1/3 of the global population) and the percentage of people living with disabilities (16%), it is highly unlikely that these figures reflect the reality of who experiences GBV in emergencies. Instead, it is likely that GBV response services are inaccessible to these women and girls.

GBV and disability experts suggest that, despite having some resources for disability inclusion within GBV response initiatives, the overall field is still unable to adequately support women and girls with disabilities. Further to this, GBV responders also posit that the way in which disability inclusion efforts are funded – in that disability-rights and inclusion actors are funded to work with people living with disabilities and GBV actors will often refer survivors to those specific agencies – could be one additional cause for this low rate.

It must also be noted that the GBVIMS does not collect data on individuals' sexual orientation, gender identity and expression, and sex characteristics (SOGIESC). The ethical considerations surrounding the collection of data on individuals' SOGIESC has been debated across various sectors, often weighing the importance of collecting data to better understand the lived experiences of lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI+) individuals against valid concerns about the safety of those who choose to disclose such personal information. This is particularly relevant in the GBV sector, where it is increasingly recognized that women with diverse SOGIESC, trans men, and nonbinary individuals face a higher risk of violence due to the intersection of SOGIESC-based oppression (including homophobia, biphobia, and transphobia), patriarchy, misogyny, and other systems of discrimination that shape LGBTQI+ people's experiences of violence.

LESSONS FOR PROGRAMMING AND POLICY MAKERS

Lessons for Programming: The tactics for reaching these disparate populations will vary. Given the multiple suggestions of cause for why women and girls living with disabilities are not accessing services, a thorough reflection and analysis of existing barriers is first essential to understand why the gaps exist; this should be undertaken in each context to ensure saliency of the analysis.

For older women, both cultural and physical barriers to accessing services must be considered when developing programming that reached them. At the same time, the role of older women as decision-makers in communities and family lives should not be underestimated but instead better used to ensure access for all to GBV services.

Lessons for Policy Makers: GBV actors must engage with LGBTQI+ stakeholders to determine whether and how SOGIESC data collection within GBV case management systems and the GBVIMS could be safely, ethically, and appropriately implemented. Concurrent discussions must include a focus beyond data collection and usage, with a focus on determining how people with diverse SOGIESC can safely access services, not just have data collected on their lives and experiences.

The data shows that we are not reaching people living with disabilities and older persons to the extent we should, meaning that we must find new ways to identify people within those populations that are experiencing GBV. As they may interact with social welfare systems that are not geared towards preventing and responding to violence, strengthening linkages across these systems – and specifically with social work systems – could be a critical way to ensure access to services.

4. **Violence occurs most often where women and girls should be safe.**

Given that the most common perpetrators are those within the survivor's inner circle, it follows that the most common incident locations were someone's home - with the survivor's residence (64%) and the alleged perpetrator's residence (15%) representing almost 80% of incident locations. Incidents in the bush/forest/field/garden represented the smallest of the most common incident locations (7.5%).

Despite the fact that "home" was not safe for the majority of survivors, an analysis of referral to alternative safe houses and shelters showed that these were not a viable option for the vast majority of survivors. In 62% of cases where a safe house/shelter should have been available, no safe house/shelter existed for referral.

Where safe houses/shelters do exist, clients often decline to use them. In Uganda, for instance, 84% of clients declined referral to a safe shelter, even though they were available. This finding calls into question the quality and utility of a service that is commonly cited as available for women and girls who have experienced IPV.

Shelter design can unintentionally create long-term disadvantages for survivors. For instance, while shelters do not formally require documentation, asset relinquishment, or severing social ties, entering a shelter often has these effects in practice as many women leave behind their habitual residence, productive assets, community networks, and sources of informal support to access these shelters. Despite these major life changes to enter shelters, shelters are typically funded as short-term emergency measures, with no built-in exit strategy; as a result, survivors may find themselves living in under-funded, temporary facilities with limited pathways back to stability, while alleged perpetrators retain access to the household, assets, social capital, and community legitimacy. This dynamic illustrates how shelters (while protective in the immediate moment) can also reinforce structural inequalities when not embedded in broader systems of legal, economic, and social recovery, and underscores that safe shelters/housing cannot be treated as a standalone intervention, but one that is embedded within the social services systems that can prevent long-term harm.

Experts across multiple country programs suggest that when services are delivered through trusted community-based structures and systems, survivors access support more quickly and more safely. This reinforces the importance of building systems of delivery with local women's groups, community-based organizations (CBOs), and community networks as core protection actors.

LESSONS FOR PROGRAMMING

A lack of available safe houses/shelters may encourage increased investment in safe houses/shelters as an alternative to unsafe homes; decline rates call that inclination into question though. Service providers must question whether the safe house/shelter system is viable within current funding levels, what alternatives exist beyond safe houses/shelters for women and girls, and what would increase quality of safe houses/shelters to increase uptake. When presented with the above data, GBV responders were unsurprised, citing cases where safe houses/shelters were 10 times over capacity as rationale for why women and girls would choose not to leave their homes in favor of a safe house/shelter.

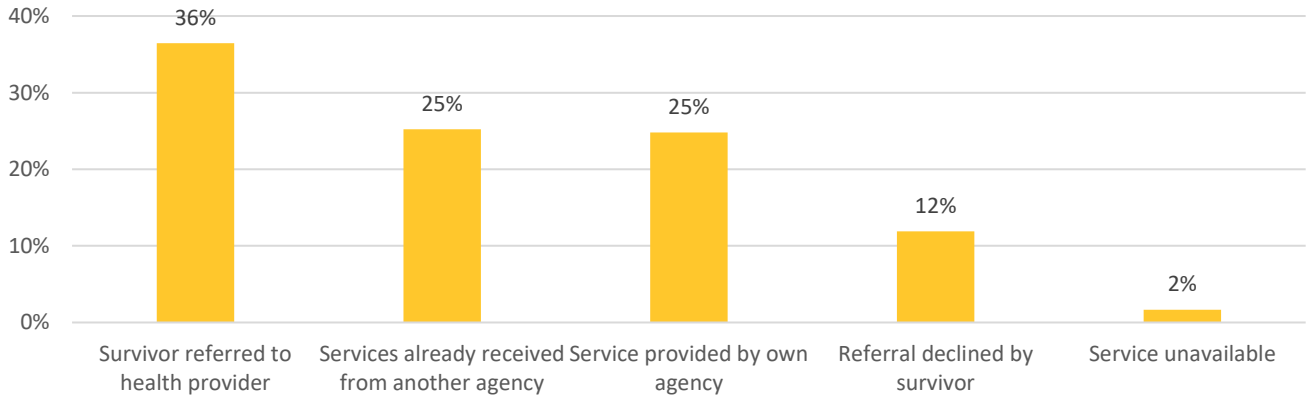
Programs like Safe at Home, that address the co-occurrence of violence against women and violence against children, work to make home a safer place for women and children. Providers must also look to long-term solutions – such as access to capital and employment – that allow survivors to leave unsafe homes but not for shelters.

5. **The majority of our clients – regardless of the type of violence they experience – sought referrals to "*care*" services, not *"redress"* services.**

GBVIMS data includes information on the types of referrals that are available and taken up by survivors. Upon analysis of this data, it became clear that survivors sought GBV services that provided them with care (i.e. psychosocial services, health care services, or economic empowerment programming) over those for which they could find redress from their violence (i.e. legal services or reporting violence to police).

The most robust connection between GBV and other service types was with Health services. For IRC clients specifically, IRC is either able to provide or refer to medical services in the vast majority of applicable cases; only 1.7% of the time were health services not available to clients who needed them and 87% of survivors who needed it received health care or accepted a referral. This is likely reflective of the time and resources the IRC has put into connecting sexual and reproductive (SRH) and GBV services over the past decade; upon detailed analysis, there was even a small shift seen towards IRC directly providing both health and GBV services to clients, rather than referring, more over the second 6 years of the data set than the first 6 years. Only 12% of clients declined a referral for health services when the GBV case manager deemed that this referral was applicable to their case.

Chart 6: Applicable health/medical service referrals pathway



Other care services, such as access to livelihoods, were also sought by survivors. Unfortunately, they were not as widely available as Health referrals; for 60% of survivors that sought access to livelihood programs, these programs were not available to them.

Such high interest in further referral is not the story for "redress" services, however. Globally, 55% of clients declined an applicable legal referral and 56% declined referral to police or other security actors. The reasons for GBV survivors declining redress and justice through legal assistance or reporting to police are well known and documented – including lack of appropriate legal frameworks, social and cultural barriers, stigma, and more[6] - and the data bears out that survivors are declining these services at high rates.

This should not be interpreted as disinterest in justice, however, but as an indication that current justice pathways are likely perceived as unsafe, ineffective, or punitive. In many settings, reporting may increase the risk of retaliation or expose survivors to stigma. It is also important to recognize that justice for survivors does

[6] https://reliefweb.int/report/world/survivor-centred-justice-gender-based-violence-complex-situations#:~:text=Social%20and%20cultural%20barriers%20to,on%20victims%20not%20to%20report.

not always align with formal, criminal-law models focused on punishment or imprisonment. In many contexts, what women consider meaningful justice is the ability to maintain access to productive assets, secure habitual residence for themselves and their children, and ensure financial support or alimony. These are often the conditions that allow survivors to rebuild safety and autonomy. When justice systems do not offer these practical outcomes - or when pursuing them exposes survivors to further harm - formal reporting becomes a far less viable or desirable pathway. The data therefore reflects rational decision-making by survivors navigating systems that cannot offer meaningful, safe, or accessible remedies.

Photo Credit: J Zocherman for the IRC

The data also shows that the perpetrator's profile matters when clients determine whether to seek redress services and that power dynamics between survivors and perpetrators play a clear role. For instance, when the perpetrator was a landlord and had say over their shelter or housing, 75% of survivors chose not to pursue legal service referral. Survivors also declined referral to police and security actors at high rates when the perpetrators were military/police/security personnel (51% declined), a supervisor/employer (55%), a parent/caregiver (69% declined), and a member of a non-state armed group (73% declined).

Table 1: Referral pathway taken by survivors, by type of service

	Health / Medical services	Livelihoods program	Legal assistance services	Police / other security actor
Referral declined by survivor	12%	12%	55%	56%
Survivor referred to service	36%	8%	14%	16%
Service already received from another agency	25%	5%	4%	13%
Service provided by own agency	25%	15%	10%	2%
Service unavailable	2%	60%	16%	13%

LESSONS FOR POLICY MAKERS AND PROGRAMMERS

Lesson for Programmers: GBV responders must consider perpetrator profile when working with clients to determine if and how referrals will be assessed by clients, with power dynamics and consequences of referrals understood by all parties. GBV responders should also analyze client data from the GBVIMS in their context frequently to identify trends regarding uptake of referral by type, with an overlay of perpetrator profile so that trends can be identified and responded to in real time.

Lesson for Policy Makers: The ecosystem around GBV survivors is not yet responsive to their needs and wants. Continued investment in connections and integration between services – such as GBV and Health – are critical but do not go far enough to provide an ecosystem in which survivors can both recover and access justice, which is a key priority of many governments.

For survivors to comfortably uptake both care and redress services, the protection ecosystem must be built out and the empowerment of survivors to safely access services of all sorts should be the overarching goal. **Donor Governments and Humanitarian actors should invest in social work and the social service workforce as a key way to build access to and uptake of all relevant services for GBV survivors, while utilizing social work's rights-based approach to ensure survivor-centered response.**

Photo Credit: Khaula Jamil for the IRC

What's Next for GBV Prevention and Response?

Recommendations and Ways Forward

Across over a decade of data, a few priorities clearly emerge that must be addressed if we are to reach GBV survivors and those at risk **at scale**. We must **strengthen the GBV prevention and response ecosystem** through investments in:

- **Social services systems** that provide case management, economic support, safe housing, and integrated services, including GBV and SRH services;
- **Governance** and the safe management of where women and girls live (including camps), through support such as documentation, ensuring freedom of movement, and ensuring risk mitigation;
- **Community-led and localized responses** that ensure community intermediaries, women's groups, and CBOs can reach women and girls with quality care and case management.

These shifts require not only programmatic adjustments, but changes in how humanitarian response plans, financing mechanisms, and governance structures define and resource protection. To actualize these shifts, we must:

- Identify or create new ways to finance GBV prevention and response beyond traditional grants and other funding mechanisms;
    - Financing mechanisms must concentrate on ensuring predictable, multi-year financing for social services in displacement settings, rather than emergency-only funding cycles because, without stable investment, core components like safe housing, case management, and livelihoods cannot be scaled or sustained.
- Invest in, analyze, and use data to implement programming that works for GBV survivors and those at risk of GBV.

The Violence, Prevention and Response Unit (VPRU) supports programming that prevents and responds to violence against women, children, and other at-risk groups. Over the past 25 years, IRC has been a global leader in protection programming in refugee settings and in other conflict-affected contexts. In nearly 40 countries across Africa, Asia, Europe, Latin America, the Middle East, and the U.S., the IRC delivers innovative programs focused on preventing and responding to violence against women and girls.

The IRC recognizes that with intentional support and investment, women and adolescent girls can transform their lives and their communities and our Women's Protection and Empowerment (WPE) programs aim to achieve a world in which women and girls pursue their potential, free from violence and inequality.

We do so by providing care to women and girls who experienced violence, tackle root causes of violence, restore dignity, and create opportunities for transformation within their communities and systems. Examples of WPE programming include case management for survivors of violence; engaging men in accountable practices; mental health care and psychosocial support for people in distress; and support to strengthen national social work systems.

In 2024 alone, WPE reached over 505,000 clients, including: 25,528 girls who accessed empowerment programming; 238,528 women, men, and children who accessed violence prevention programs; and women and girls who visited safe spaces for case management, psychosocial support, and leadership and literacy activities nearly 685,000 individual times.