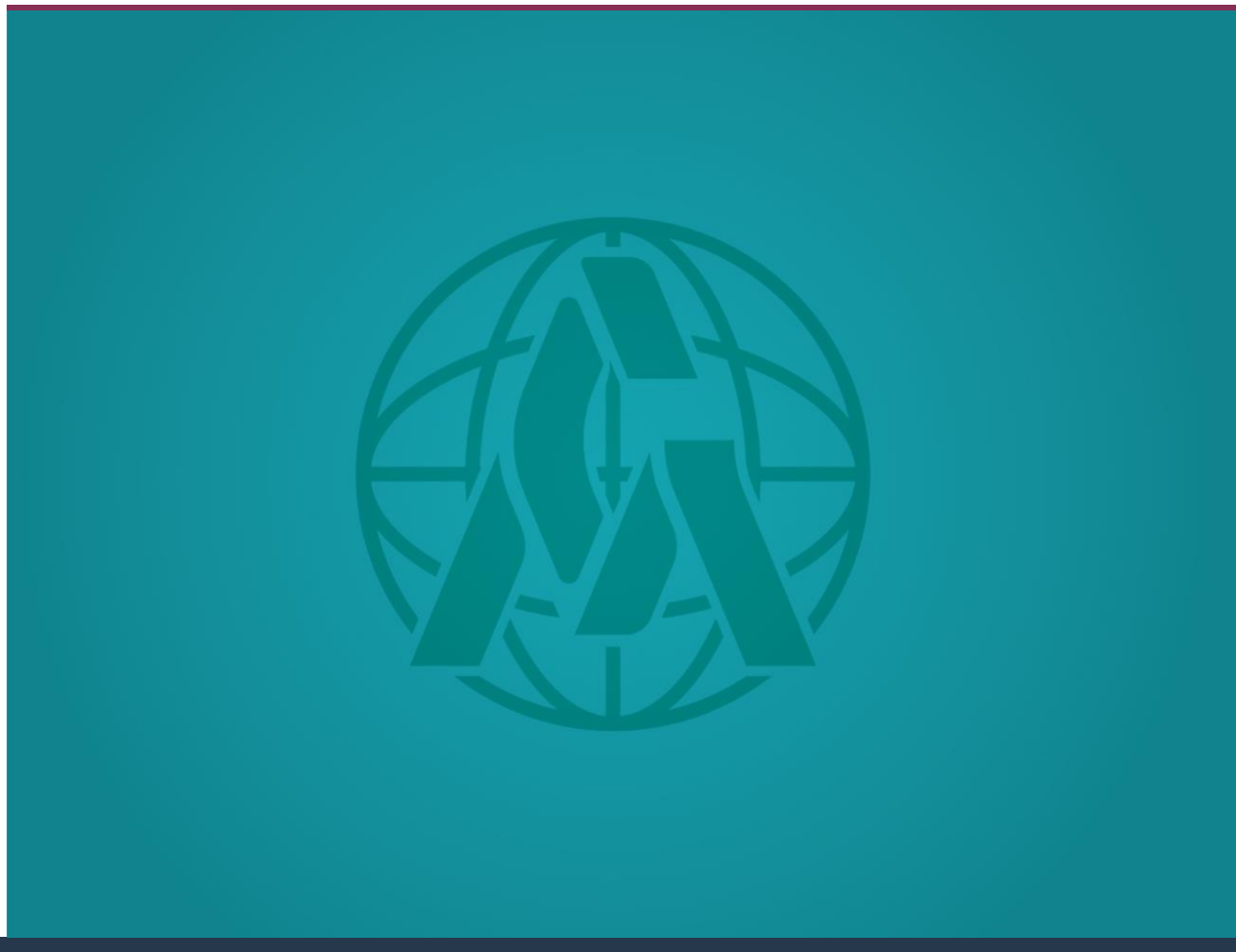
MURAD CODE PROJECT

GUIDANCE ON IMPLEMENTING THE MHPSS PRINCIPLES OF THE MURAD CODE

FEBRUARY 2026



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Importantly, the Guide was co-developed with survivor experts who have lived experience with systematic and conflict-related sexual violence. However, we realise that the provided guidance may be incomplete or not adequately reflect the full range of experiences and recommendations of survivors.

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IICI Institute for International Criminal Investigations

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1. PURPOSE, SCOPE AND AUDIENCE

1.1 PURPOSE AND RATIONALE

The Global Code of Conduct for Gathering and Using Information about Systematic and Conflict-Related Sexual Violence[1] ("Murad Code", "Code" and "MC") applies:

- to the direct, indirect, in-person and remote gathering of information from and about survivors in any form (including digital, written, verbal, audio-visual, photography) and its subsequent transportation, transfer, storage, use, sharing or publishing,
- in relation to systematic and conflict-related sexual violence (SCRSV) (defined broadly and inclusively),
- for any purpose which involves sharing or publishing such information but excluding information-gathering for the purpose of immediate care or support of survivors.

Access to mental health and psycho-social support (MHPSS) is a minimum requirement under the Murad Code for any such engagements (including interviews) with survivors of SCRSV. Numerous minimum standards reflected in the Code expressly and implicitly concern MHPSS.

Focusing primarily on individuals, teams and organisations operating with constrained resources and/or in high-risk or challenging environments, this resource provides practical guidance on implementing two of the Code's standards, namely, Principles 5.6 and 7.7. Those principles require that appropriate, accessible support be in place before, during, and after any in-person or remote interaction with survivors:



Principle 5.

Preparation is the Foundation

5.6 *Look for SCRSV information which is not from or about survivors*: *We recognise that useful information about SCRSV is not always from or about a survivor. We will seek to collect and use such information about SCRSV from wider sources (such as statistics, expert reports or analysis, and perpetrator information) as this information poses less risk for survivors, and can mitigate over-reliance on survivor information.*

[1] The Code was published in April 2022 and is available at https://www.muradcode.com/murad-code in more than 15 languages.



Principle 7.

Build Systems, Competency and Support

7.7 ***Ensure appropriate support:*** *We will only proceed when there is appropriate, accessible support in place which can respond to a survivor's needs. This includes medical, psycho-social, protection and legal support. We will discuss these options with the survivor and help refer them safely if they choose. If these needs are acute, we will prioritise access and referrals ahead of our work. We will put in place a clear plan for emergency access to support so it can be available before, during or after our interaction with the survivor.*

Here, "MHPSS readiness" refers to the ability and readiness to comply with Principles 5.6 and 7.7: knowing what support exists, verifying that it is safe, accessible and suitable for the survivor(s) concerned, and ensuring that it can be activated before, during and after engagement, in line with the mentioned minimum standards.

Ensuring MHPSS readiness is not an add-on; it is a safeguard and a precondition at the heart of ethical and effective information-gathering. It enables survivors to make informed choices, builds trust, and protects both well-being and the integrity of information by reducing avoidable distress, fear, shut-down or pressure which can undermine survivors' consent. Proceeding without such support risks harm to survivors, teams gathering and using information about SCRSV, the credibility of their work, and trust in processes, campaigns and institutions.

There are contexts and times where ensuring MHPSS readiness will not be possible. The belief that creative solutions can always be found to compensate for unsafe or unsuitable conditions can be dangerous.

The perception that MHPSS requires complex or costly measures is often misplaced: meeting the minimum standard depends more on coordination, survivor-centred planning and patience (delaying engagement until we are MHPSS ready) than on budget size. Sometimes, even a single suitable peer or community support option can meet this threshold when formal services are absent or unsuitable, provided it is assessed as safe, accessible, confidential, effective and suitable for the survivor concerned.

This Guidance shows how information-gatherers and users can map, plan, verify, and, where necessary, pause or adapt before proceeding when safe support is not yet available. It translates minimum standards into concrete actions that any information-gatherer and user can apply, regardless of setting or resources.

The Guidance lastly briefly highlights aspects of trauma-informed interaction with survivors and the importance of avoiding and managing the risks of vicarious trauma and other harmful effects of such information-gathering work on practitioners.

1.2 SCOPE AND LIMITATIONS

This Guidance covers planning, mapping, vetting, referral and the decision-making on whether to proceed, adapt or pause once a determination has been made that engagement with survivors is necessary in order to gather or use information about SCRSV, in line with the Murad Code.

It assumes that foundational work required by the Code has already been competently undertaken, including preliminary contextual analysis, attention to culture, stigma and power dynamics, and general and individualised threat and risk assessments (risk assessments) and plans (including those reflected in MC Principles 4 ("Add value or don't do it"), 5 ("Preparation is the foundation"), 6 ("Know and understand the contexts", 7 ("Build systems, competency and support") and 8 ("Gather information from other sources")). Mapping or outreach to potential support providers must itself be undertaken in accordance with those assessments and plans, as contacting services or individuals may pose risks in some contexts.

Interview methodology, staff-care frameworks, and clinical treatment models are beyond this scope but remain essential to comprehensive survivor-centred systems. This Guidance should never be interpreted as encouragement to proceed with information-gathering where the Murad Code indicates restraint.

1.3 DEFINITION OF MHPSS

MHPSS encompasses all actions that protect or promote psycho-social well-being and prevent or reduce distress, and/or treat mental 'disorder'. Consistent with the Murad Code and widely used humanitarian definitions, MHPSS includes any type of local or external support that aims to protect or promote psycho-social well-being and/or prevent or treat mental distress, provided it is safe and appropriate in context.

Plain-language definition*:* In this Guidance, MHPSS refers to practical actions that help survivors feel safe, connected and emotionally stable throughout information-gathering and use work and beyond.

MHPSS Supports vs. Trauma-Informed Practice: Adopting trauma-informed practices (TIP) is essential risk mitigation, but does not fulfil the MC Principle 5.6 requirement to ensure access to MHPSS services, which is the resource (harm mitigation and recovery). These functions should be understood as complementary but distinct.

1.4 DEFINITION OF LOW-RESOURCE AND HIGH-RISK ENVIRONMENTS

Low-resource environments are settings where safe MHPSS is limited by shortages, insecurity, mobility restrictions, low trust in institutions, stigma, socio-cultural beliefs and practices, and/or economic barriers. High-risk environments involve heightened security risks or political danger. Ethical standards remain non-negotiable regardless of whether the context is low-resource, high-risk, or both, even as their implementation may be complicated and must be adapted to contextual constraints.

1.5 WHO IS THIS GUIDANCE FOR?

Like the Murad Code (including its Foreword, and Principles 7.2-7.4), this Guidance is for organisations, teams and individual practitioners. It is for field and policy practitioners, recognising that responsibilities differ by role, but ethical obligations remain consistent. It applies to anyone gathering or using information about SCRSV, at all levels of seniority, with or without formal MHPSS training. They can include documenters, investigators, journalists, community advocates, civil society, asylum and law-enforcement officials, lawyers, programme managers, interpreters, policymakers and donors, particularly those operating with constrained resources or in challenging contexts.

1.6 AVOID ASSUMPTIONS AND UPHOLD RIGHTS

Ethical engagement means recognising and respecting survivors as decision-makers. No single model, local, international, survivor-led or clinical, is automatically safe and otherwise suitable. Each should be assessed for safety, accessibility, confidentiality, effectiveness and suitability for the survivor(s) concerned. Survivors retain the right to safe, respectful and non-coercive support; to informed consent or refusal; and to dignity and autonomy inclusive of intersectional identities and power differentials such as age, gender, sexual orientation, ability or identity.

1.7 KEY TAKEAWAYS

- Ensuring MHPSS readiness is a minimum standard for information-gatherers and users working with survivors of SCRSV.
- This Guidance focuses on upholding this minimum standard, as captured in Murad Code Principles 5.6 and 7.7, across all contexts.
- Information-gatherers and users (broadly defined as in the Code's Foreword) share responsibility for meeting these standards.
- Assumptions about support must be confirmed.
- Mappings and referral pathways must be reviewed regularly and whenever contexts or services change.
- Together, these standards ensure that no information-gathering activity proceeds without verified, survivor-accepted support in place.
- Ensuring MHPSS readiness is part of a process:

This Guidance addresses the MHPSS readiness considerations that arise when practitioners have determined - following thorough preparatory work - that engaging survivors is necessary to secure or verify information about SCRSV. Before any such engagement, practitioners must complete essential groundwork including preliminary contextual, cultural and stigma research (MC Principles 5.6, 6, 7.7); comprehensive general and individualised risk assessments (Principle 5.3); confirming that the practitioner and any other team member possess necessary competencies (Principle 7.4); and determining that the intended outcomes are realistic and will add value without causing harm (Principles 4.2-4.6).

Risk assessments are not one-time exercises but ongoing processes that must be updated throughout the work. Any outreach to potential contacts - including MHPSS providers, support organisations, community leaders or survivors themselves - should only proceed after conducting these risk assessments and in accordance with their findings. In some contexts, even seemingly low-risk actions, such as contacting an MHPSS provider with general questions, can endanger teams and survivors if undertaken without proper risk analysis. This Guidance provides guidance on identifying, engaging with, and supporting MHPSS services and systems once these foundational prerequisites are in place.

2. MINIMUM STANDARDS IN PRACTICE

This section translates Murad Code Principles 5.6 ("Know about available support") and 7.7 ("Ensure appropriate support is in place") into practical steps. The aim is to ensure that support that is accessible, safe, confidential, effective and suitable exists before, during and after any information-gathering activity.

2.1 RESPONSIBILITY

The lead information-gatherer or focal point should verify MHPSS readiness, while supervisors and coordination leads ensure documentation, follow-up and oversight. All team members share accountability for maintaining ethical conditions. Policy and procedures should clearly set out, require, encourage and enable that every relevant person, including consultants, act responsibly.

If any condition cannot be met → Pause, Adapt or Stop. Pausing is compliance, not failure; it protects survivors, teams and information credibility.



Principle 3.

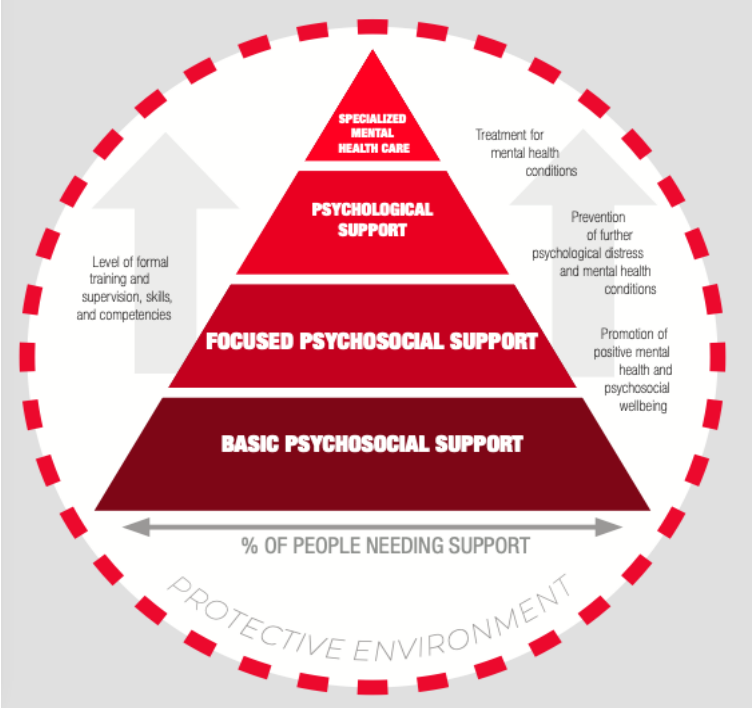
Be Responsible and Have Integrity

3.1 ***Responsibility of information-gatherers:*** *We understand that survivor choice does not replace responsible decision-making by information-gatherers. We recognise that circumstances may arise when our assessment of our own competencies, safety and other risks may lead us to decide not to proceed, even when a survivor is prepared to accept those risks. In such circumstances, if we already are in contact with the survivor, we will discuss with them our concerns, reasons and any alternatives.*

2.2 MINIMUM DUTIES FOR MHPSS READINESS

MHPSS may be provided holistically through integrated, multi-layered support, including informal, community-based and specialised services, depending on context and survivor preference. No hierarchy of support is implied; suitability must be assessed on a case-by-case basis.





THE IASC MHPSS INTERVENTION PYRAMID

Applicable for the whole population **in emergency settings**

THE INTERNATIONAL RED CROSS RED CRESCENT MOVEMENT FRAMEWORK

Applicable for the whole population, **in all contexts and all times (emergency / non-emergency)**

The five steps (on the following page) for MHPSS readiness represent the minimum ethical threshold required to proceed. They need to be taken in line with prior general and individualised risk assessments and plans required by the Murad Code.

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STEP	ACTION	BENCHMARK	REQUIRED IMPLEMENTATION NOTES
1 (MAP)	In line with comprehensive threat and risk assessments, map formal and informal supports (e.g., health centres, NGOs, helplines, in/formal peer supports, faith-based institutions, survivor networks). Review existing mappings where available before creating new ones.	≥ 2 verified options per area (updated regularly, especially if circumstances change, or at least once every 12 months).	Mapping itself should be conducted safely and discreetly, informed by risk assessments.
2 (RECORD)	Safely record contact details, operational hours, languages, confidentiality procedures, security, cost of services, and inclusion/ exclusion indicators.	Complete log stored securely.	Assess whether providers are able, willing and have the competence needed to support survivors with relevant identities and needs.
3 (CONSULT)	Consult survivors and trusted community representatives to confirm trust in and accessibility of supports, and existing community capacity (e.g. to provide PFA).	≥ 1 consultation per location.	Ensure consultation does not expose survivors or teams to risk.
4 (VERIFY)	Verify each service option for confidentiality, responsiveness and inclusivity.	≥ 1 vetted support active and able to respond within 72 hours (or 24 hours in urgent cases) before engagement, and a contingency plan in place.	Re-verify regularly and whenever context or services change.
5 (BACK-UP)	Identify a back-up support if the primary fails, with consideration of service withdrawal and/or contingency planning. This may include remote, phone or helpline support.	Reachable within 24 hours of disclosure.	Define triggers for activating backup options.

How such suggested steps are implemented will necessarily vary by context, security conditions, survivor preference and available resources. Variation must not mean lowering or ignoring minimum standards.

If the risk assessment shows that no support can be accessed safely within a timeframe appropriate to the survivor's needs, pause and adapt before proceeding. Mapping and vetting records must be stored securely and separately from identifiable survivor data.

2.3 VETTING CHECKLIST[2]

CRITERION	DEFINITION / DUE DILIGENCE QUESTION	EXAMPLE OF UNSUITABLE SUPPORT
CONFIDENTIAL	Service is able to protect information and survivor privacy; no mandatory reporting that risks exposure without explicit consent.	A service known to share records with others without survivors' consent.
ACCESSIBLE	Reachable and affordable within a timeframe appropriate to the survivor's needs.	A service that cannot realistically be accessed.
SUITABLE	Able and willing to provide impartial and independent support to the survivor, given the purpose of engagement and context.	A service works with all survivors but has no expertise and experience to specifically work with children (when children are among the survivors that you may work with).
RESPONSIVE	Able to respond with quality services within a reasonable timeframe for the context.	A provider unable to respond at all when needed.
INCLUSIVE	Appropriate for the unique identities, circumstances, etc, of the survivor(s) you are likely to work with.	A service that excludes or mistreats a survivor of a particular sex, gender identity, religious or ethnic background.

[2] For an example, see https://cdn1.internationalmedicalcorps.org/wp-content/uploads/2022/05/IMC-GBV-05-GBV-Response-Developing-a-Referral-Pathway.pdf.

2.4 ADAPTATION IN PRACTICE: CREATIVE ALTERNATIVES

Where formal and/or informal support is absent or unsuitable, alternative pathways may be appropriate. However, they should still be assessed for accessibility, safety, confidentiality, effectiveness and responsiveness to the survivor(s) concerned and their self-identified priorities, before any engagement proceeds. Examples of potential ways forward for low-resource contexts are:

- No formal services? Consider a trusted peer listener, survivor network, community counsellor or remote helpline.
- Restricted movement or connectivity? Consider secure and private phone, video or satellite support.
- Service withdrawal? Prepare and activate a second support option where possible and inform survivors of contingency options.
- Build community capacity: Support trusted local people to learn, where appropriate, Psychological First Aid (PFA) and safe-listening skills.

These examples do not imply that suitable support can always be identified, or that information-gathering should proceed where risks cannot be mitigated.

> ***THE RED LINE: Ethical Restraint.*** *If a vetted MHPSS referral is unavailable, or if the current context poses an immediate or otherwise unacceptable safety risk to either survivor or practitioner, this particular part of the work may have to be paused. Causing psychological harm through retraumatisation or poor response and support outweighs the value of the information and violates the rights of survivors and possibly others too.*

A pause can provide more time to, for example, do further mapping and consultation, or identify resources and potential ways forward. These steps may then allow you to proceed.

2.5 IMMEDIATE PRE-ENGAGEMENT PREPARATION

Plans, assessments, and mappings may be done well in advance of the direct or remote interaction (engagement) with a survivor. Immediately prior to such interaction, they must be updated and confirmed. Those who would engage the survivor need to ensure that they have the necessary competence and the necessary information (including names and contact details of supports) ready for use during the interaction. Such pre-interaction planning and preparation also needs to include an escalation plan; it covers what those who would engage with the survivor would themselves immediately do (first response), and who and how they should contact other support, in case of severe distress of the survivor during the in-person or remote interaction.

If current conditions pose immediate safety risks to the survivor, the team, or others connected to the engagement, pause and reassess.

Minimum Readiness Check Immediately Prior to Interaction (In-Person or Remote):

- Functioning and accessibility of one trusted, reachable support (suitable to particular survivor to be engaged) and one verified back-up confirmed – both able to respond within **72 hours** of engagement.
- Both options able to respond within **24 hours** in urgent cases.

2.6 DISCUSSING AND REFERRALS TO SUPPORTS

- **Discuss with the survivor their potential needs** and **brief the survivor** on available options and their rights, and clearly explain the available resources and supports.
- **Confirm** their **informed consent** for any requested referral to their chosen support.
- **Initiate the referral** when the survivor wishes or if appropriate and requested by the survivor, provide the contact details of the supports for the survivor to establish contact when they want.
- **Provide crisis contacts** for delayed distress, especially if follow-up or post-interaction communication may not be possible.
- Where follow-up contact may not be possible, this should be discussed upfront with the survivor, including what this means for consent and safety planning.

Consent Reminder: Survivors must be able to withdraw or change consent without consequence. Continuing without valid consent breaches the minimum standards captured in MC Principle 7.7.

2.7 AFTER INTERACTION

MHPSS responsibilities continue beyond the interaction with the survivor. A survivor's circumstances and wishes may change, as may that of the information-gathering and use process. Therefore, before sharing, publication or other use of the survivor information, information-gatherers and users should, where safe, feasible and consented, seek to:

- As applicable, update survivors, and confirm or renew their consent to the use of their information
- Confirm that at least one trusted support remains accessible.

The Murad Code recognises that follow-up communication and post-interaction check-ins on whether supports remain functional, accessible, suitable, etc, may not always be possible; where this is the case, this limitation should be discussed upfront with survivors and reflected in consent.

If follow-up contact is not possible, this does not in itself preclude information use, provided it was discussed upfront and consent was informed, and provided such use truly is necessary and follows and is in line with a recently updated risk assessment.

2.8 TEAM ACCOUNTABILITY AND DOCUMENTATION

All team members must flag ethical, safety, contextual or well-being-related concerns immediately. Reporting such risks is an ethical requirement. Maintain secure storage for mapping and vetting lists and record all pauses or adaptations in supervisory reports. Supervisors should review records regularly to detect systemic risks.

3. TRAUMA-INFORMED APPROACHES AND RESPONSES DURING INTERACTIONS WITH SURVIVORS

This section highlights a few aspects of trauma-informed and otherwise safe interviews or other interactions with survivors. Examples of relevant Murad Code Principles are Principle 7.3 ("Select the right team and partners"), 7.4 ("Build the right competencies"), 7.5 ("Recognise our limitations"); 9 ("Take the time, create the space") including 9.3 ("Create a supportive environment"); and 10 ("Ensure respectful and safe interactions") including 10.2 ("Be trauma-sensitive"), 10.4 ("Create a safe interview process") and 10.5 ("Give survivor control over how they tell their story"). It does not constitute or summarise other guidance on how to do trauma-informed and safe interactions.

Interactions which respect the well-being rights of survivors, require competent practitioners, resourced and supported teams. They must have experience in trauma-informed interactions and how to respond to distress of survivors during interactions. They must understand the escalation plan prepared prior to the interaction.

Examples of signs of severe distress that survivors seemingly cannot manage alone include:

- Talking about wanting to harm themselves or others, or to end their life
- Appearing completely disoriented or disconnected from reality, or detached from themselves
- Showing panic, fear or distress that does not settle with calm reassurance
- Showing no coping mechanisms to address ongoing emotional reactions.

If signs such as these are present, the information-gatherer should pause and focus on immediate safety and calming, which may include:

- Pausing the interaction and naming safety as the priority
- Checking for immediate danger and prioritising movement to a safer place
- Staying with the survivor if it is safe to do so
- Creating calm by lowering voice, slowing pace, and allowing space to breathe
- Offering simple grounding support (such as slow breathing or a small comforting object)
- Seeking additional help where possible through the escalation plan, or, if no professional support is available, by asking the survivor who they would feel safest with at this time
- Supporting the survivor's sense of control.

Distress may present in different forms, including silence, agitation, dissociation, pain or quiet compliance, and does not always appear as visible distress. When such signs are present, it is appropriate to pause and check in with the survivor, for example by asking whether they would like a break, and to offer grounding support where this is welcomed.

Where interpreters are involved, they should be briefed in advance on, for example, tone, pacing and how to recognise signs of distress, with space to debrief afterwards where appropriate. Interpreters can greatly contribute to ensuring a survivor-centred engagement.

Survivors' choices must be respected throughout. Choosing to pause or stop is never a failure and should be clearly named as a valid and supported option. Where there is uncertainty about the mental health impact of the interaction or the survivor's well-being, information-gatherers should err on the side of safety by pausing first and reviewing later, rather than continuing in ways that may cause harm.

Ethical closure is an active process that extends MHPSS responsibility beyond the interaction; for example:

- Ask if there is anything else they would like to share and close out the discussion on a point that is not connected to what happened to them or sharing potentially difficult details.
- Offer referrals aligned with survivor preferences: "What would help you feel most supported right now?" or offer specific options to support the survivor in choosing. Ensure the referral is aligned with the survivor's preference and needs (peer, GBV caseworker, specialised care, etc.).

Here are additional examples of trauma-informed interviewing or other interactions with survivors.

DO'S (EXAMPLES)	DON'TS (EXAMPLES)
Check in regularly and allow the survivor's cues to guide pace and direction.	Ask survivors to start from the beginning or recount their experience in a fixed, linear or imposed order.
Offer grounding or emotional support in ways that do not require disclosure, detail or continuation.	Repeat distressing details unnecessarily.
Use open-ended, non-judgmental, consent-based language and revisit consent throughout the interaction.	Assume calmness, silence, cooperation or apparent agreement indicates consent or comfort.
Normalise pausing or stopping as valid, supported and ethically appropriate choices. (Including pausing or stopping after a survivor starts to cry, but ideally after discussion with the survivor.)	Continue questioning after signs of freeze, flight, fawn, fight or withdrawal, distress or disengagement. Don't assume that crying necessarily means that the survivor wants the interaction to stop.

4. VICARIOUS TRAUMA AND OTHER HARMFUL EFFECTS ON PRACTITIONERS

Murad Code Principle 7.10 ("Manage risks of vicarious trauma") underscores that managing the risks of vicarious trauma and other harmful effects on practitioners, teams and others forms an essential part of ethical information-gathering and use processes. Gathering and using information about SCRSV can cause harm to those directly or indirectly engaging with survivors (including interpreters and consultants), as well as to analysts, translators, managers, and others. Such harm can be caused before or after interviewing or other interactions with survivors. Embedded support should be considered an essential part of the culture, processes and structure of any team or organisation doing this work.

- Provide training and briefings on the risks of and how to manage vicarious trauma and other harmful effects of this work to practitioners, managers and others.
- Make care shared: Begin and end engagements with short team check-ins (e.g., silence, shared tea, a brief verbal check-in).
- Integrate decompression: Schedule breaks, rotate roles, and avoid back-to-back interviews. Build-in moments of reflection appropriate to team size and context.
- Embed care in leadership: Supervisors and organisations should model realistic workloads and ensure peer support.

5. CONCLUSION

Upholding the MHPSS commitments in the Murad Code necessitates diligence, realism and preparation. It requires recognising that survivor dignity and safety are non-negotiable, even in the most resource-constrained environments. By focusing on assessment, non-assumptive vetting, and the red line of ethical restraint, practitioners can ensure their work contributes to the gathering and use of information about SCRSV which is survivor-centred and effective.