UNHCR
The UN Refugee Agency



# Gender-Based Violence Affecting Refugee Women and Girls

## Evidence from Five Refugee Settings on GBV Trends, Risks and Service Gaps (2024–2025)

# Foreword

What we deliver matters. But so does what we fail to see.

When fewer refugee women and girls report gender-based violence, does that mean they are safer? Or are there fewer opportunities to safely disclose violence and seek support? When a survivor reaches a GBV case worker, can we assume that she will receive the services she needs? Whose experiences remain invisible in the evidence on which we base our decisions?

These are some of the difficult questions that this report seeks to confront.

Drawing on evidence from five refugee operations, the analysis challenges us to look beyond recorded incidents and examine the circumstances in which violence occurs, the barriers survivors face, and the capacity of protection systems to respond. The findings remind us that access to protection cannot be measured by numbers alone.

At a time of increasingly difficult choices about humanitarian resources, we have a particular responsibility to ask whose safety, rights and choices may be compromised by the decisions we make. We must protect lifesaving services without neglecting prevention, remove the barriers that prevent refugees from accessing national systems, and recognize the expertise and leadership of refugee women and the organizations they lead.

For UNHCR, preventing and responding to gender-based violence is fundamental to international protection. When we speak about access to asylum, education, self-reliance, inclusion or durable solutions, we must also ask whether refugee women and girls can pursue these opportunities safely, exercise their rights and make meaningful choices about their own lives.

My hope is that this report does more than strengthen our understanding of gender-based violence. I hope it challenges our assumptions, informs our priorities and holds us accountable for the protection outcomes we collectively seek to achieve.

Ultimately, the value of this evidence will lie not in what it tells us, but in how we apply it.

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# Executive Summary

Gender-based violence (GBV) remains a serious protection risk for refugee women and girls, at a time when humanitarian funding reductions are placing essential prevention and response services under increasing pressure. As specialized services contract, survivors may face greater barriers to accessing assistance, while reduced opportunities for safe disclosure can make violence less visible in service-based data. Understanding these dynamics is essential to ensuring that protection priorities and funding decisions reflect assessed risks and needs, rather than recorded incident trends alone.

This report examines GBV trends, risks and service gaps affecting refugees and asylum-seekers across five refugee settings: **Bangladesh, Jordan, Lebanon, South Sudan and Tanzania**. It draws on anonymized, aggregated GBV incident data recorded between January 2024 and June 2025 by **33 organizations using the Gender-Based Violence Information Management System (GBVIMS)**, complemented by secondary evidence and consultations with **26 GBV experts and practitioners**. The findings describe incidents disclosed by survivors accessing participating services; they do not measure GBV prevalence or provide representative estimates of violence across refugee populations.

**5**
refugee settings: Bangladesh, Jordan, Lebanon, South Sudan and Tanzania

**33**
organizations using the Gender-Based Violence Information Management System (GBVIMS)

**26**
GBV experts and practitioners

## Key Findings

**01** **Insecurity, forced displacement, service access and opportunities for safe disclosure** shaped recorded GBV incident trends across refugee operations.

**02** **The overwhelming majority of refugee survivors accessing GBV services are women and girls (98%)**. At the same time, older women, persons with disabilities, unaccompanied and separated children, LGBTIQ+ persons, men and boys may be underrepresented in GBV service-based data due to persistent barriers to safe disclosure and access to GBV services.

**03** **While physical assault and emotional abuse accounted for the largest share of recorded incidents**, refugee women and girls also experienced sexual violence, forced marriage, and other forms of GBV across domestic, public, workplace, and displacement settings. These findings underscore the diverse and intersecting forms of violence affecting refugee women and girls across participating operations.

**04** **Intimate partners were the primary alleged perpetrators of reported GBV against refugee women and girls, and private residences were the most frequently recorded incident locations**. Across operations, unemployment, economic insecurity, precarious livelihoods, and forced displacement-related stressors were consistently associated with heightened risks of violence within households, while fear, stigma, insecurity, and power imbalances may constrain disclosure of violence perpetrated by strangers, military and authority figures.

**05** **Timely disclosure is achievable when survivor-centred services are accessible, known and trusted**: 42% of recorded incidents were disclosed within five days. Across refugee settings, early disclosure was associated with functioning referral pathways, community-led awareness efforts, and sustained investments in GBV services. At the same time, significant delays in disclosure persist, highlighting the continued impact of stigma, insecurity, fear of retaliation, mobility constraints, and social norms that discourage help-seeking.

**06** **Gaps in survivors' access to necessary services increased.** Recorded instances in which a needed service was unavailable, relative to recorded GBV incidents, were approximately 50% higher in the first half of 2025 than in the first half of 2024. This highlights persistent gaps in refugee survivors' access to lifesaving GBV response services when they needed them most, with potentially irreversible consequences for the wellbeing, safety and health of refugee women and girls and other groups at heightened risk of violence.

**07** **Refugee women and girls are agents of change whose leadership, knowledge and collective action are central to strengthening community protection and advancing sustainable GBV prevention and response.** Consultations highlighted the importance of trusted community networks, community-led awareness-raising and accessible referral pathways in facilitating safe disclosure and access to specialized services. Conversely, the erosion of community protection networks was identified as contributing to heightened protection risks. These findings reinforce the importance of investing in the leadership, collective power and capacities of refugee women and girls, including through local women-led and refugee women-led organizations, and enabling them to shape protection priorities, influence decision-making and lead locally driven solutions.

## Key Observations and Protection Implications

Taken together, these findings reveal three interconnected protection challenges: **violence rooted in unequal power relations and forced displacement-related vulnerabilities; barriers that determine which survivors and forms of violence become visible; and gaps in the capacity of protection systems to provide effective assistance**. Declining recorded incidents cannot be interpreted as declining protection needs, particularly where insecurity, funding reductions and service disruptions constrain opportunities for safe disclosure. The predominance of intimate partner violence, alongside less visible forms of sexual violence, child and forced marriage and violence affecting underserved groups, underscores the importance of differentiated prevention and response approaches that address intersecting protection risks.

> **"…accessible and trusted GBV services are essential not only for responding to violence but also for enabling survivors to safely seek protection."**

The analysis also demonstrates that **accessible and trusted GBV services are essential not only for responding to violence but also for enabling survivors to safely seek protection**. Yet access to GBV case management does not guarantee comprehensive assistance when essential health, psychosocial, legal, child protection and safe accommodation services are unavailable or inaccessible. Addressing these gaps requires maintaining specialized response capacities, strengthening functioning referral pathways and supporting safe refugee inclusion in national systems, with adequate resources and safeguards for confidentiality, survivor safety and informed choice. Strengthening protection systems also requires

shifting power and resources towards refugee women and girls, ensuring that their priorities, expertise and collective action shape how protection responses are designed, delivered and evaluated.

Beyond specialized services, GBV can undermine access to asylum, documentation, justice, education, livelihoods and durable solutions, reinforcing the need to integrate GBV prevention, response and risk mitigation across refugee protection and assistance.

## A Call for Collective Action and Sustained Investment

The findings call for a coordinated approach that **protects the continuity of lifesaving GBV services while investing in sustainable, inclusive and locally led protection responses**. Five priorities emerge: **(1)** sustaining essential survivor-centred services, including case management, where critical gaps persist; **(2)** strengthening refugees' safe and equitable inclusion in national GBV systems; **(3)** investing in locally led and community-led prevention and response; **(4)** integrating GBV prevention and risk mitigation across refugee protection and assistance; and **(5)** strengthening coordination, ethical evidence and financing accountability.

These priorities require complementary action by governments, donors, UNHCR, specialized humanitarian and development actors, and local, women-led and refugee-led organizations.



*Partner Field Monitoring Visit in Lebanon* ©UNHCR/Sophie Etzold]

# Overview of global trends

An estimated 840 million women worldwide have survived physical and/or sexual violence during their lifetime[1], while around 50,000 women are killed each year by a partner or family member.[2] Intimate partner violence (IPV) remains pervasive, with approximately one in three women globally having experienced IPV.[3] These figures underscore the scale and persistence of violence against women globally, across both private and public spheres. At the same time, conflict can heighten the risk of GBV, including sexual violence, and is one of several factors that can drive people to flee their homes. Conflict-related sexual violence has increased by 25% since 2023,[4] showing how violence against women and girls intensifies further in contexts of conflict, insecurity, and crisis.

Gender-based violence both drives and is exacerbated by forced displacement within countries and across borders. More than 60 million forcibly displaced and stateless women and girls face heightened risks of violence throughout displacement, transit, asylum and return.[5]

Yet, while risks are increasing, access to specialized GBV services is shrinking. Funding cuts are leaving refugee women and girls without critical support at a time of escalating need. Across UNHCR operations, including beyond the five settings covered in this report, an internal survey found that more than 171 Women and Girls Safe Spaces closed in 2025, leaving many survivors and women at risk without access to essential services. In parallel, 63% of surveyed operations reported that staff cuts among GBV partners had led to long delays before survivors could access specialized GBV caseworkers, leaving survivors with fewer options for accessing time-sensitive services and increasing the risk of adverse physical and mental health consequences. A further 74% of operations reported an increase in the number of survivors assigned to each caseworker between 2024 and 2025. In many contexts, caseloads now far exceed the global standard of a maximum of 20 active cases per caseworker, stretching frontline response capacity, and undermining the quality of support available to survivors.

The consequences are particularly acute for refugee women and girls throughout the displacement cycle, where they face overlapping and increased protection risks. These include high exposure to GBV — such as sexual violence, exploitation, and intimate partner violence—along informal routes, transit points, and overcrowded displacement settings. Risks are further compounded by trafficking and smuggling linked to onward movements, limited access to accurate information and documentation, and significant barriers to safe disclosure and service access due to reduced availability, insecurity, and lack of confidentiality.

[1] World Health Organization, *Violence against women prevalence estimates, 2023: global, regional and national prevalence estimates for intimate partner violence against women and non-partner sexual violence against women* 2025.
[2] UNODC and UN Women, Femicides in 2024: Global Estimates of Intimate Partner/Family Member Femicides, 2025.
[3] World Health Organization, *Violence against women prevalence estimates, 2023: global, regional and national prevalence estimates for intimate partner violence against women and non-partner sexual violence against women* 2025. UN warns of steep rise in sexual violence during conflict | UN News
[4] UN News, UN warns of steep rise in sexual violence during conflict | UN News, 2025.
[5] UN News, Millions of women and girls forced to flee face high risk of gender-based violence: UNHCR | UN News 2024

# Methodology

## Background and rationale

Addressing GBV against refugee women and girls is central to the protection mandate of UNHCR as underlined in its GBV Policy.[6] Notwithstanding funding cuts in 2025, UNHCR and its partners reached 1.6 million people, primarily refugee women and girls, across 77 countries through GBV prevention and response programs.

As a founding member of the Gender-Based Violence Information Management System (GBVIMS), UNHCR supports the safe and ethical collection of GBV incident data to inform service provision. While country teams routinely analyze data within refugee settings, a consolidated perspective across contexts has been lacking. This report aims to fill that gap by presenting trends from multiple refugee settings and drawing lessons to strengthen programming and decision-making.

To provide this consolidated perspective, the analysis draws on anonymized and aggregated GBV incident data collected through GBV case management services by 33 organizations using the Gender-Based Violence Information Management System (GBVIMS) across five contexts. **GBVIMS** is a globally standardized system used in humanitarian settings to ethically collect, manage, analyze, and share consolidated data on recorded GBV incidents to inform programming, in line with strict data protection and informed consent protocols.

## Research Design

This analysis used a triangulation approach to strengthen interpretation of observed GBV incident trends across five refugee operations (Bangladesh, Jordan, Lebanon, South Sudan, and Tanzania) between January 2024 and June 2025. The 18-month period was selected to enable comparison across three consecutive six-month periods (Semester 1 2024, Semester 2 2024, and Semester 1 2025) and to examine changes observed before and during the major humanitarian funding reductions that affected GBV services across multiple operations in 2025. Where percentage changes are presented, Semester 1 2024 serves as the baseline period if not indicated otherwise.

The analysis combined three complementary sources of evidence: GBV incident data, a secondary data review, and consultations with GBV experts. This approach enabled triangulation of findings and supported interpretation of changes in patterns of recorded GBV incidents.

**GBV incident data:** Analysis of anonymized GBV incident data recorded through GBVIMS between January 2024 and June 2025. Only incidents involving survivors identified in GBVIMS as refugees or asylum-seekers were included; data on survivors from other population groups were excluded from the analysis. Participating operations were requested to provide aggregated data on incident characteristics, including survivor and alleged perpetrator profiles, service utilization and referral patterns, and timeliness of reporting. Data were compiled and reviewed in aggregated form to protect confidentiality. Unless otherwise indicated, all percentages presented in the analysis are calculated from the combined dataset across the five participating operations. Data submissions were reviewed for completeness, consistency, and comparability. Follow-ups for clarification, re-extraction of selected statistics and technical support where needed to align submissions with analytical requirements of the exercise.

[6] UNHCR, *Policy on the prevention of, risk mitigation and response to gender-based violence*, 2020.

**Secondary data review:** A structured review of relevant GBV, protection, displacement, and humanitarian assessments, reports, and operational updates produced by UN agencies, NGOs, coordination mechanisms, and other actors. Information was systematically extracted into a standardized analytical framework covering contextual developments, GBV risks and patterns, affected population groups, service availability and accessibility, operational constraints, and factors influencing help-seeking and GBV disclosure. Findings from the secondary data review were used both to structure bilateral consultations with GBV experts and to contextualize and interpret quantitative GBVIMS findings. The review helped identify key themes, population groups, emerging risks, and evidence gaps for further exploration during consultations, while also providing an additional source of triangulation for the interpretation of findings.

**Consultations with GBV experts:** Findings from the analysis of GBV incident data and the secondary data review were presented to and discussed remotely with 26 GBV coordinators, GBVIMS focal points, and operational GBV specialists from all five participating refugee operations. Two multi-country validation workshops were conducted with representatives from all participating operations, complemented by bilateral validation meetings with each operation. These consultations were used to validate preliminary findings, contextualize observed trends, identify factors influencing help-seeking behaviors and reporting patterns, and interpret changes in recorded incidents in relation to broader contextual and operational developments, including displacement dynamics, funding reductions, service disruptions, and access constraints. The bilateral validation meetings also supported data quality checks, interpretation of context specific trends and identification of sensitivities prior to the cross-country synthesis. Participating countries were also given opportunities during the review process to comment on the interpretation of findings and propose recommendations.

## Sampling

The dataset includes GBV incidents recorded through service provision among survivors who accessed GBV case management services during the reporting period. Inclusion was limited to incidents documented through GBVIMS and to survivors who provided informed consent for the use of their anonymized data in aggregated analysis. A request for participation in the analysis was shared with a wider group of refugee operations. The five operations included in this report (Bangladesh, Jordan, Lebanon, South Sudan, and Tanzania) reflect those that consented to participate and were willing and able to contribute data for the exercise, rather than a purposive selection of contexts. Data contributions were consolidated from multiple participating organizations operating in refugee settings, including both UNHCR partners and non-partner organizations contributing through GBVIMS.

The data do not represent GBV prevalence and reflects only incidents disclosed by survivors who were able and willing to access services. Globally, less than 40% of the women who experience violence seek help of any sort,[7] underscoring that incident data capture only a fraction of incidents and that recorded trends are shaped by survivors' access to safe, trusted and available support.

## Ethical considerations

All data was collected and managed in accordance with GBVIMS ethical guidelines, including informed consent, confidentiality, and survivor safety. No identifiable survivor information was accessed or analyzed. Data access was restricted to authorized personnel, and findings are presented only in aggregated form to minimize risk of harm.

[7] UN Women, *Facts and figures: Ending violence against women*, 2025.

## Limitations

Several methodological limitations should be considered when interpreting the findings. This analysis covers five participating refugee settings and does not constitute a representative global analysis of GBV. Its findings reflect incidents disclosed to participating services and cannot be generalized to all refugees within these settings or to refugee populations globally.

Geographical and operational coverage also varied over the analyzed period. In **Lebanon**, the escalation of conflict in the end of 2024 resulted in three participating organizations temporarily suspending operations in conflict-affected areas after their teams were displaced; services subsequently resumed gradually as conditions allowed. In **South Sudan**, GBV prevention and response services in refugee settings expanded in January 2024 to one additional refugee settlement, thereby increasing the geographical coverage of the program. In **Jordan** and **Tanzania**, the participating organizations maintained the same geographical coverage throughout the study period. These changes in service presence and geographical coverage may have affected both the number and profile of incidents captured across semesters and should be considered when interpreting the magnitude of country-level changes. They do not negate the analytical value of the recorded trends, but reinforce that the findings describe patterns within participating services and should not be interpreted as directly comparable changes in GBV incidence or prevalence across refugee populations.

Although GBVIMS uses standardized core data elements, the analysis was not based on a single standardized cross-country statistics reporting structure developed specifically for this exercise. Some locally adapted categories and reporting structures therefore differed across operations limiting the comparability of selected indicators and scope for cross-tabulation. Data collection tools, data-entry practices, and the availability of indicators were not fully consistent across participating operations and reporting periods. As a result, some indicators were available only for a subset of operations or reporting periods. The number of participating organizations also varied across operations resulting in difference in coverage represented in the available data. Findings should therefore be interpreted as indicative of patterns within the available GBVIMS data rather than providing comprehensive or fully comparable measures of the situation across all participating operations.

The data request was circulated to all refugee operations using the GBVIMS with an established Information Sharing Protocol. The analysis draws on data voluntarily contributed by five refugee operations: Bangladesh, Jordan, Lebanon, South Sudan and Tanzania. While geographically and operationally diverse, these settings share several protection and operational challenges, including displacement-related vulnerabilities, humanitarian funding pressures and barriers to accessing specialized GBV services.

Data were reviewed in aggregated form to protect confidentiality. Because indicators were aggregated separately rather than at the level of individual incidents, it was not possible to cross-tabulate variables, conduct intersectional analyses, or compare incident characteristics, survivor profiles and service outcomes with one another. To support interpretation within these limitations, recorded trends were triangulated with findings from the secondary data review and validation consultations with GBV experts from the five participating operations.

Furthermore, GBV incident data have limitations in capturing the full scope of violence affecting children and adolescents. Lower representation of child and adolescent survivors, particularly adolescent girls, should not be interpreted as lower exposure to GBV. In some contexts, children and adolescents may access support through child protection entry points, case management services, national child protection systems, or parallel child protection information management systems. As a result, service pathways and recording practices influence where child survivors are identified and recorded and may reduce their visibility within GBV incident data.

# Analysis of GBV Trends

## 1. Insecurity, forced displacement, service access and opportunities for safe disclosure shaped recorded GBV incident trends across refugee operations

| Country | % Change / S1–S3 (Recorded incidents) | Trend change (S1 → S2 → S3) |
|---|---|---|
| Jordan | ▼ -79% | |
| Tanzania | ▼ -11% | |
| Lebanon | ▲ 1% | |
| South Sudan | ▲ 10% | |
| Bangladesh | ▲ 58% | |

Across the five refugee operations included in this analysis, trends in recorded GBV incidents varied considerably over the 18-month period. While some operations reported substantial increases in recorded incidents between Semester 1 2024 and Semester 1 2025, others recorded marked declines. Overall changes ranged from a 79% decrease in **Jordan** to a 58% increase in **Bangladesh**, highlighting considerable variation across operational contexts. These divergent trends underscore the importance of interpreting recorded incident data alongside contextual developments, service availability, displacement dynamics and survivors' opportunities for safe disclosure. Trends in recorded incidents should not be interpreted as changes in population-level GBV prevalence or incidence. Rather, they may reflect changes in survivors' ability and willingness to safely disclose violence and access GBV case management services, influenced by insecurity, displacement, humanitarian access and broader operational constraints.

Examination of the three semesters reveals that aggregate trends were not linear. Across the five operations, recorded incidents declined by 26% between Semester 1 and Semester 2 of 2024 before increasing by 52% in Semester 1 2025. The decline observed in Semester 2 2024 was driven primarily by a sharp reduction in recorded incidents in **Lebanon** (-58%) during a period with conflict and mass displacement. This coincided with a temporary reduction in service coverage: following the escalation of conflict at the end of 2024, three participating organizations suspended operations in conflict-affected areas after their teams were displaced, and services resumed only gradually as conditions allowed. Recorded incidents subsequently increased in Semester 1 2025, alongside a substantial increase in **Bangladesh**.

Secondary data and consultations with GBV experts suggest that changes in recorded incidents were shaped by a combination of contextual, operational and service-related factors that varied across settings. Although the direction of change differed between operations, consultations consistently highlighted the importance of service availability, humanitarian access, displacement dynamics and opportunities for safe disclosure in shaping recorded incident trends. Across multiple settings, funding constraints affected the availability of GBV prevention, risk mitigation and response services, while conflict, insecurity and displacement influenced both survivors' exposure to risk and their ability to seek support.

In **Jordan** (-79%[8]), the decline in recorded incidents coincided with significant funding reductions that reduced staffing levels and the availability of specialized GBV services. GBV experts reported that service

[8] Due to technical challenges affecting data abstraction during the reporting period, the Jordan figure (-79%) is based on data from one DGO only and is therefore not inclusive of all participating DGOs in the country. It may therefore differ from the figures presented in the 2024–2025 GBVIMS Jordan Annual Analysis Report.

providers increasingly had to prioritize survivors assessed as being at highest risk, resulting in longer waiting times and more limited access to support for other survivors seeking assistance.

A more moderate decline was observed in **Tanzania** (-11%)**,** a camp-based setting, where trends appear to reflect changes in the operational environment and population dynamics. GBV experts associated the decline in recorded incidents partly with the Government's policy of reducing services for Burundian refugees in the context of the accelerated voluntary repatriation process. At the same time, several protection services were scaled down, including through the closure of women's centers and child-friendly spaces, reducing the availability of safe and trusted entry points through which survivors could disclose violence and access GBV support.

In **Lebanon**, overall trends remained broadly stable (+1%) despite substantial fluctuations between semesters. Service providers noted that GBV risks increased after 2024's conflict escalation, driven by overcrowded collective shelters and poor living conditions. However, fewer survivors sought help during the escalation. Disclosures rose again after the ceasefire in early 2025, despite ongoing funding cuts, resulting in overall stable trends for the period.[9]

By contrast, **Bangladesh** recorded a 58% increase in recorded incidents. GBV experts linked the substantial increase in recorded incidents to a deteriorating security environment, the increased mobility of armed groups, worsening economic conditions, and the erosion of community protection networks. They also noted that reductions in GBV risk mitigation measures, due to funding cuts heightened exposure to violence. At the same time, secondary data, including inputs from GBV experts, indicates that service providers increasingly narrowed their response to a limited set of essential interventions, particularly GBV case management.[10] This concentration of services may have helped sustain survivors' access to disclosure pathways and reporting mechanisms, thereby contributing to the continued recording of incidents, even as the overall service scope contracted.

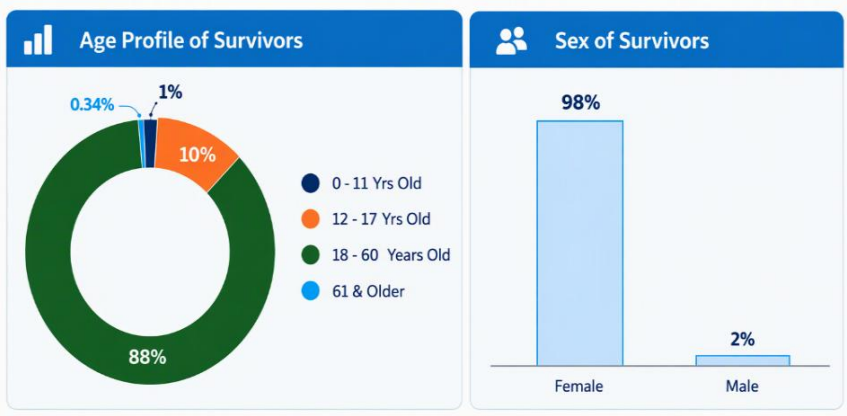
In **South Sudan**, modest increases (+10%) were observed despite persistent displacement and insecurity. Consultations suggested that lifesaving GBV response services, including clinical management of rape, continued to be supported despite wider funding constraints, helping maintain access to services and enabling safe disclosure. GBV experts also noted that continued awareness-raising efforts by both GBV and non-specialized actors, and the influx of refugees and returnees from Sudan may have contributed to the increase in recorded incidents.

Collectively, these findings indicate that recorded incident trends were shaped not only by underlying protection risks but also by the extent to which survivors were able to access trusted services and safely disclose violence. While declining trends were observed in **Jordan** and **Tanzania** where service availability and opportunities for disclosure were constrained, consultations in **Bangladesh** and **South Sudan** indicated that core GBV response services remained available as key entry points for survivors, helping sustain opportunities to disclose violence and seek support.

[9] GBVIMS Lebanon, *GBVIMS 2024 Annual Report*, 2025.
[10] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.

2. **The overwhelming majority of refugee survivors accessing GBV services are women and girls. At the same time, adolescent girls, older women, men and boys, persons with disabilities, unaccompanied and separated children, and LGBTIQ+ persons may be underrepresented in GBV service-based data due to persistent barriers to safe disclosure and access to GBV services.**

## Age and sex of survivor




Recorded GBV incidents show a predominantly female survivor profile, with 98% of survivors identifying as female and 2% as male, indicating that women and girls constitute the majority of those accessing services and disclosing incidents. As reflected in recorded incidents and consultation findings, refugee women and girls were the primary users of GBV case management services across the participating operations. Consultations with GBV experts highlighted multiple forms of GBV affecting refugee women and girls in both private and public settings, often in contexts shaped by displacement, insecurity, economic hardship and constrained access to support services.

Men and boys account for a small proportion of survivors represented in the incident data. This should be interpreted first in light of the fact that many GBV services are designed primarily or exclusively for women and girls, which may limit the availability and accessibility of appropriate service points for male survivors. Their low visibility in the data may also reflect context-specific barriers to help-seeking and disclosure, including stigma, fear of negative social consequences, and gaps in caseworkers' capacity to respond to the full range of forms of GBV affecting men and boys, particularly those from marginalized groups. It should therefore not be interpreted as evidence of an absence of sexual violence against men and boys. GBV experts from **Bangladesh** further highlighted that although male survivors can access case management services through Multi-Purpose Community Centres (MPCCs) and integrated service delivery facilities, awareness of these services remains limited.

Social and cultural norms also play a significant role. GBV experts from **Bangladesh** noted that sexual violence against men and boys remains highly stigmatized in the Rohingya community, with survivors often experiencing shame, fear of social exclusion, concerns about masculinity, and fear of retaliation. These barriers discourage disclosure and help-seeking, resulting in substantial underreporting of GBV incidents involving male survivors.

GBV experts in **Lebanon** highlighted that, in some areas, local organizations implemented tailored outreach sessions for men and boys, facilitated by specialized staff such as social workers and psychologists. These activities were followed by an increase in recorded incidents disclosed by male survivors, while recorded incidents remained unchanged in areas where such interventions were not implemented. GBV experts reported that many of the male survivors accessing specialized services are LGBTIQ+ persons. Services are primarily provided through local organizations that work across population groups, including Lebanese nationals, refugees and migrants.

The age distribution of recorded GBV survivors shows a clear predominance of adults aged 18–60, who account for 88% of recorded incidents[11], which may reflect greater ability among adults to independently disclose violence and access services. This is also supported by consultations with GBV experts across operations, which highlighted that adults are generally more likely to disclose violence and independently seek support, while young children and adolescents often face greater barriers linked to dependence on caregivers, restricted mobility, stigma, and the fact that cases involving children may be more likely to be identified and managed through child protection systems rather than GBV services.

Adolescents aged 12–17 represent 10.66% of survivors. This proportion reflects adolescents who disclosed GBV and accessed participating services; it should not be interpreted as an estimate of the scale or prevalence of GBV affecting adolescents. Patterns of disclosure may also differ according to age, sex, dependence on caregivers, availability of adolescent-friendly services and the case-management pathway through which a child is identified. The proportion of recorded incidents involving survivors aged 12–17 varied considerably across contexts, from 6% in **Bangladesh** to 19% in **Lebanon**. As highlighted in consultations and secondary data from **Bangladesh**[12] and **Lebanon**[13], incidents involving adolescent girls included sexual violence in both urban and camp settings, including when living with extended family members or other caregivers during displacement. Consultations in **Bangladesh**, **Lebanon** and **South Sudan** identified child marriage as a continuing protection concern affecting adolescent girls, particularly in contexts characterized by economic hardship, insecurity and displacement, and/or in contexts where cultural factors frame marriage as a form of protection in highly volatile environments.

In **South Sudan**, GBV experts reported increasing sexual abuse against refugee women and adolescent girls, including conflict-related sexual violence, linked to the combined effects of conflict in Unity and Upper Nile States, inflation, lack of livelihood opportunities, and the erosion of community-based protection mechanisms amid broader economic hardship and displacement. The consultation also suggested that the visibility of adolescent survivors, who accounted for 10% of recorded incidents in South Sudan, may partly reflect sustained GBV awareness-raising, including through non-traditional GBV partners, such as community leaders and women support networks within camps, which appears to have strengthened knowledge of available services and disclosure pathways among adolescents and their caregivers.

Children aged 0–11 account for 1% of incidents recorded in the GBV incident dataset. This low proportion should not be interpreted as indicating lower exposure to GBV. Younger children may face particular barriers to disclosure and identification, including those linked to their age, dependence on caregivers, limited mobility, stigma and the fact that abuse may occur within family or other trusted relationships. In addition, depending on the context and the nature of the case, child survivors may be identified and supported through child protection case management, national child protection systems or other child-specific pathways, and their cases may therefore not be reflected in GBVIMS data. The GBV incident dataset alone consequently cannot provide a complete picture of GBV affecting children.

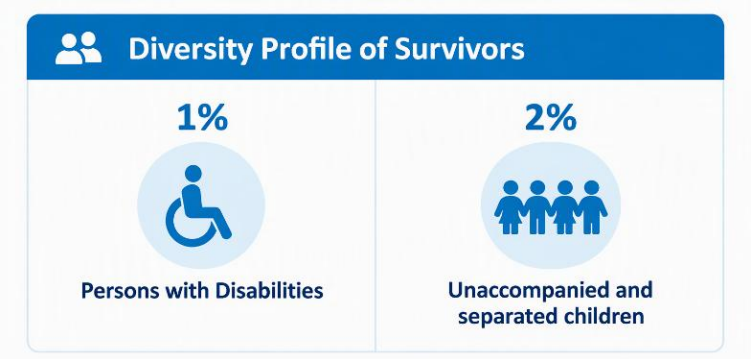
In **Bangladesh**, children aged 0–11 accounted for less than 0.4% of recorded incidents, compared with 1% across the combined dataset. GBV experts nevertheless report incidents involving child survivors of sexual violence in their context, while noting that caregivers are often reluctant to disclose such incidents. More broadly, they also noted that the very low representation of children in the GBV incident data may also reflect the availability of multiple child protection service providers across the camps, meaning that

[11] It should be noted, however, that this analysis is based exclusively on GBVIMS data and does not include Child Protection (CP) case management data; as such, it does not fully capture the scope of GBV affecting children, which is often reported and managed through CP-specific systems.
[12] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.
[13] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024.

cases involving children—including different forms of GBV—may be identified and managed through child protection pathways rather than GBV services.

Older adults (61+) represent 0.34% of recorded incidents. The very low representation of older adults in service-based data should not be interpreted as an absence of risk but may reflect barriers to disclosure and service access, including challenges in accessing services due to physical inaccessibility, lower awareness of available services, and age-related exclusion from outreach and referral pathways.

## Diversity profile of survivors




Around 1% of recorded incidents were disclosed by persons with disabilities. Secondary data and consultation findings indicate that women and girls with disabilities face GBV risks driven by the same structural gender inequalities affecting other women and girls, with disability acting as an intersecting factor that significantly increases GBV risks, particularly in camps or informal settlements where overcrowding, insecurity, and lack of privacy prevail. At the same time, access to services remains especially constrained for survivors with disabilities due to limited disability-inclusive GBV services, inaccessible communication, transportation barriers, and intersecting stigma, discrimination, and economic hardship.

In **Lebanon**, 2% of recorded incidents involved survivors with disabilities. Secondary data from **Lebanon** suggests that women and girls with disabilities face disproportionately higher risks of sexual harassment and exploitation, often perpetrated by family members, community members, or caregivers. They are frequently perceived as less able to defend themselves or to safely disclose abuse or access services, which further increases risks of exploitation. Those living in camp settings may face compounded risks due to overcrowding, lack of privacy, and limited protective infrastructure. Emerging evidence also indicates that younger women and girls with disabilities are increasingly at risk of online and technology-facilitated GBV, as perpetrators exploit perceptions of vulnerability to target them for economic and sexual exploitation in digital spaces.[14] GBV experts further highlighted that social isolation may increase exposure to digital risks, including harmful online interactions and technology-facilitated GBV.

At the same time, consultations across contexts indicate that survivors with disabilities encounter physical and systemic barriers to access service points. In addition, survivors may be underrepresented in the data due to limited capacity to capture disability-related information, including limited use of tools such as the Washington Group Questions. In **Jordan**, 7% of recorded incidents involved survivors with disabilities, compared with around 1% across the combined dataset. GBV experts noted that, after identifying the very low visibility of survivors with disabilities in their data, they introduced targeted training for service providers and strengthened awareness-raising on accessibility measures, including physical accessibility and communication support such as sign-language interpretation. Disclosures by women with disabilities subsequently increased, suggesting that targeted measures to reduce access and communication barriers may improve opportunities for survivors with disabilities to safely disclose violence and seek support.

More broadly, the low visibility of persons with disabilities in service-based data should not be interpreted as lower exposure to violence. As UN Women notes, “women with disabilities are at least two to three

[14] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024.

times more likely than other women to experience violence, including by family members, intimate partners, caregivers and within institutional facilities".[15]

Across bilateral consultations, unaccompanied and separated children (UASC) also appear underrepresented in the GBVIMS dataset, accounting for 2% of all recorded incidents. This should not be interpreted as evidence of lower exposure to GBV. UASC may face heightened risks of sexual violence, exploitation, and other forms of GBV, while also encountering significant barriers to disclosure and access to services. In many contexts, child survivors among UASC may be identified first through child protection, guardianship or national welfare mechanisms, rather than through GBV case management structures and GBVIMS, as highlighted by GBV experts in **Lebanon and Bangladesh**. Taken together, these factors suggest that the apparent underrepresentation of children—including UASC—in GBVIMS data is largely driven by parallel case management systems and structural barriers to disclosure, rather than lower exposure to GBV risks.

**7%**

**JORDAN**

7% of recorded incidents involved survivors with disabilities, compared with around 1% across the combined dataset

**2%**

**LEBANON**

2% of recorded incidents involved survivors with disabilities

The GBVIMS captures information on GBV incidents disclosed by survivors accessing services, using a standardized set of variables designed to safeguard confidentiality and support comparability across contexts. In line with data protection and do-no-harm principles, the system does not systematically collect or disaggregate data by sexual orientation, gender identity, gender expression or sex characteristics (SOGIESC), particularly given the risks of stigma, discrimination and further harm associated with disclosure in certain contexts. While this limits the visibility of the specific experiences and protection risks of LGBTIQ+ persons within GBVIMS datasets, it reflects the overriding commitment to survivor safety, dignity and confidentiality. The limited visibility of these experiences in the data should therefore not be interpreted as an indication of lower exposure to GBV or fewer protection needs.

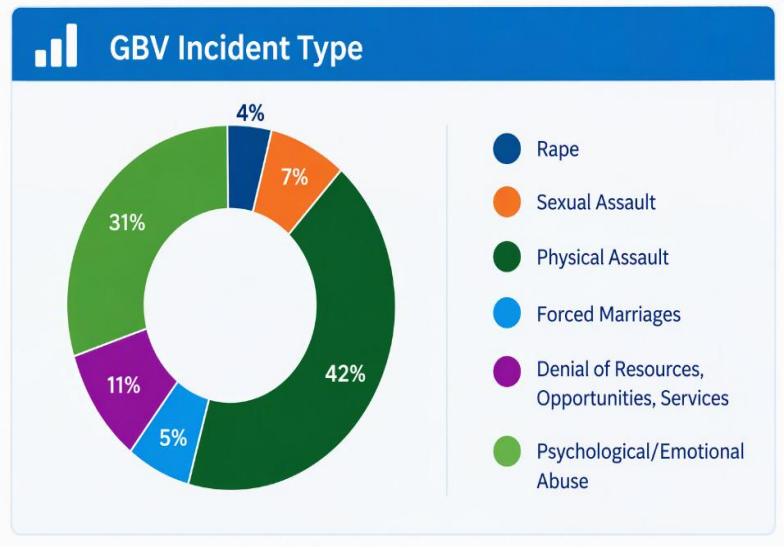
At the same time, evidence from secondary data and consultations indicates that LGBTIQ+ refugees face heightened and intersecting risks of GBV, including violence perpetrated by family members, community actors, and authorities, as well as discrimination, stigma, and social exclusion that constrain access to services and safe disclosure pathways. These risks can be compounded in contexts where people face criminalization or discrimination on the basis of their sexual orientation and/or gender identity. In **South Sudan**, the issue is described by GBV experts as highly sensitive, with some forms of support reportedly available but not publicly accessible.

Overall, these findings underscore that stigma, discrimination, criminalization, and the use of informal or non-GBV service entry points continue to constrain access to safe disclosure, contributing to the under-representation of LGBTIQ+ survivors in GBV incident data despite heightened and intersecting GBV risks across contexts. They also highlight the importance of diversity-inclusive, survivor-centered GBV services that proactively address barriers to access, strengthen trust and confidentiality, and ensure that diverse GBV survivors can safely seek and receive support.

[15] UN Women, *Facts and Figures: Women and Girls with Disabilities*, 2022.

3. **While physical assault and emotional abuse accounted for the largest share of recorded incidents, refugee women and girls also experienced sexual violence, forced marriage, and other forms of GBV across domestic, public, workplace, and displacement settings. These findings underscore the diverse and intersecting forms of violence affecting refugee women and girls across participating operations.**

**Physical assault or abuse** constitutes the largest share of recorded incidents across the five refugee operations analyzed (42%), followed by emotional or psychological abuse. Refugee women and girls also experienced sexual violence, forced marriage and other forms of GBV, reflecting the diverse forms of violence captured in the incident data. Secondary data and consultations further indicate that these incidents occurred across a range of settings, including domestic, public, workplace and displacement contexts.




A substantial proportion of reported physical assaults were described by GBV experts as occurring within intimate partner relationships. Across operations, GBV experts and secondary sources consistently identified heightened household tension, financial strain and constrained living conditions as contextual factors associated with increased risks of physical intimate partner violence. While IPV accounted for the largest share of recorded incidents among refugee women accessing services, this pattern should be interpreted with caution. IPV is one of the most prevalent forms of violence against women globally across diverse communities and socio-economic contexts. Its prominence in refugee settings does not reflect inherent characteristics of refugee populations but rather the interaction of harmful gender norms and pre-existing gender inequalities with displacement-related stressors and economic hardship. This pattern is explored further in Finding 4.

In **Bangladesh**, physical assault remains the most common form of GBV for which survivors seek support, accounting for 54% of all recorded incidents Secondary data suggest that physical violence—particularly within intimate partner relationships—is increasingly normalized amid rising insecurity. During focus group discussions, women reported enduring physical assault within marriage as a trade-off for perceived protection.[16] Similar patterns were identified in other operations. In **Lebanon**, physical assault is the most common type of recorded GBV, accounting for 33% of all recorded incidents. According to secondary data, refugees face heightened intimate partner violence risks, including physical assault, linked to overcrowding in accommodation or displacement sites, substandard living conditions, and economic dependency. The same source also identifies workplace violence as a concern, with working women and adolescent girls reportedly subjected to physical assault by employers, particularly in unregulated sectors and where workers have irregular legal status. Consulted community members

[16] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.

reported that male colleagues and supervisors exploit gendered and workplace power imbalances to perpetrate violence against women and girls.[17]

In **South Sudan**, physical assault account for 41% of all recorded incidents, representing the largest share of incidents in the operation. Secondary data indicates that overcrowded camps and competition over scarce resources contribute to heightened risks of violence. In this context, climate-induced food scarcity and financial hardship reinforce household power imbalances, with disputes over resource access frequently escalating into physical violence.[18] Consultations further highlighted the link between physical assault in intimate relationships and unemployment, which contributes to frustration and increased household tension, while harmful coping mechanisms, including excessive alcohol use, may further exacerbate the risk of violence. Similarly, in **Tanzania**, physical assault accounted for 27% of all recorded incidents. GBV experts associated heightened risks of physical assault within intimate partner relationships with unemployment and increased household stress. They highlighted restrictive encampment policies that limit refugees' access to formal employment outside the camps, alongside reductions in food assistance due to funding cuts, as factors contributing to economic pressure within households.

In **Jordan**, physical assault represented the second-largest share of recorded incidents (16%), following emotional or psychological abuse. GBV experts similarly reported that reductions in services, including cash-based assistance linked to funding cuts, contributed to increased tension within households and heightened risks of physical assaults against women, girls, and boys. This trend was reportedly further exacerbated by the suspension of work permits for Syrian refugees, which reduced household income and intensified financial strain within families. Consultations suggested that these pressures, shaped in part by gendered expectations around breadwinning, contributed to heightened risks of violence within the home.

More broadly, secondary data indicates that mobility restrictions, proximity to checkpoints, fear of detention and residence in conflict-prone areas exacerbate household stress and increase IPV risk. In **Lebanon**, for example, refugee women in the North indicated that proximity to checkpoints and conflict-affected areas heightened IPV risks. The frequent stopping of men at army checkpoints, combined with fear of deportation, generates significant stress within households, which in turn may increase the risk of IPV for women and girls.[19] GBV experts further highlighted that the situation not only intensified household stress but also altered household coping and mobility patterns. Fears of detention and deportation restricted the movement of men and adolescent boys, leading women and girls to assume a greater presence in public spaces and interactions outside the home. This shift reflected changing household roles and responsibilities and was driven by the perception that women and girls faced a lower risk of detention or deportation.

In some contexts, it was reported that physical assault within intimate partner relationships led to attempted femicide and femicide. In **Bangladesh**, for example, recorded incidents of femicide and attempted femicide have been documented across multiple camps, underscoring the severity of violence experienced by refugee women within their homes. These incidents have resulted in severe injuries and deaths, while also leaving some children without parental care.[20] The GBVIMS does not capture femicide, as the data is exclusively based on survivors who are alive and have sought support. The system currently does not enable the recording of femicide cases, even in situations where women and girls had previously received services after experiencing rape, physical assault, or emotional abuse by an intimate partner and

[17] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024
[18] UNFPA, *Vulnerability Assessment on the Impact of Climate Change on Gender Equality, Sexual and Reproductive Health, and Gender-Based Violence in South Sudan*, 2025.
[19] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, November 2024.
[20] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.

were subsequently killed. However, across all contexts of intimate partner violence (IPV), femicide remains a critical risk.

Beyond intimate partner relationships, refugee women and girls also face physical assault in public spaces, workplaces, and settings affected by criminal or armed violence. In some contexts, GBV experts reported that women and girls are subjected to physical assaults in public transportation and on the streets by community members. In **Lebanon**, secondary data indicates that working women and adolescent girls are frequently subjected to physical assault by employers. These risks are exacerbated for those working in unregulated sectors or with irregular legal status. Consulted community members also reported that male colleagues and supervisors exploit gendered and workplace power imbalances to abuse women and girls.[21] GBV experts further noted that challenges related to residency status are widespread among refugees in Lebanon and constitute a broader structural protection concern. They highlighted that obtaining or renewing legal residency remains difficult for many refugees due to administrative and socioeconomic barriers, contributing to heightened risks across refugee populations.

**Psychological and/or emotional abuse** accounts for 31% of recorded incidents, representing the second largest share among recorded incident types. Secondary data and consultations with GBV experts indicate that psychological and emotional abuse occurs across a range of contexts, including intimate partner relationships, family settings, workplaces, and digital environments. Within intimate partner relationships, emotional abuse appears to be shaped by many of the same factors associated with physical violence, including insecurity, financial stress and overcrowded living conditions. Consultations further suggest that, in some cases, emotional abuse may precede or escalate into physical or sexual intimate partner violence. Furthermore, in some contexts emotional abuse is not broadly perceived to constitute violence, posing a barrier for disclosure.

In **Lebanon**, psychological abuse accounted for 31% of all recorded incidents, the same proportion as in the combined dataset. Secondary data on women more broadly indicates that women described a range of controlling behaviors by husbands or other male family members, including verbal abuse, threats, monitoring of women's and girls' movements and social interactions, humiliation, and forced isolation. These behaviors were described as mechanisms of punishment and control. Secondary data also suggests that psychological abuse may occur beyond family settings, with refugee women reported to face verbal harassment and intimidation in the workplace, particularly in situations characterized by unequal power relations and precarious employment. Secondary data also suggests that psychological abuse may occur beyond family settings, with refugee women and girls reporting verbal harassment and exploitation by employers, colleagues, and customers in workplace settings.[22] GBV experts in **Lebanon** also reported an increase in disclosures of psychological abuse following the 2024 escalation of hostilities and subsequent returns to areas of origin. This pattern may reflect the effects of escalation of conflict, exposure to violence and lack of law enforcement and accountability mechanisms as well as overcrowded collective shelters and shared living arrangements, where women may face psychological abuse perpetrated not only by family members but also by other community members.

In **Bangladesh**, psychological abuse accounted for 24% of all recorded incidents, representing the lowest share among the five participating operations. Secondary data suggests that declines in recorded incidents of this form of GBV in 2025 may not indicate a true reduction in incidence, but rather a shift in perception and reporting. Increased dependency and the use of marriage as a perceived protective mechanism—for both women and their daughters—have contributed to the normalization of emotional abuse within households, resulting in abuse being tolerated, overlooked, or less likely to be disclosed.[23]

[21] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024
[22] ibid
[23] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.

In addition to occurring within households and intimate relationships, psychological and emotional abuse may also be perpetrated through digital technologies. In one context, GBV experts highlighted cases in which women and LGBTIQ+ individuals were filmed while being subjected to sexual violence and were subsequently blackmailed with threats to share the footage. In other cases, women were subjected to threats by intimate partners through social media platforms. These examples highlight the intersection between psychological and emotional abuse and technology-facilitated GBV, demonstrating how violence, coercion and control often operate across an online–offline continuum.

### Technology-Facilitated GBV

In **Lebanon**, women and girls experience technology-facilitated GBV, including cyber harassment, online stalking, and digital blackmail. Female migrant workers appear to face particular exposure to these risks, including monitoring of online profiles, persistent unwanted messages, and the use of personal information—such as images, media, or private communications—to extort economic or sexual favors.[24]

GBV experts in Lebanon highlighted that restrictive social norms, mobility constraints, and fears of arrest, detention or deportation associated with irregular legal status can limit the ability of refugee women and girls to move freely in public spaces. As a result, women and girls may rely more heavily on digital platforms for communication, social interaction, accessing information and services, education, and livelihood opportunities, which may in turn increase exposure to technology-facilitated violence and exploitation. At the same time, this form of violence is likely underreported, as many women and girls may not recognize technology-facilitated GBV as a form of violence and therefore may not disclose.

Together, physical assault and psychological or emotional abuse account for nearly three-quarters (73%) of recorded incidents. However, psychological and emotional abuse likely remains underrepresented in service-based data, as it is often normalized, minimized, or not recognized as a form of violence requiring support.

**Denial of resources, opportunities, or services** accounts for 11% of recorded cases. Secondary data indicates that this form of violence often includes economic and financial abuse within intimate partner and family relationships, manifested through control of household resources, restrictions on women's access to finances, or coercion to surrender income or assets, thereby reinforcing dependency and limiting autonomy.

In **Bangladesh**, denial of resources, opportunities or services accounted for 13% of all recorded incidents. Secondary data indicates increasing financial control by male spouses, including reports of men gambling away household assets or in extreme cases, even their spouses.[25] Beyond household financial control, this form of violence also includes restrictions on girls' access to education, mobility, and safe spaces. Escalating insecurity has contributed to the widespread withdrawal of adolescent girls from public spaces, including schools and Women and Girls safe spaces.

In **Lebanon**, this form of GBV accounted for 7% of all recorded incidents. Secondary data indicate that adolescent girls face heightened risks of child marriage and denial of access to education as families resort to negative coping mechanisms amid increasing economic hardship.[26] Denial of resources, opportunities or services represented a larger share of recorded incidents in **South Sudan**, at 14%. Secondary data suggests that worsening economic instability caused by climate-induced food shortages

[24] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024.
[25] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.
[26] GBVIMS Lebanon, *Gender-Based Violence Information Management System Annual Report 2024*, 2025.

and financial hardships has forced many families to resort to child marriage, where girls are deprived of education, autonomy and future opportunities.[27] While often framed as protective measures, these restrictions result in a systemic denial of essential resources and opportunities. GBV experts further reported that women in **South Sudan** may also be denied control over income they earn themselves, reinforcing economic dependency and limiting their decision-making power.

**Sexual assault** accounts for 7% of recorded incidents but remains one of the most underreported forms of GBV due to stigma, fear of retaliation, family rejection, and community ostracization, all of which significantly constrain disclosure. Secondary sources indicate that sexual assault against refugee women and girls occurs across multiple settings, including domestic, workplace, and public or semi-public environments.

In **Bangladesh**, this incident category accounts for 4% of all recorded incidents. Secondary data suggests that refugee women and girls living with extended relatives due to displacement face heightened risks, particularly from relatives who provide them shelter in camp settings.[28] In **Lebanon**, the corresponding share was highest of all operations, at 12%. Secondary data similarly indicates that women and girls living with extended family members due to displacement were found to face higher risk of sexual violence and exploitation by caregivers and relatives due to overcrowding, lack of privacy and dependency due to limited economic means. At the same time, these forms of GBV remain significantly underreported due to stigma, fear of retaliation, and the risk of ostracization by family and community members.[29] According to GBV experts in **Lebanon**, the heightened risk of sexual violence and exploitation by extended family members affects both Syrian refugee women and girls and Lebanese women and girls internally displaced due to conflict.

Beyond domestic settings, secondary data also highlights workplace-related sexual violence and exploitation. In **Lebanon**, women working in unregulated sectors and with irregular legal status are reported to face heightened risks of sexual harassment and abuse by employers or colleagues.[30] Sexual assaults are further recorded in public and semi-public spaces such as transport hubs, WASH facilities, firewood collection areas, and markets, particularly in camp-based and transit settings, although incidents in these locations remain significantly underreported despite being widely recognized as high-risk. In **Tanzania**, where this incident category accounts for 3% of all recorded incidents, GBV experts report that refugee women experience sexual abuse while collecting firewood or engaging in farming activities outside the camp. The corresponding share in **South Sudan** was also 3%. Safety audit findings indicate that women do not feel safe and face heightened risks of sexual assaults in various locations, including washrooms, shelters and firewood collection areas. Furthermore, secondary data indicate that escalating climate stressors have forced women and girls to travel long distances into isolated and insecure areas to fetch water and gather firewood, increasing the risk of sexual violence.[31]

Taken together, secondary data suggest that sexual assault in refugee settings is closely linked to conditions of displacement, dependency, economic precarity, and unsafe access to basic resources and services, while stigma and fear of repercussions continue to inhibit disclosure.

**Rape** constitutes 4% of recorded incidents but remains one of the most severely underreported forms of GBV due to stigma, fear of retaliation, limited access to confidential services, and restrictive social norms.

[27] UNFPA, *Vulnerability Assessment of the Impact of Climate Change on Gender Equality, Sexual and Reproductive Health and Gender-Based Violence in South Sudan*, 2025.
[28] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.
[29] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024.
[30] ibid
[31] UNFPA, *Vulnerability Assessment of the Impact of Climate Change on Gender Equality, Sexual and Reproductive Health and Gender-Based Violence in South Sudan*, 2025.

In **Tanzania**, rape accounted for 19% of recorded incidents—the highest share among the five participating operations. GBV experts highlighted that marital rape is rarely disclosed due both to the legal framework and the widespread perception that rape cannot occur within marriage. As a result, most rape incidents disclosed to service providers reportedly involve adolescent girls or women raped outside the camp by perpetrators other than intimate partners. Even in such cases, GBV experts note that mediation is frequently initiated by the families of the survivor and the alleged perpetrator, suggesting that rape, including outside intimate or domestic relationships, may still be addressed through informal mediation rather than formal protection or justice mechanisms. The use of mediation in cases of marital rape (or broader IPV) and other forms of sexual violence exposes survivors to severe trauma, increase risks of violence and longer-term consequences on their health and wellbeing.

Secondary data and consultations across operations indicate that marital rape remains a significant but rarely disclosed form of violence, particularly in contexts where it is not criminalized and harmful social norms frame sex within marriage as an obligation, as documented in **Lebanon** and **Tanzania**.

Beyond intimate partner relationships, rape is also reported in camp and displacement settings, where overcrowding, lack of privacy, and insecurity heighten risks, including in contexts involving armed or criminal groups. In **Bangladesh**, rape accounts for 4% of all recorded incidents. According to secondary data, incidents of gang rape have been recorded across multiple camps, and survivors have reported threats, fear of retaliation, and heightened insecurity, particularly in areas where organized groups operate with impunity. While these threats have significantly deterred help-seeking, available data suggests that survivors continue to disclose the most extreme forms of sexual violence, including gang rape and sexual violence perpetrated by organized groups, while other forms of sexual violence remain largely underreported.[32] GBV experts state that women and girls most at risk are those living in households where there is no male family member, either temporarily or permanently. In some reported cases, rape was described as a form of retaliation towards a member of a rival group.

GBVIMS data also show that incidents of rape are documented in isolated public spaces, including rural fields, roads, and public transport, particularly in contexts characterized by insecurity and limited access to protection services. In such settings, distance, insecurity, and delayed access to support may further heighten GBV risks and constrain timely disclosure.

**Forced marriage** represents 5% of recorded cases but is widely recognized as under-identified. Secondary data indicates that forced and child marriage remain significant in multiple refugee contexts, driven by economic hardship, prolonged insecurity, climate-related shocks, and entrenched patriarchal norms, **as documented in Bangladesh, South Sudan and Lebanon**. Families often frame child marriage as a “protective” or economic coping strategy, contributing to its normalization and invisibility in GBV service data.

In **Lebanon**, forced marriage accounts for 14% of all recorded incidents—the highest share among the participating operations. Secondary data indicates that poverty, economic collapse and cultural norms drive child marriage prevalence among refugee girls, particularly in rural areas. Child marriage is often used to alleviate financial burdens on families, affecting mostly girls from impoverished families. In this context, child marriage is perceived as protection for girls when in unstable, insecure and highly volatile environments.[33] GBV experts highlight that forced marriage was highest disclosed among Syrian refugees and commonly used as a coping mechanism for the economic situation. However, following the closure of a dedicated project on child and forced marriage due to funding cuts, GBV experts reported a decline in disclosures, likely linked to reduced outreach and fewer related activities.

[32] GBV Sub-Sector Cox’s Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.
[33] GBV Working Group Lebanon, *Gender-Based Violence Safety Audit for Lebanon*, 2024.

Similar dynamics were also documented in **Bangladesh**, although forced marriage accounted for 0% of recorded incidents. This very low recorded share contrasts with secondary data indicating that some families may resort to child marriage of adolescent girls as a harmful coping mechanism, including in response to perceived risks such as abduction or sexual violence.[34] GBV experts highlighted that married adolescent girls are frequently exposed to intimate partner violence but often face significant barriers to safe disclosure and access to support due to their age, limited autonomy, and constrained decision-making power. These barriers, together with married girls' dependence on family members, may contribute to the very limited visibility of forced marriage in the incident data despite evidence that child marriage remains a significant protection concern.

## PROGRAMME SPOTLIGHT

**Strengthening community engagement with religious leaders for GBV prevention and response in Bangladesh**

UNHCR's collaboration with Imams and female religious teachers in Cox's Bazaar refugee camps demonstrates the impact of grounding Community-Based Protection (CBP) in a robust socio-cultural and political context analysis. By recognizing the influence of faith leaders and leveraging their capacity through tailored training on rights-based approaches, facilitation skills and self-care, UNHCR enabled meaningful community engagement on sensitive protection issues. These leaders, in coordination with Radio Listening Groups, played a key role in promoting messages on GBV prevention and access to services, contributing to tangible protection outcomes, including a reduction in child marriage, strengthened referral pathways, and greater women's participation and empowerment. This case illustrates how deep understanding of local power dynamics, values, and social structures is critical to designing and sustaining impactful CBP strategies.

In **South Sudan**, forced marriage accounted for 1% of recorded incidents. This low recorded share contrasts with secondary data suggesting that climate stressors may be associated with child marriage among adolescent girls, particularly in areas where economic hardship and displacement are widespread.[35] GBV experts identified gaps in policies and laws as contributing factors to child and forced marriage. At the same time, some consultations indicated that, although child marriage remains highly prevalent among the broader population, it has reportedly declined in recent years. The consultations suggest that this decline may reflect sustained and widespread efforts to address child marriage, including work with partners to support the establishment of local laws and engagement with community structures, chiefs and other influential community members.

Legal exceptions permitting marriage below 18 with judicial or guardian consent further complicate prevention of child marriage prior to its occurrence and response, as observed in **Lebanon.** In addition, forced and child marriage may be captured through Child Protection Information Management System (CPIMS) data instead when child protection actors represent the first point of contact in referral pathways for child survivors. Cases involving child marriage may also be identified or managed through child protection or national child welfare pathways, depending on the context and the needs of the child. Consequently, GBVIMS data alone are unlikely to capture the full extent of child marriage, or the range of protection needs affecting married girls and those at risk.

[34] GBV Sub-Sector Cox's Bazar, *Bangladesh Rohingya Refugee Response: Quarterly Bulletin, Q2 April–June 2025*, 2025.
[35] UNFPA, *Vulnerability Assessment of the Impact of Climate Change on Gender Equality, Sexual and Reproductive Health and Gender-Based Violence in South Sudan*, 2025.




*UNHCR Regional Bureau for East and Horn of Africa and the Great Lakes Director, Mamadou Dian Balde, visits the Girl Shine project in Juba, South Sudan* ©UNHCR/Gift Friday Noah

**54%**

**BANGLADESH**

physical assault remains the most common form of GBV for which survivors seek support, accounting for 54% of all recorded incidents

**19%**

**TANZANIA**

rape accounted for 19% of recorded incidents—the highest share among the five participating operations

**14%**

**LEBANON**

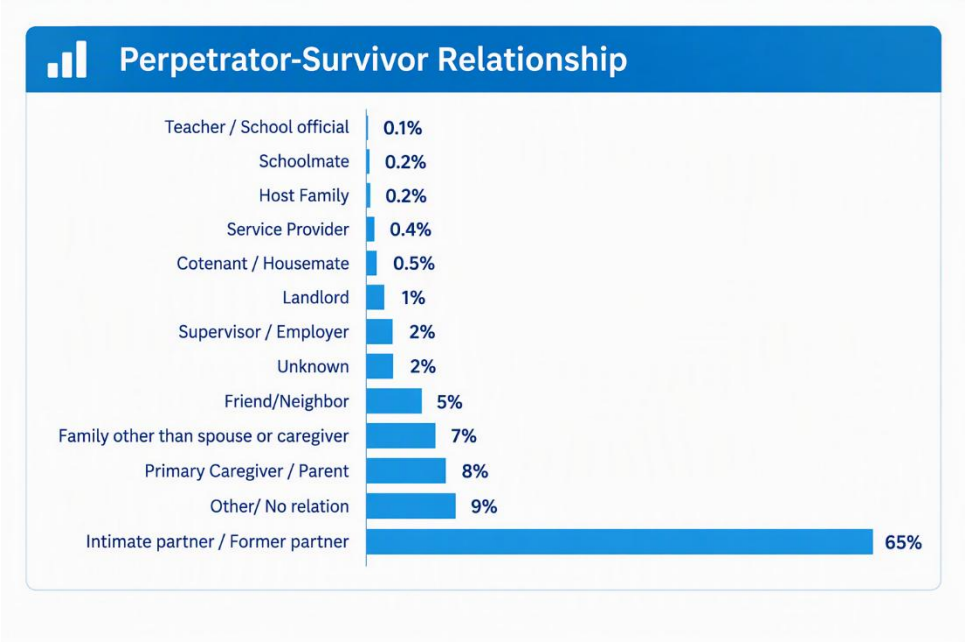
forced marriage accounts for 14% of all recorded incidents—the highest share among the participating operations

**4. Intimate partners are the primary perpetrators of reported GBV against refugee women and girls, and the data demonstrate that private residences are the most frequently recorded incident locations, not necessarily where the overall risk of violence is highest. Across operations, unemployment, economic insecurity, precarious livelihoods, and forced displacement-related stressors were consistently associated with heightened risks of violence within households, while fear, stigma, insecurity, and power imbalances may constrain disclosure of violence perpetrated by strangers, military and authority figures.**

Analysis of **perpetrator–survivor relationships** shows that intimate and former intimate partners account for 65% of recorded GBV incidents, making intimate relationships the most frequently disclosed context of violence across the five participating operations. This is consistent with the preceding analysis, which found that physical assault, psychological abuse and denial of resources were most commonly disclosed within intimate partner relationships.

Consultations and secondary data further indicate that structural and policy-related conditions—including restrictions on employment, encampment policies and broader limitations on freedom of movement—may heighten risks within intimate relationships, as observed in **Tanzania** and **Lebanon**. Limited access to

safe and dignified livelihoods may reinforce economic dependency and power imbalances within relationships, constraining survivors' ability to leave abusive situations, as highlighted in **South Sudan**.



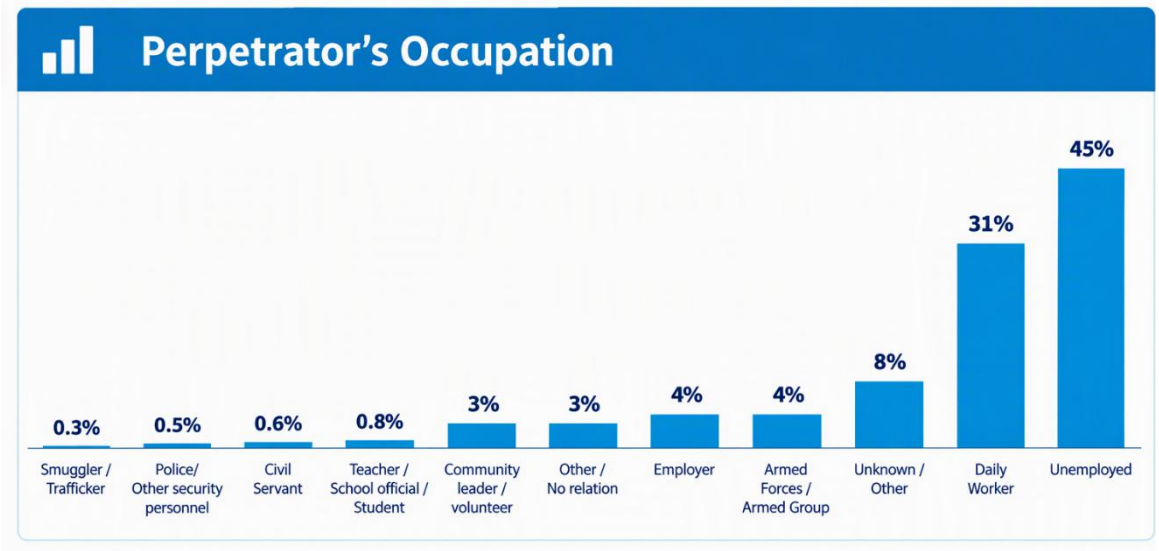

These findings describe patterns among incidents disclosed by survivors who were able and willing to access services; they do not measure the prevalence of violence within any population. This pattern is consistent with broader evidence showing that violence against women frequently occurs within intimate relationships and is rooted in structural gender inequalities, which may be exacerbated by economic insecurity, displacement-related stressors and reduced access to support systems. As the current GBVIMS dataset did not capture alleged perpetrators' nationality, the findings must not be used to attribute responsibility to, or stigmatize or discriminate against, any nationality, population group or community.

Alleged perpetrators with no prior relationship represent 9% of recorded incidents, primarily reflecting incidents of GBV occurring in public or community settings. **However, this figure is likely influenced by under-reporting linked to fear, stigma, and limited safe disclosure pathways**. In **Lebanon**, GBV experts highlighted that sexual violence occurring in overcrowded shelters may go undisclosed due to fear of consequences, including concerns about losing access to shelter or support. In **Bangladesh**, GBV experts reported that fear of retaliation by criminal or organized groups may deter survivors from seeking assistance following incidents of GBV. Consultations also highlighted that technology-facilitated forms of GBV may remain underreported when survivors do not recognize these experiences as forms of violence or are unaware that support services are available. Taken together, these barriers suggest that incidents perpetrated by individuals with no prior relationship to the survivor may be less likely to be disclosed and recorded, and the 9% recorded share should therefore be interpreted with caution.

Beyond intimate partner relationships and incidents involving perpetrators with no prior relationship to the survivor, alleged perpetrators were most commonly identified as primary caregivers or parents (8%), family members other than spouses or caregivers (7%), and friends or neighbours (5%). These findings highlight that GBV disclosed by refugee women and girls may occur within broader family, caregiving, and community settings. While these categories account for a smaller proportion of recorded incidents than intimate partners, they nevertheless underscore the importance of prevention and response strategies that address GBV risks across households, extended family networks, and communities.

## Perpetrator's occupation

Patterns in alleged perpetrators' occupations provide insights into the socioeconomic contexts in which recorded GBV incidents occur, with 45% reported as unemployed and 31% working as daily labourers. These findings should be interpreted with caution, as the available data do not establish whether unemployed individuals are disproportionately represented among alleged perpetrators or whether employment status influences the likelihood of perpetrating GBV.




In refugee settings, occupational patterns must also be understood in relation to country-specific legal and socioeconomic conditions, including varying degrees of access to employment, freedom of movement and livelihood opportunities. Consultations and secondary evidence across participating operations highlighted how economic insecurity and displacement-related stressors can exacerbate household tensions and reinforce existing unequal power dynamics. In Bangladesh, where Rohingya refugees face significant restrictions on employment and mobility, a randomized study involving 2,513 married refugee couples found that women whose husbands participated in paid livelihood activities were 31% less likely to experience physical threats from their husbands than women in the control group. However, paid employment alone did not substantially transform household power dynamics or increase women's agency in the short term.[36]

These findings underscore the potential contribution of refugees' access to decent work and economic inclusion to GBV prevention, particularly when complemented by gender-transformative approaches that address unequal power relations and strengthen women's economic autonomy.These dynamics were particularly emphasized by GBV experts in **Bangladesh**, **South Sudan**, and **Tanzania**.

A notable proportion of incidents (8%) classify the perpetrator's occupation as "Unknown". This reflects the proportion of incidents where survivors did not know the perpetrators prior to the incident. GBV experts further highlight that some survivors may be reluctant to share more information regarding alleged perpetrator for various reasons. This also reflects GBV caseworkers' not feeling comfortable enquiring or prioritizing this data points given the limited relevance of occupational details to the survivors' immediate safety, as highlighted in consultations with GBV experts in **Jordan, South Sudan** and **Tanzania.**

A smaller proportion of incidents involved employers (4%), armed actors (4%), community leaders or volunteers and Other/No Relation (3%) each, teachers (1%), civil servants (1%), and police or other security actors (0.5%). Although comparatively limited in number, these incidents carry significant

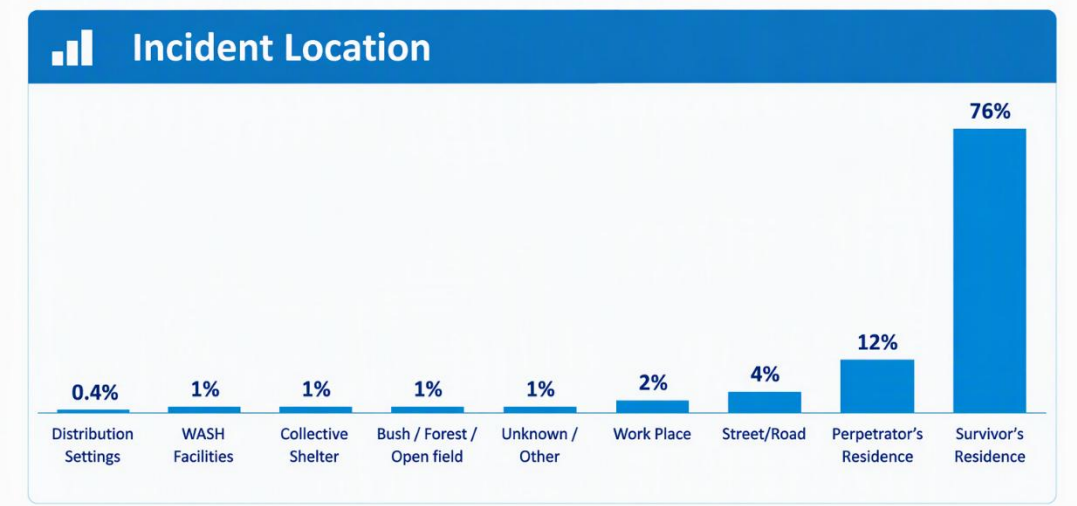
[36] Hsu, Y., Hussam, R., Kelley, E. M., Lane, G., and Adee, M. I. A. (June 2025). Bangladesh Policy Brief: The Impact of Livelihood Activities among Rohingya Refugees. UNHCR, University of Chicago and Harvard Business School, pp. 3–5.

protection implications due to potential abuses of authority and power imbalances between survivors and alleged perpetrators. In some contexts, fear of retaliation, dependence on the perpetrator, or concerns regarding access to services and livelihoods may further discourage disclosure. These dynamics may be particularly relevant in settings affected by conflict and insecurity, such as **South Sudan**.

Incidents attributed to smugglers or traffickers (0.3%) further highlight the exploitation and protection risks that refugee women and girls may face during displacement. However, this relatively small recorded share should be interpreted cautiously, as it reflects the incidents that became visible through GBV case management services in the operational contexts covered and does not indicate the overall scale of trafficking-related GBV. Patterns of mobility and exposure, barriers to safe disclosure, service access, data-collection practices and the use of other protection or disclosure pathways may all affect the visibility of these incidents in the data.

## Incident location

Data on incident locations shows that the survivor's residence accounts for 76% of recorded GBV incidents, making the home the most frequently disclosed location of violence. An additional 12% of incidents were reported as occurring in the perpetrator's residence. Together, these findings indicate that nearly nine out of ten (88%) recorded incidents occurred within private residential settings. This aligns with the broader finding that intimate and former intimate partners account for the majority of alleged perpetrators and highlights the home as the primary setting of disclosed violence against refugee women and girls. It also reflects wider evidence showing how structural gender inequalities, economic stress, overcrowding, and unequal power relations within households may contribute to heightened GBV risks.




Incidents occurring at the perpetrator's residence (12%) further underscore the importance of private settings as locations of risk, particularly for refugee women and girls relying on extended family or hosts during displacement, **as observed in Jordan** and **Bangladesh**. GBV experts in Bangladesh note that incidents disclosed as occurring in the perpetrator's residence also include newly arrived refugee women residing with relatives in the camps.

Public spaces, including streets and roads, accounted for **4%** of recorded incidents, while workplaces represented **2%**. Although these proportions are comparatively small, they highlight ongoing GBV risks in community and work-related environments. Open areas such as forests, fields, farms, and fishing areas accounted for **1%** of incidents. Collective shelters, WASH facilities, and collective shelter each represented approximately **1%** of recorded incidents, while distribution settings accounted for 0.4%. Although these locations accounted for relatively small proportions of recorded incidents, incidents

occurring in these locations remain significant protection concerns, with contributing factors including overcrowding, lack of privacy, poor lighting, and displacement-related living conditions.

**88%**

nearly nine out of ten (88%) recorded incidents occurred within private residential settings

**65%**

intimate and former intimate partners account for 65% of recorded GBV incidents

**45%**

alleged perpetrators reported as unemployed



*Women participating in empowerment programmes showcase their products and achievements during International Women's Day celebrations in Nyarugusu refugee camp, Tanzania* © UNHCR

5. **Timely disclosure is achievable when survivor-centred services are accessible, known and trusted: 42% of recorded incidents were disclosed within five days. Across refugee settings, early disclosure was associated with functioning referral pathways, community-led awareness efforts, and sustained investments in GBV services. At the same time, significant delays in disclosure persist, highlighting the continued impact of stigma, insecurity, fear of retaliation, mobility constraints, and social norms that discourage help-seeking.**

## Time between incident and reporting to GBV services

The distribution of reporting delays shows that 33% of recorded incidents were disclosed within 0-3 days, making this the most common reporting timeframe across the five participating operations. Early disclosure and therefore access to GBV case management services may reflect the continued availability of referral pathways and trusted community mechanisms, survivors' awareness of available services, and their ability to safely access support. Relatively high proportions of incidents disclosed within 0–3 days were observed in Bangladesh (45%), South Sudan (43%), and Tanzania (40%).

**33%**
of recorded incidents were disclosed within 0-3 days

**29%**
of survivors disclosing incidents more than one month after occurrence, a pattern common in humanitarian settings

**51%**
**JORDAN**
recording the highest share, with 51% of incidents reported more than one month after occurrence

In Jordan, 15% of incidents were recorded within 0-3 days. While this proportion remains relatively low compared with other participating operations, GBV experts noted improvements in the timeliness of disclosure over the semesters. This observation is supported by GBVIMS data, which show an increase in the proportion of incidents disclosed within 0–3 days and a decline in the proportion disclosed more than one month after occurrence between 2024 and the first half of 2025. GBV experts associated this trend with the institutionalization of survivor-centred approaches within government systems, supported by UNHCR through technical and financial support for the development of national guidelines and the capacity strengthening of frontline actors. Other UN agencies and partners may also have introduced interventions that contributed to the change observed. These efforts may have contributed to increased trust in services and reduced barriers to timely disclosure.

At the same time, delayed disclosure remains significant, with 29% of survivors disclosing incidents more than one month after occurrence, a pattern common in humanitarian settings. Country-level analysis shows variation across operations with **Jordan** recording the highest share, with 51% of incidents reported more than one month after occurrence, while **Bangladesh** recorded the lowest, at 16%.

In **Lebanon**, with 41% of survivors disclosing incident after more than one month, GBVIMS data indicate a gradual improvement in timeliness over the reporting period, with the proportion of disclosures occurring within 0-3 days increasing and the proportion disclosed after more than one month declining. GBV experts highlighted that delayed disclosure—more than one month after the incident—was more common during the conflict escalation, but became less frequent following the ceasefire. Consultations associated this shift with stronger referral systems and outreach efforts during that period, building on partners' broader capacity-building efforts on safe disclosures and GBV referral pathways. They further highlighted geographic disparities, noting that survivors in areas with greater service availability and better access to transportation are more likely to disclose incidents earlier.

In **Bangladesh**, while the overall proportion of incidents disclosed more than one month after occurrence was relatively low (16%), GBV experts highlighted that a substantial share of sexual violence cases, particularly rape, were disclosed only after more than one month. Such delays may prevent survivors from accessing HIV post-exposure prophylaxis within the critical 72-hour period and may limit timely access to other components of post-rape care, although medical care and support remain important regardless of when a survivor seeks assistance. GBV experts described this trend as reflecting a combination of factors, including limited awareness of the importance of seeking medical help early. Delayed disclosure is also linked to the normalization of certain forms of violence, particularly intimate partner violence, where emotional, verbal, and economic abuse may not be immediately recognized as warranting support. In such cases, survivors often delay seeking services until violence escalates or becomes severe. In addition, community-based resolution mechanisms—such as engagement with religious or community leaders—are frequently prioritized, further delaying access to formal GBV services. Fear of retaliation, including threats from perpetrators or community actors, as well as restrictions imposed by community structures, also act as significant barriers to disclosure.

Mid-range delays were observed, with 9% of disclosures occurring within 4–5 days, 19% within 6–14 days, and 11% between two weeks and one month, potentially reflecting risk assessment within

households, uncertainty about service availability, and economic dependency, as highlighted across multiple operations including **Jordan and Lebanon.** In **South Sudan**, GBV experts noted that refugee women subjected to violence during their journey from Sudan, sometimes waited until they reached the refugee camp in South Sudan before disclosing the incident.

Overall, the findings suggest that timely disclosure is closely linked to survivors' ability to safely access trusted services. While one-third of survivors sought support shortly after an incident, delays in disclosure remained common across contexts, reflecting a combination of displacement-related barriers, insecurity, social norms, limited awareness of available services, and challenges in accessing support. Strengthening survivor-centred referral pathways, community awareness, and access to quality GBV services therefore remains critical to ensuring timely access to lifesaving assistance. Service provision by GBV case management organizations

6. ***The rate of recorded service unavailability instances relative to recorded GBV incidents increased by approximately 50% between the first half of 2024 and the first half of 2025, highlighting persistent gaps in refugee survivors' access to lifesaving GBV response services when they needed them most, with potentially irreversible consequences on the wellbeing, safety and health of refugee women and girls and other groups at heightened risks of violence.***

Across the five participating operations, comparable GBVIMS data on services provided and referrals by GBV case management organizations were available for six service categories: psychosocial services, health/medical services, legal assistance, child protection, safe house/shelter, and police/other security services. To support cross-country comparability, the analysis in this section is limited to these six categories. Other service categories were reported by only a subset of operations and are therefore excluded from the combined distribution presented below. These include mental health, basic needs, livelihoods, NFIs and education services. Percentages were calculated using the total number of recorded GBV incidents in the relevant reporting period as the denominator, rather than the total number of records within each service or indicator subset.

## Service provision by GBV case management organizations

Psychosocial services represented 97% of all recorded services provided to survivors by the 33 case management organizations across the five operations, underscoring its role as the primary entry point for survivors and its centrality within GBV case management. Its predominance also reflects operational realities, as conflict, funding cuts, limited specialized services, and insecurity restricting movement often make PSS the only consistently accessible intervention across operations, as observed in contexts affected by service contractions such as **Jordan**, **Lebanon**, and **South Sudan**.

**97%**
**PSYCHOSOCIAL SERVICES**
represented 97% of all recorded services provided to survivors

**7%**
**HEALTH OR MEDICAL SERVICES**
accounted for 7% of recorded services provided

**6%**
**LEGAL ASSISTANCE**
accounted for 6% of recorded services provided

Health or medical services accounted for 7% of recorded services provided, followed by legal assistance at 6%. These lower proportions should not be interpreted as indicating limited survivor need, especially

considering that not all specialized GBV service providers have the technical capacity or mandate to provide health or medical services, Furthermore, depending on the context, survivors may have accessed these services before approaching a GBV caseworker or received assistance through a subsequent referral. In **Bangladesh**, health or medical services represented only 2% of recorded services provided to survivors by participating GBV case management organizations in the country. GBV experts noted that some survivors had already received health care before meeting with a GBV caseworker, while others chose not to access health services unless their health concerns were severe. Survivors who did access health services were often seeking care following rape.

Child protection services represented 2% of recorded services provided. This partly reflects the age profile of survivors accessing GBV case management services, as children and adolescents accounted for approximately 11% of recorded survivors across the five operations. However, taken together, these figures do not provide a complete picture of the protection needs of child survivors or the support they accessed. Consultations indicate that, depending on the context and the child's assessed needs, child survivors may be referred from GBV case management to specialized child protection actors, while others may be identified and supported directly through child protection pathways. Services provided through those pathways may be captured in CPIMS, national child protection systems or other data systems rather than in the GBVIMS data analyzed for this report.

Safe house or shelter services accounted for 1% of the services recorded. Consultations with GBV experts indicate that shelter access is sometimes limited by scarce capacity and the limited geographical availability of safe accommodation. Survivors may also decide not to access shelter because of concerns about family separation, retaliation, conditions within the facility or safety after leaving the shelter. The low proportion should therefore be understood in relation to both service availability and survivors' individual circumstances and informed decisions.

Overall, the distribution reflects a survivor-centred response in which psychosocial support remains the most consistently provided service, while access to health, legal, child protection, shelter and other police or security services depends on survivors' assessed needs and preferences, the availability of specialized providers, and the accessibility and functioning of wider referral pathways. The lower proportions recorded for these services should not be interpreted as evidence of lower need or demand. Rather, they must be considered alongside differences in service-delivery arrangements, survivors' informed choices and the access barriers documented throughout the analysis.

## PROGRAMME SPOTLIGHT

**Advancing locally led GBV programming through safe and responsible transition: Lessons from Kakuma and Dadaab refugee contexts in Kenya**

During the COVID-19 pandemic, when many humanitarian actors reduced or suspended activities, Refugee-Led Organizations (RLOs) and Women-Led Organizations (WLOs) in Kakuma and Dadaab remained at the forefront of service delivery, including identifying and referring GBV cases. Building on this experience, UNHCR progressively strengthened their role in GBV prevention and response through a phased approach combining capacity strengthening, financing, technical accompaniment and quality assurance.

UNHCR first mapped RLOs and WLOs to identify their capacities, areas of specialization and comparative advantages. Organizational support strengthened planning, budgeting, implementation, financial management and accountability systems, while organizations involved in GBV programming received foundational training on Gender-Based Violence (GBV) and Protection from Sexual Exploitation and Abuse (PSEA). Grant Agreements provided a mechanism for progressively channeling financial resources directly to RLOs and WLOs, based on their capacities and areas of comparative advantage.

The transition was gradual. GBV community sensitization was used as an initial entry point. UNHCR provided training materials, technical guidance and ongoing coaching, and sessions were initially co-facilitated by WLOs, UNHCR and members of the GBV Working Group. This enabled organizations to build practical experience while maintaining technical support and quality assurance. As capacities strengthened, some RLOs progressed to independently implementing activities, with periodic monitoring and technical follow-up by UNHCR. Continuous monitoring informed decisions on expanding funding and the scope of responsibilities.

This experience demonstrates that the responsible transition towards locally led GBV programming by RLOs and WLOs goes beyond the transfer of resources or functions. It is a progressive process that combines direct financing, capacity strengthening, technical accompaniment, monitoring and safeguards, enabling community-based actors to assume greater leadership while maintaining the quality and integrity of GBV programming.

While Kenya was not among the five operations included in this analysis, this example illustrates how UNHCR is operationalizing a safe and responsible transition towards locally led GBV programming, building on the leadership, capacities and trusted relationships of refugee-led and women-led organizations within their communities.

# Referrals to other service providers

Referral patterns provide an indication of the volume of referrals to other services recorded as part of the multisectoral response for survivors accessing GBV case management. For each reporting period, the number of referrals recorded for each service category was divided by the total number of reported GBV incidents recorded during the same period. The resulting percentages therefore show the volume of recorded referrals to each service category relative to the number of recorded GBV incidents and allow changes in referral patterns to be compared across reporting periods. As a single incident may result in referrals to more than one service, and survivors may already have accessed a service or declined a referral, these percentages should not be interpreted as the proportion of survivors who needed, were referred to, or ultimately received a particular service.

Health or medical referrals increased steadily across the three reporting periods, from 13% of recorded incidents in Semester 1 2024 to 16% in Semester 2 2024 and 21% in Semester 1 2025, representing an overall relative increase of approximately 62% between Semester 1 2024 and Semester 1 2025. This indicates that health or medical referrals were recorded for an increasing proportion of recorded GBV incidents over the period. Timely access to medical care is particularly important for survivors of rape and other forms of sexual and physical violence. However, consultations indicated that access to health services varied considerably depending on service availability, distance, transportation and insecurity. In **South Sudan**, funding reductions affecting health facilities constrained the wider availability of services supporting GBV survivors.

**13% → 21%**

**HEALTH OR MEDICAL REFERRALS**

increased steadily across the three reporting periods

**11% → 9%**

**LEGAL ASSISTANCE REFERRALS**

showed a fluctuating pattern

**<1%**

**SAFE HOUSE OR SHELTER REFERRALS**

remained below 1% of recorded incidents across all three reporting periods

**Legal assistance** referrals showed a fluctuating pattern. They were recorded for 11% of recorded incidents in Semester 1 2024, increasing to 12% in Semester 2 2024 before declining to 9% in Semester 1 2025. This represents a relative increase of approximately 16% between the first two periods, followed by a decline of approximately 24%, resulting in an overall relative decrease of about 11% between Semester 1 2024 and Semester 1 2025. Consultations indicated that survivors' decisions to pursue legal assistance may be influenced by concerns about confidentiality, mandatory reporting, retaliation, mediation with perpetrators, accessibility of formal procedures and trust in legal institutions. In **Jordan**, GBV experts reported that fear of mandatory reporting and possible mediation with perpetrators was a key reason why some survivors declined legal services. These concerns were compounded by stigma, fear of retaliation by known perpetrators, broader safety risks and, in severe cases, fear of so-called "honour" killings. More broadly, barriers to accessing legal services included discrimination, limited trust in authorities, narrow legal definitions and fear of retaliation, as reported across **Jordan** and **Lebanon**.

**Police or other security** referrals also fluctuated across the reporting periods. They were recorded for 2% of recorded incidents in Semester 1 2024, rising to 3% in Semester 2 2024 before declining to 2% in Semester 1 2025. This represents a relative increase of 40% between Semester 1 and Semester 2 2024, followed by a decline of approximately 46%, resulting in an overall relative decrease of 25% between Semester 1 2024 and Semester 1 2025. Consultations indicated that survivors' decisions concerning police or other security involvement were shaped by individual safety assessments, concerns about retaliation, confidence in authorities and preferences regarding formal or informal resolution.

**Safe house or shelter** referrals remained below 1% of recorded incidents across all three reporting periods. They declined from 0.75% in Semester 1 2024 to 0.55% in Semester 2 2024 and remained at 0.55% in Semester 1 2025, representing an overall relative decrease of approximately 27% between Semester 1 2024 and Semester 1 2025. The consistently low proportion of shelter referrals should not be interpreted as evidence of limited need for safe accommodation. Rather, consultations indicated that access may be constrained by factors including limited capacity, eligibility requirements, geographical availability, and survivors' concerns regarding family separation, retaliation, facility conditions, or safety following departure from a shelter.

**Psychosocial** referrals remained very low throughout the period, at 0.02% of recorded incidents in Semester 1 2024, 0.05% in Semester 2 2024 and 0.02% in Semester 1 2025. While the rate increased temporarily in Semester 2 2024, the absolute change was very small and there was no overall change

between S1 2024 and S1 2025. The low level of external psychosocial referrals should not be interpreted as indicating limited psychosocial needs. Basic psychosocial support is ordinarily provided directly through GBV case management and therefore generally does not require referral to another service provider. Referrals may instead be made where a survivor requires more specialized psychosocial or mental health support beyond that available through the case management organization, as highlighted by GBV experts in **Bangladesh**.



*Refugee girls participate in a Girl Shine session at a Women and Girls Safe Space in Bangladesh.*©UNHCR

## Unavailable services

Service-unavailability data indicate where gaps in access to specialized support were recorded during GBV case management. The indicator captures instances in which a survivor required support from another service provider but the relevant service was unavailable at the time. To assess changes over time, recorded instances of service unavailability were compared with the total number of reported GBV incidents in each reporting period. The percentages therefore reflect the frequency with which service gaps were recorded relative to recorded incidents and should not be interpreted as the proportion of survivors requiring a service or as a direct measure of overall service availability or capacity.

Across the five participating operations and six comparable service categories, unavailable services were recorded at levels equivalent to approximately 2% of recorded incidents in Semester 1 2024, 4% in Semester 2 2024 and 3% in Semester 1 2025. Recorded service unavailability therefore approximately doubled between Semester 1 and Semester 2 2024. Although it subsequently declined, by Semester 1 2025 it remained approximately 50% above the level recorded in Semester 1 2024. While not a direct measure of overall service capacity, it highlights persistent gaps in access to essential multisectoral support, particularly safe accommodation, health, legal and child protection services. This is particularly concerning because it indicates that, even after survivors reached GBV case management and a need for additional support was identified, the required service was not always available.

Patterns varied considerably by service category. **Safe house or shelter** services were the most frequently recorded as unavailable, accounting for 1.5% of recorded incidents in Semester 1 2024, 1.5% in Semester 2 2024 and 2.1% in Semester 1 2025. This represents an overall relative increase of 40% between Semester 1 2024 and Semester 1 2025. This finding is particularly important when considered alongside the consistently low proportion of safe house or shelter referrals and warrants careful interpretation: recorded service unavailability reflects identified gaps in access and does not capture the full extent of survivors' need for safe accommodation.

**Health or medical** service unavailability was recorded for 0.6%, 0.7% and 0.2% of recorded incidents in Semester 1 2024, Semester 2 2024 and Semester 1 2025, respectively, representing an overall relative decrease of approximately 67% between Semester 1 2024 and Semester 1 2025.

**Legal assistance** service unavailability increased from 0.1% in Semester 1 2024 to 0.6% in Semester 2 2024, before declining to 0.2% in Semester 1 2025. Although the Semester 1 2025 rate was twice that recorded in Semester 1 2024, the absolute difference was small. **Security or protection** service unavailability was not recorded in Semester 1 2024, increased to 0.5% in Semester 2 2024, and declined to 0.2% in Semester 1 2025. **Child protection** service unavailability followed a similar pattern, increasing from 0% in Semester 1 2024 to 0.4% in Semester 2 2024, before declining slightly to 0.3% in Semester 1 2025. Psychosocial service unavailability was not recorded in any of the three reporting periods.

Although GBVIMS incident data do not directly measure service capacity, the pattern indicates that service unavailability was recorded for a greater proportion of recorded incidents in Semester 1 2025 than in Semester 1 2024. Across the five contexts, GBV experts associated service-access constraints with recent funding reductions affecting GBV and wider humanitarian programming, including in **Jordan**, **Lebanon** and **Tanzania**.

# Beyond the Numbers: Key Observations and Protection Implications

This analysis draws on anonymized, aggregated GBVIMS incident data from 33 contributing organizations across five refugee operations—Bangladesh, Jordan, Lebanon, South Sudan and Tanzania—between January 2024 and June 2025, complemented by secondary evidence and consultations with 26 GBV experts and practitioners. Together, these sources provide valuable insights into patterns of violence, disclosure and access to protection. However, GBVIMS captures incidents disclosed by survivors accessing participating services, rather than all incidents occurring within refugee populations. The findings therefore cannot establish population-level GBV prevalence or changes in prevalence over time. Within these limitations, seven interconnected observations emerge.

### 1. Diverging incident trends highlight the importance of looking beyond recorded numbers to understand protection risks.

Between the first half of 2024 and the first half of 2025, recorded incidents increased in Bangladesh (+58%) and South Sudan (+10%), remained broadly stable in Lebanon (+1%), and declined in Tanzania (−11%) and Jordan (−79%). These variations cannot be interpreted as corresponding changes in GBV prevalence. Consultations suggest that insecurity, displacement, humanitarian access and service availability influenced reporting patterns. Declining reports may reflect reduced opportunities for disclosure rather than improved safety, while increases may partly reflect greater access to trusted services. Recorded trends must therefore be interpreted alongside the accessibility and continuity of protection services.

### 2. Violence within intimate relationships predominates in recorded incidents, while forced displacement-related vulnerabilities can reinforce gender inequality and dependency.

Intimate or former intimate partners accounted for 65% of alleged perpetrators, while 88% of incidents disclosed to participating GBV services were recorded as occurring in private residential settings. These figures reflect patterns of disclosure and service access, rather than the relative level of GBV risk across different settings. Physical assault (42%), psychological or emotional abuse (31%) and denial of resources or opportunities (11%) reveal overlapping forms of violence, coercion and control. Consultations highlight how economic insecurity, overcrowding, restricted livelihoods and limitations on freedom of movement can exacerbate existing gender inequalities and constrain survivors' autonomy. Incidents involving caregivers, employers and other persons in positions of authority also point to risks of exploitation and abuse beyond intimate relationships. These findings underscore the importance of combining specialized GBV services with broader protection interventions that strengthen women's access to rights, livelihoods and socioeconomic opportunities

### 3. Sexual violence and other serious forms of GBV remain insufficiently visible in incident data.

Sexual assault (7%), rape (4%) and forced marriage (5%) represented relatively small proportions of recorded incidents, yet consultations and secondary evidence identify significant barriers to disclosure,

including stigma, fear of retaliation, economic dependency and harmful social norms. In Tanzania, experts highlighted that marital rape is rarely disclosed, while in Bangladesh, virtually no forced-marriage incidents were recorded despite evidence identifying child marriage as a protection concern among Rohingya refugees. Sexual exploitation in workplaces and displacement settings, violence along unsafe routes to essential resources, and technology-facilitated GBV also emerge from qualitative evidence. These findings demonstrate that low recorded proportions should not be equated with limited protection needs, particularly where violence is normalized, concealed or difficult to disclose safely.

### 4. Women and girls are overwhelmingly the majority of the survivors accessing services (98%). The low visibility of survivors with disabilities and other marginalized survivors highlights persistent barriers to inclusive protection.

Women and girls overwhelmingly constitute the survivors accessing GBV services (98%) in the five participating operations, reinforcing the importance of sustained women- and girl-focused programming. At the same time, survivors with disabilities were underrepresented (approximately 1%), while older persons, unaccompanied and separated children, and LGBTIQ+ refugees may face additional barriers linked to discrimination, dependency and inaccessible services. In Jordan, targeted accessibility measures were followed by increased disclosures among women with disabilities. These examples illustrate how inclusive outreach, accessible services and trusted referral pathways may improve opportunities for disclosure while maintaining dedicated protection for women and girls. Male survivors accounted for only 2% of recorded incidents, a figure that cannot establish the extent of GBV affecting men and boys. In Bangladesh, experts identified stigma, shame and restrictive norms around masculinity as barriers to disclosure among Rohingya men and boys. In Lebanon, targeted outreach was followed by increased disclosures among male survivors, suggesting the importance of appropriate and trusted entry points.

### 5. Refugee girls face distinct and intersecting GBV and child protection risks requiring coordinated, age-appropriate responses.

Adolescents aged 12–17 accounted for approximately 11% of recorded survivors, while children aged 0–11 represented only 1%. These figures do not capture the full extent of violence affecting refugee children. For girls, gender inequality intersects with age-related dependency, restricted autonomy and limited decision-making power. Sexual violence, child and forced marriage, abuse by caregivers and restrictions on education and mobility create overlapping protection risks. In Bangladesh, child marriage is sometimes perceived as protection against insecurity, despite exposing adolescent girls to further violence, dependency and lost opportunities. Children experiencing GBV may also be identified and supported through child protection rather than GBV case-management systems, limiting their visibility in GBVIMS. These findings underscore the need for coordinated GBV and child protection responses that recognize refugee girls' intersecting rights and protection needs as both girls and children, ensure access to age-appropriate and survivor-centred services, and strengthen safe referral pathways across protection systems.

### 6. Timely disclosure depends on survivors' safety, trust and access to functioning protection systems.

Across the five operations, 42% of recorded incidents were disclosed within five days, while 29% were disclosed more than one month after occurrence. Consultations identify stigma, fear of retaliation, mobility constraints and limited awareness of services as factors influencing disclosure. Delays in reporting sexual violence, including rape, can restrict access to time-sensitive medical care. Conversely, improvements in disclosure timeliness in Jordan and Lebanon were associated by experts with strengthened survivor-centred approaches, outreach and referral pathways. Although these associations do not establish

causality, they suggest that investment in accessible services, community engagement and institutional capacity can create safer opportunities for survivors to seek assistance. Disclosure is therefore shaped not only by individual circumstances but also by the accessibility and trustworthiness of protection systems.

### 7. Access to GBV case management does not necessarily guarantee comprehensive protection and recovery.

Most concerningly, the analysis identifies a persistent gap between needs identified through GBV case management and the availability of essential multisectoral services required to address them. Recorded service unavailability approximately doubled between Semester 1 and Semester 2 2024. Although it subsequently declined, by Semester 1 2025 it remained approximately 50% above the Semester 1 2024 level. This is particularly concerning because it shows that, even after survivors reached GBV case management and a need for additional support was identified, the required service was not always available. Psychosocial support remained the predominant service provided directly by participating case-management organizations, while access to health, legal assistance and safe accommodation depended on specialized providers and functioning referral pathways. Shelter was the service most frequently recorded as unavailable, while safe accommodation referrals remained below 1%. Consultations linked service constraints to funding reductions, disruptions and wider pressures on humanitarian systems. Furthermore, the availability of formal services does not always guarantee safe access, particularly where discriminatory practices, mandatory reporting or informal mediation undermine survivor choice and access to justice. Inclusion in national systems must therefore be accompanied by adequate capacity, accessibility and survivor-centred safeguards.

## Overall Protection Implications

Taken together, these findings reveal three interconnected dimensions of GBV in refugee settings: violence rooted in unequal power relations, barriers that determine which survivors and forms of violence become visible, and the capacity of protection systems to provide effective assistance. Reduced access to trusted services may leave protection needs increasingly invisible, even where risks persist.

At the same time, the analysis identifies enabling conditions associated with timely help-seeking. Across participating operations, consultations highlighted the importance of trusted community mechanisms, accessible referral pathways, awareness of available services and continued access to survivor-centred support. These findings underscore that maintaining accessible and trusted GBV services is critical not only to responding to violence, but also to ensuring that survivors can safely seek assistance and other protection services when they need it.

For UNHCR and its partners, these findings reinforce that addressing GBV is integral to international protection, extending beyond specialized services to refugee inclusion, documentation, self-reliance & livelihoods, access to justice and community-led protection.

# Recommendations

The following five priorities emerge from the report's analysis and provide a framework for collective action:

| KEY PRIORITY | RECOMMENDED ACTION |
|---|---|
| **01**<br>**Protect and sustain lifesaving, survivor-centred GBV services where critical service gaps persist and national systems lack the capacity to respond** | Prioritize the continuity, quality and accessibility of essential GBV services in contexts where critical service gaps persist and national systems lack the capacity to adequately meet survivors' needs, particularly where funding reductions, insecurity and displacement further constrain access. This includes sustaining specialized services where necessary, while supporting national systems to progressively strengthen their capacity to deliver inclusive, quality and survivor-centred responses.<br><br>Ensure differentiated, survivor-centred responses tailored to the specific protection needs associated with different forms of GBV, particularly intimate partner violence, sexual violence, and child and forced marriage, recognizing their distinct risks, consequences and barriers to accessing safety, justice and specialized assistance. |
| **02**<br>**Strengthen refugees' safe and equitable inclusion in national systems** | Promote safe, equitable and sustainable access to national GBV prevention and response systems, particularly in protracted refugee situations, while maintaining specialized humanitarian support where national services are unavailable, inaccessible or insufficient.<br><br>Invest in the capacity of national and local institutions to provide inclusive, quality and survivor-centred services by addressing barriers to refugee access, safeguarding confidentiality and survivor safety, and strengthening coordination and sustainable financing across governments, humanitarian and development actors. |
| **03**<br>**Strengthen community-based protection and locally led GBV prevention and response** | Strengthen the leadership and institutional capacities of local women-led, refugee women-led and community-based organizations as essential actors in GBV prevention and response.<br><br>Invest in community-based protection mechanisms and collective action to address violence within households and communities, transform harmful social and gender norms, and facilitate safe disclosure and access to specialized services.<br><br>Advance equitable, long-term partnerships backed by direct, flexible and sustainable financing, ensuring that diverse refugee women and girls meaningfully shape protection priorities, programme design and decision-making. |

| KEY PRIORITY | RECOMMENDED ACTION |
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| **04**<br>**Strengthen GBV prevention and risk mitigation across refugee protection and assistance** | Invest in evidence-informed, gender-transformative prevention approaches that address the underlying drivers of GBV, including unequal power relations, harmful gender norms and the social acceptance of violence. Tailor interventions to the specific drivers, manifestations and contexts of different forms of GBV, with particular attention to intimate partner violence, sexual violence, and child and forced marriage, including forms of violence that may be underrepresented in service-based data.<br><br>Support engagement with men and boys, including through men's groups, to challenge harmful masculinities, promote equitable and non-violent relationships, and foster positive behavioural and social change, while ensuring accountability to women and girls.<br><br>Systematically integrate GBV risk mitigation across refugee protection and assistance, including shelter, WASH, site planning and management, transport, livelihoods and cash assistance. Address environmental, socioeconomic and displacement-related factors that can exacerbate exposure to violence, including unsafe infrastructure, isolated locations, restricted mobility, economic insecurity and dependency, recognizing that GBV risks exist across households, communities and public spaces. |
| **05**<br>**Strengthen GBV coordination, ethical evidence and financing accountability** | Use protection analysis, service-access evidence and coordinated monitoring to inform strategic prioritization, sustain essential GBV capacities and improve accountability for results in refugee settings. Invest in context-specific research and participatory protection analysis to deepen understanding of the drivers, patterns and consequences of different forms of GBV and address critical evidence gaps.<br><br>Strengthen operational learning and evaluation to generate evidence on what works, for whom and under which conditions in preventing and responding to GBV in displacement settings.<br><br>Strengthen coordination and safe, ethical information management to identify service gaps, guide programme adaptation and ensure that available resources respond to assessed protection risks and underserved populations. Through appropriate GBVIMS governance mechanisms, explore how existing data limitations, including those related to fatal outcomes such as femicide and the visibility of LGBTIQ+ survivors' experiences, could be addressed while safeguarding survivor safety, confidentiality and the do-no-harm principle. |

## Conclusion - A collective investment priority

The evidence from the five refugee settings reinforces that sustained GBV financing is essential not only to respond to violence but also to preserve the safe and trusted services through which survivors can seek support. Against the backdrop of severe humanitarian funding constraints, investments must **prioritize the continuity of lifesaving GBV services while advancing sustainable, inclusive and locally led protection responses.** This requires coordinated action by governments, donors, UN agencies including UNHCR, humanitarian and development partners, and local, women-led and refugee-led organizations, building on their complementary mandates and capacities.

In line with its international protection mandate, UNHCR will focus its engagement where protection risks and gaps are greatest, maintaining targeted interventions where essential services remain unavailable or insufficient, and supporting safe and equitable refugee inclusion in national GBV systems. Critically, UNHCR's unique contribution is to link survivor-centred GBV case management and specialized services with broader international protection pathways, including legal protection, asylum, registration, documentation and durable solutions, ensuring that GBV does not become a barrier to refugees' rights, safety and inclusion.


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