

INTERAGENCY GENDER-BASED VIOLENCE CASE MANAGEMENT GUIDELINES

PROVIDING CARE AND CASE MANAGEMENT SERVICES
TO GENDER-BASED VIOLENCE SURVIVORS IN
HUMANITARIAN SETTINGS

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Primero



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This resource represents the culmination of a two-year project spearheaded by the Gender-based Violence Information Management System (GBVIMS) Steering Committee to build capacity on GBV case management, information management, and strengthen the links between these in order to improve services provided to GBV survivors. The GBV IMS Steering Committee, comprised of global GBV experts from the International Medical Corps, International Rescue Committee, UNICEF, UNFPA and UNHCR, along with regional and country level colleagues, piloted the GBV Capacity Development project in six countries: Central African Republic, Jordan, Lebanon, Mali, Niger and Somalia. Pilot activities included providing training on GBV case management and the GBVIMS to service providers in these countries. The content of this resource has both informed and been informed by the pilot.

This resource aims to set standards for quality, compassionate care for GBV survivors in humanitarian settings, with particular focus on the provision of case management services. Our hope is that this resource and the accompanying training materials will provide GBV service providers in humanitarian settings with the information and guidance they need to establish and provide quality case management services to GBV survivors.

The GBVIMS Steering Committee would like to thank the following people for their contributions to this resource: Meghan O'Connor, who led the writing and review process for this resource and the accompanying training materials; the interagency review group comprised of members of the GBV AoR and the GBV IMS Steering Committee as follows: Janis Risdell, Laura Canali, Maria Caterina Ciampi, Megan Lind, Mendy Marsh, Micah Williams, and Sophie Read-Hamilton; additional reviewers who contributed to specific sections of the resource including Emma Pearce, Kristy Crabtree, Constanze Quosh, Lachin Hasanova, Zahra Mirghani and Renate Frech, and George Odhiambo. We also wish to extend a special thank you to UNICEF's GBV in Emergencies team for allowing content and tools from the *Communities Care: Transforming Lives and Preventing Violence* program to be adapted for sections of this resource.

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INTRODUCTION

Gender-based violence (GBV) is an umbrella term for any harmful act perpetrated against a person based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty.¹ These acts can occur in public or in private spaces. Common forms of GBV include sexual violence (rape, attempted rape, unwanted touching, sexual exploitation and sexual harassment), intimate partner violence (also called domestic violence, including physical, emotional, sexual and economic abuse), forced and early marriage and female genital mutilation. GBV is recognized as a widespread international public health and human rights issue.

During humanitarian crises, many factors can exacerbate risks of experiencing GBV. These include—but are not limited to—increased militarization, lack of community and State protections, displacement, scarcity of essential resources, disruption of community services, changes in cultural and gender norms, disrupted relationships and weakened infrastructure.²

In humanitarian settings, responding to sexual violence has been a priority because conflict-related violence, in particular rape as a tactic of war, has received international attention. However, there is growing recognition that populations affected by conflict and natural disaster experience various forms of GBV during crisis and displacement, and during and following return. In particular, intimate partner violence is increasingly recognized as a critical concern in humanitarian settings.³ Other forms of violence particular to adolescent girls have also emerged as especially necessary to address.⁴

GBV in all of its forms has tremendous physical, emotional and social consequences for the person victimized by it, who is often referred to as a 'survivor'.⁵ Survivors of GBV have the right to receive quality, compassionate care and support that addresses the harmful consequences of violence in order to help them heal and recover. **This resource aims to set standards for quality, compassionate care for GBV survivors in humanitarian settings, with particular focus on the provision of case management services.** It builds upon and should be used in conjunction with other GBV response resources, such as the *Caring for Survivors of Sexual Violence in Emergencies Training Package*⁶ and the *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*.⁷

1 Interagency Standing Committee. (2015). *Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action*. Geneva, IASC. <http://gbvguidelines.org>

2 Ibid

3 Ibid

4 UNICEF. (2014). *A Statistical Snapshot of Violence against Adolescent Girls*. UNICEF, New York.

5 A survivor is a person who has experienced gender-based violence. The terms 'victim' and 'survivor' can be used interchangeably. 'Victim' is often used in the legal and medical sectors, whereas 'survivor' is generally preferred in the psychological and social support sectors because it implies resiliency. This resource will use the term 'survivor' in order to reinforce the concept of resiliency.

6 Interagency Standing Committee. (2010). *Caring for Survivors of Sexual Violence in Emergencies Training Pack*. <http://www.unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf>

7 International Rescue Committee and UNICEF (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. <http://gbvresponders.org/response/caring-child-survivors/>

1.1 SCOPE OF THE RESOURCE

Why this resource is focused on case management

Due to its relevance to and history of being used to support vulnerable populations requiring a range of services across sectors, case management has become a common approach in humanitarian settings, drawing largely from the field of social work.⁸ Because GBV results in harmful physical, emotional and social consequences that often require information and care from multiple service providers, social work case management has become an integral part of the response to GBV in humanitarian settings. **GBV case management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.**⁹ Case management has also become the primary entry point for survivors to receive crisis and longer-term psychosocial support, given the lack of more established health and social support service providers in humanitarian settings.

The growing number of humanitarian actors providing case management services to GBV survivors has led to a need to establish standards for good practice to ensure that survivors receive quality services. This resource is intended to set such standards for a range of humanitarian settings—refugee, non-refugee, conflict-related, and natural disaster situations, both emergency and protracted—and provide guidance for organizations and actors who support survivors.

Who this resource is for

A wide variety of people and organizations in humanitarian contexts provide help to GBV survivors, including social and community workers and volunteers, community- and clinic-based health workers, police officers, lawyers and paralegals, and teachers, among others. This resource has been developed for staff of organizations that provide care, support, and protection services to GBV survivors in humanitarian settings, including social work-informed case management and psychosocial support. While it is largely focused on the case management process, there are some sections that will be helpful for organizations or community groups not implementing a comprehensive case management programme (e.g. health providers, legal service providers, women’s organizations, and community support groups) but who are key providers of specialized support to GBV survivors.

Populations this resource covers

The term ‘GBV’ is most commonly used to describe violence perpetrated against women and girls. The United Nations Declaration on the Elimination of Violence against Women¹⁰ defines GBV as “a manifestation of historically unequal power relations between men and women, which have led to the domination over and discrimination against women by men and to the prevention of the full advancement of women.” In defining GBV, the *Inter-agency Standing Committee (IASC) Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* (2015) highlight that “women and girls everywhere are disadvantaged in terms of social power and influence, control of resources, control of their bodies and participation in public life—all as a result of socially determined gender roles and relations,” and therefore GBV against women and girls must be understood in the context of this power imbalance between men and women.

8 Case management is an approach that originated in the social service and healthcare disciplines in the United States over a century ago. It evolved from the recognition that people seeking health and mental health care often have a range of other social service needs, and that a function was needed to coordinate these often fragmented services. Thus, the ‘case management’ function became a specialized role within health and social services, providing information and coordination of care and services to individuals and families, while advocating for the quality of care and services. Over time, other disciplines have adopted and adapted a case management approach to their work, with different interpretations and models according to the discipline.

9 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

10 United Nations General Assembly (1993). *United Nations Declaration on the Elimination of Violence against Women*. <http://www.un.org/documents/ga/res/48/a48r104.htm>

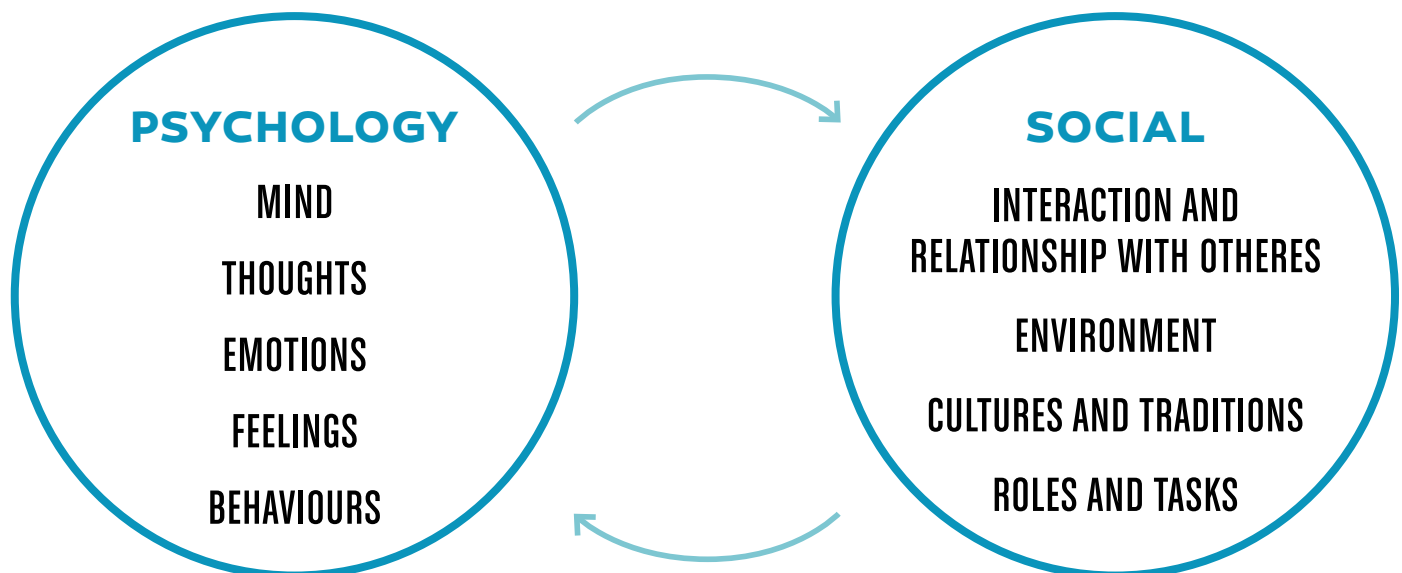
Given that most GBV survivors are women and girls, a significant portion of this resource focuses on responding to the particular experiences of women and adolescent girls who have experienced sexual violence, intimate partner violence child, early, or forced marriage. Adolescent girls have been included because of the various forms of violence they experience, beyond child sexual abuse, which are not covered in the *Caring for Child Survivors of Sexual Abuse Guidelines* (2012). A chapter offering special considerations for working with survivors with disabilities has also been included, given the increased risk of GBV faced by women and girls with disabilities and the lack of existing guidance on how to work with them and their caregivers.

The IASC GBV Guidelines also reference that in humanitarian settings some actors use the term 'GBV' to highlight the gendered dimensions of certain forms of violence against men and boys, as well as to describe the violence perpetrated against lesbian, gay, bisexual, transgender and intersex (LGBTI) persons. This resource includes sections that orient service providers to issues to consider in order to provide safe and supportive GBV case management services for these populations.

1.2 WHAT IS THE RELATIONSHIP BETWEEN CASE MANAGEMENT AND PSYCHOSOCIAL SUPPORT?

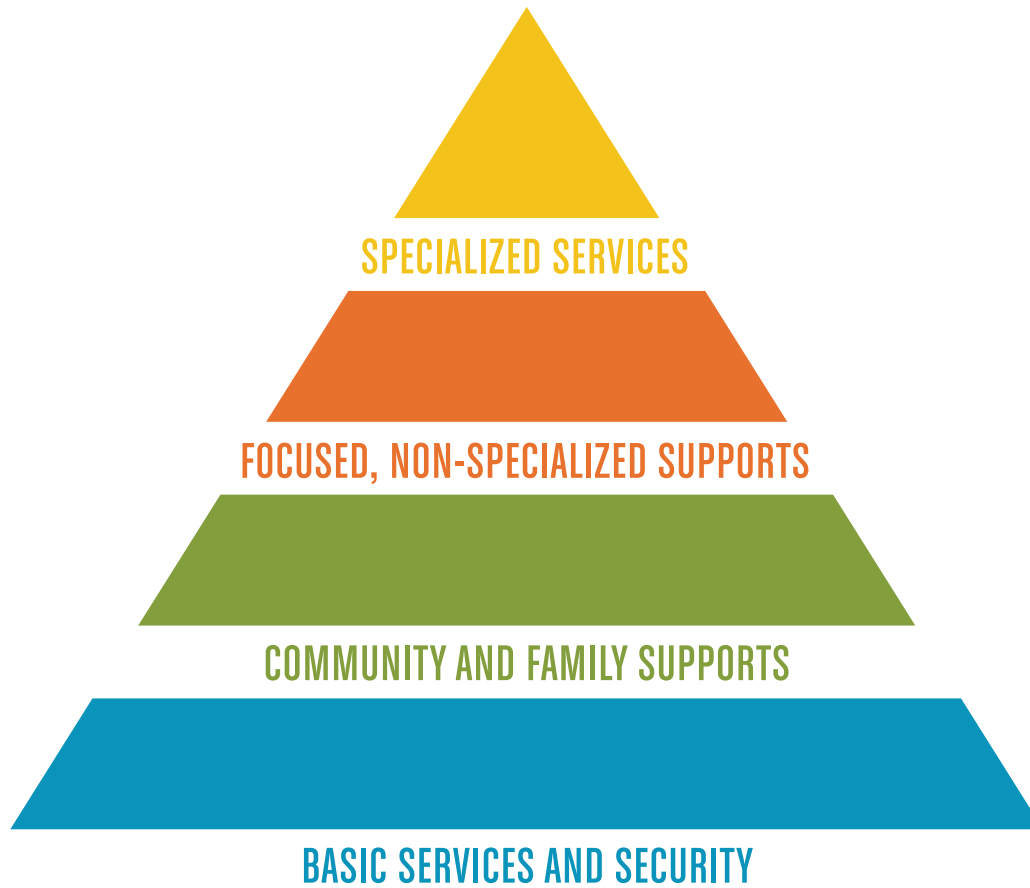
The term 'psychosocial' is used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to our functioning, such as our thoughts, emotions and behavior. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work. The diagram below illustrates this connection.¹¹

The term 'psychosocial' is used in place of 'psychological' to recognize that a person's mental well-being is not just determined by her/his psychological makeup, but also social factors. The 'social' and 'psychological' factors also influence each other.



11 Action for the Rights of Children (2009). *ARC Resource Pack, Foundation Module 7, Psychosocial Support*. <http://www.refworld.org/pdfid/4b55dabe2.pdf>

In humanitarian settings, the composite term 'mental health and psychosocial support' (MHPSS) is often used to describe any type of support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. MHPSS interventions in humanitarian settings are categorized according to a layered system of complementary supports that can meet the needs of people affected by crisis.¹² The diagram below illustrates this layered system.



Basic services and security

The majority of people are represented in the bottom level of the pyramid. Most people recover their psychosocial well-being when basic physical security is established and they obtain the social, communal and health services they need. The recommended way people in a helping profession can intervene is by ensuring that basic services consider social and cultural factors and individual dignity.

Community and family supports

A smaller but still substantial number of people require extra support from their community and families to recover their psychosocial well-being, as shown in the second level of the pyramid. People in a helping profession can support by encouraging relevant traditional supports and social networks.

Focused, non-specialized supports

A smaller number of people may need more focused services to regain their psychosocial well-being and protect their mental health, as shown in the third level. Such interventions include basic emotional and practical support, such as case management, provided by community-based workers or organizations.

¹² Interagency Standing Committee. (2007). IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: IASC. <http://mhpps.net/iasc-guidelines-on-mental-health-and-psychosocial-support-in-emergency-settings/>

Specialized services

For a very small percentage of people, the supports outlined above are not enough, and their mental health and ability to function productively depends on more specialized care. For these individuals, professional support is required from trained professionals, such as psychologists, who can provide more advanced mental health interventions.

GBV case management, when utilizing the survivor-centred approach outlined in these guidelines, can be considered a form of MHPSS, falling under the third level of the pyramid: focused, non-specialized MHPSS. It is also an important method for helping survivors access other mental health and psychosocial services, programmes and resources in their community that are part of the other layers of the MHPSS pyramid. For example, GBV case management services can help survivors access basic needs (first level) as well as reconnect with family and community support systems (second level). In situations where it is determined that a survivor requires a higher level of mental health care (fourth level), GBV case management services can facilitate a survivor's access to such care.

It is important to remember that not all survivors will want or need case management services. You can provide psychosocial support or connect a survivor to other psychosocial services without having to take a survivor through the entire case management process. In addition, in some settings trained case management specialists may not be available, and actors first receiving a disclosure from a GBV survivor may be from other humanitarian response sectors (WASH, Shelter, etc.). The roles of these actors in responding to the immediate needs of a survivor are necessarily limited, but still critical.

1.3 HOW THE RESOURCE IS STRUCTURED

Part I: Building a Foundation for GBV Case Management

This includes chapters on the survivor-centered approach and establishing GBV case management services in humanitarian settings.

Part II: Steps of GBV Case Management

This provides detailed information about the steps of GBV case management and provides guidance for caseworkers on how to carry out each step.

Part III: GBV Case Management with Women and Adolescent Girls

Building on Part I and Part II, this provides guidance on how to tailor GBV case management to working with women and adolescent girls and the specific types of GBV they face.

Part IV: GBV Case Management with Other Vulnerable Groups

Building on Part I and Part II, this provides guidance on how to tailor GBV case management to working with other vulnerable populations who are often at risk of GBV including LGBTI survivors, male survivors of sexual violence, and survivors with disabilities.

Part V: Monitoring Quality of Services, Supervision and Staff Care

This provides guidance and tools for monitoring the quality of GBV case management services, approaches to mentoring and supervision for GBV case management, and staff care.

Part VI: Annexes and Tools

This includes the tools and other supplementary materials that are referenced throughout the resource.

Part VII: Glossary

This includes definitions of key terms that are used throughout the resource.

THROUGHOUT THIS RESOURCE, YOU WILL SEE THE FOLLOWING ICONS:



Training materials

Training materials that will support supervisors and practitioners in building caseworkers' capacity to deliver GBV case management services are part of this resource package. In the beginning of each chapter, there is a list of training modules that correspond to the information provided in the chapter.



Context Clues

As every country's and community's context is different, these guidelines will need to be adapted to the particular environment in which you are working. "Context clues" are provided to remind readers of adaptations they will need to think about and plan for according to their context.



Helpful to Know

This highlights additional information to keep in mind as you provide support and services to GBV survivors.



Sample Scripts

Sample scripts provide an example of what a caseworker may say to a survivor. The scripts are meant to be suggestions of language that could be used as part of the survivor-centred approach. Some caseworkers, especially those who are new to case management, may find them useful for learning and practice—though it is not necessary to use them verbatim. Programmes and staff should adapt them as needed and appropriate.



Tools

There are several tools included in the guidelines that you can use to support the development, implementation and monitoring of your case management services. These tools are highlighted throughout the resource and can be found in Part VI.

PART I

BUILDING A FOUNDATION FOR GBV CASE MANAGEMENT



Meredith Hutchison / International Rescue Committee

CHAPTER 1

A SURVIVOR-CENTRED APPROACH TO GBV CASE MANAGEMENT

IN THIS CHAPTER, YOU WILL RECEIVE INFORMATION AND GUIDANCE ON:

- A survivor-centred approach to GBV case management
- Theoretical, practical and research foundations for a survivor-centred approach
- Guiding principles that underpin a survivor-centred approach

G BV case management is a structured method for providing help to a survivor. As mentioned earlier, it involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed about all the options available to them, and that issues and problems facing a survivor are identified and followed up in a coordinated way.¹³ It has unique characteristics that distinguish it from other approaches to case management. The approach is called “survivor-centred.”

1.1 WHAT IS A SURVIVOR-CENTRED APPROACH?

A survivor-centred approach aims to create a supportive environment in which each survivor’s rights are respected and in which the person is treated with dignity and respect. A survivor-centred approach recognizes that every survivor:¹⁴

- Has equal rights to care and support
- Is different and unique



TRAINING MATERIALS

- Modules 1–6: Core Concepts For Understanding and Working on GBV
- Module 7: Theoretical Foundation for a Survivor-Centred Approach
- Module 8: Guiding Principles and Roles and Responsibilities

¹³ UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

¹⁴ Ibid.

- Will react differently to their experience of GBV
- Has different strengths, capacities, resources and needs
- Has the right, appropriate to her/his age and circumstances, to decide who should know about what has happened to her/him and what should happen next
- Should be believed and be treated with respect, kindness and empathy.

Using a survivor-centred approach means that you:

- **Validate the person's experience.** A survivor-centred approach emphasizes the importance of communicating to the survivor that we believe her/him and that we do not judge their experience or their decisions about what to do. We trust that they are the experts of their situation.
- **Seek to empower the person.** A survivor-centred approach puts the individual at the centre of the helping process and aims to empower the person. We recognize that an experience of GBV may take away a person's control over their body and mind. Our interactions with a survivor should aim to restore their sense of control by making sure they are the decision-makers throughout the helping process.
- **Emphasize the person's strengths.** A survivor-centred approach recognizes that survivors have existing ways of coping and problem-solving. Understanding and building upon a survivor's inner and outer resources—for example, prior successes in managing the aftermath of or overcoming a stressful or traumatic event—is a great way to begin to shift the focus from their weaknesses and problems to their strengths. This strengths-based approach helps to build and recognize people's inherent resilience.
- **Value the helping relationship.** A survivor-centred approach emphasizes that a helper's relationship with a survivor is a starting point for healing. This means that we must view all of our encounters with a survivor as an opportunity to build connection and trust.

1.2 WHY USE A SURVIVOR-CENTRED APPROACH?

The rationale and impetus for using a survivor-centred approach in working with people who have experienced GBV comes from theory, practice, advocacy by women's movements and research. It is informed by the practice of individuals and groups who have been at the forefront of working with survivors of GBV for decades—many of whom are survivors of sexual violence and intimate partner violence themselves. It is also grounded in research with survivors who have articulated the type of support that is most helpful for them to heal and recover. These elements are described below.

Social work case management

GBV case management draws from a social work approach to case management. The aspects of social work case management that are very present in a survivor-centred approach are:¹⁵

- **Person-centred services.** The survivor is at the centre of the helping process, and support is tailored to their needs and circumstances.
- **The role of the survivor-social worker relationship.** The relationship between the caseworker and the survivor is integral to helping the survivor achieve her or his goals.

15 National Association of Social Workers. (2013). *Social Work Case Management Standards*. http://www.socialworkers.org/practice/standards/sw_case_mgmt.asp#intro.

- **Person-in-environment framework.** A person is influenced by their social and physical environment, and their experiences must be understood as such. This framework is important for understanding individual experiences of violence within systemic injustices and oppression—for example, patriarchy.
- **Strengths perspective.** Rather than focus on what is wrong with a person, the caseworker supports and builds on the existing resilience and potential for growth that exists in each individual.

Trauma theory and practice

Acts of rape, sexual assault and the ongoing exposure to violence that happens in some intimate partner relationships can be traumatic. Trauma is defined as a deeply distressing or disturbing experience that involves severe stressors and often involves a loss or a major change. It affects every aspect of a person’s functioning and “overwhelms an ordinary system of care that gives people a sense of control, connection, and meaning in the world.”¹⁶ The “core experiences of psychological trauma are disempowerment and disconnection from others,”¹⁷ which means that the recovery process must place emphasis on empowerment and reconnection with others, in a healing relationship. This healing relationship can be established between a survivor and a helper or caseworker.

Women’s movements

Historically, women’s movements and organizations in the global north and south have been first responders to women’s experiences of intimate partner and sexual violence. They have been and continue to be critical in providing emotional and material support to survivors and advocating on behalf of their needs and rights. Women’s movements have also emphasized that a woman’s experience of violence must be understood in the context of patriarchy and the violence, discrimination and oppression women face daily. Emphasis is placed on supporting a survivor to re-establish power and control over her life. The helping process is one way of doing this, as is connecting the survivor to other women who have experienced violence, and creating opportunities (if and when a survivor is ready) to speak out about her experiences.

Evidence from survivors

A survivor-centred approach to GBV case management is also largely informed by what we know from health sector responses to violence against women, which have been more widely researched than other, less formalized responses. Research from health settings suggests that women who have experienced violence want the following from a service provider: attentive listening, sensitive non-judgmental enquiry into their needs, validation of their disclosure, enhancement of safety for her and her children, and the provision of support and assistance in accessing resources.¹⁸

1.3 GUIDING PRINCIPLES¹⁹

The survivor-centred approach is put in place through a set of principles that guide the work of all helpers—no matter what their role is—in all their interactions with people who have experienced GBV. The principles are described on the next page.

16 Herman, J. (1992). *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*, Basic Books, New York, 1992, p. 156.

17 Ibid, p. 133

18 Moreno, et. al (2014). The health-systems response to violence against women. *The Lancet*. 385, No. 9977, 1567 – 1579.

19 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

PRINCIPLE 1: RIGHT TO SAFETY

'Safety' refers to both physical safety and security, as well as to a sense of psychological and emotional safety for people who are highly distressed. It is important to consider the safety and security needs of each survivor, her family members and those providing care and support.

In the case of conflict-related and politically motivated sexual violence and intimate partner violence, the security risks may be even greater than usual.

Individuals who disclose GBV may be at high risk of further violence, sexual and otherwise, from the following people:

- Perpetrators
- People protecting perpetrators
- Members of their own family due to notions of family 'honor'.

PRINCIPLE 2: RIGHT TO CONFIDENTIALITY

Confidentiality refers to the right of a person to have any information about them treated with respect. It promotes safety, trust and empowerment. Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Breaching confidentiality can put the survivor and others at risk of further harm. If helpers do not respect confidentiality, other survivors will be discouraged from coming forward for help.

In GBV case management, confidentiality is maintained through strict information sharing practices that rest on principles of sharing only what is absolutely necessary to those involved in the survivor's care with the survivor's permission. It is also necessary to protect written data about a survivor or a case through safe data collection and storage practices. There are exceptions to confidentiality, which are explained in **Part II, Chapter 2**.

PRINCIPLE 3: RIGHT TO DIGNITY AND SELF-DETERMINATION

GBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in restoring dignity and self-determination. For example, survivors have the right to decline case management services or choose whether or not to access legal and other support services.

Failing to respect the dignity, wishes and rights of survivors can increase their feelings of helplessness and shame, self-blame, reduce the effectiveness of interventions and cause re-victimization and further harm.

PRINCIPLE 4: NON-DISCRIMINATION

All people have the right to the best possible assistance without unfair discrimination on the basis of gender, age, disability, race, color, language, religious or political beliefs, sexual orientation or social class.

It is important to remember that the guiding principles are interrelated and mutually reinforcing. For example, confidentiality is essential to promote safety and the right to self-determination and dignity.



HELPFUL TO KNOW: GUIDING PRINCIPLES AND THE BEST INTEREST OF THE CHILD

In cases of sexual abuse involving children, the best interests of the child need to be considered. The 'best interests of the child' principle recognizes that every child is unique and will be affected differently by sexual violence. All decisions and actions affecting her/him should reflect what is best for the safety, well-being and development of that particular child.

Children also have the right to participate in decisions affecting them, appropriate to the child's level of maturity. Children's ability to form and express their opinions develops with age, and most adults will naturally give the views of adolescent's greater weight than those of a much younger child.

More information and guidance on principles for working with child survivors can be found in the *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*.

<http://gbvresponders.org/response/caring-child-survivors/>

CHAPTER 2

UNDERSTANDING THE CONTEXT FOR GBV SERVICES

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Information you need about your context before setting up GBV case management services
- Strategies and tools for collecting the information you need
- Establishing service coordination among key actors

Caseworkers, as the people linking a GBV survivor to different types of help, require knowledge of the services available in their community and the actors who provide them. Understanding the **availability, accessibility and quality** of services in your context can support you in setting up case management services that are safe and ethical.^{20, 21}

2.1 UNDERSTAND THE CONTEXT

The IASC GBV Guidelines highlight that humanitarian actors “ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem...regardless of the presence or absence of concrete ‘evidence’”, and that “waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data.” Thus, GBV actors do not have to know the prevalence or incidence rates of GBV before setting up programmes.

However, it will be important for you to understand general contextual issues and trends, such as those related to security, demographic profile of the displaced population and the nature and dynamics of their displacement, information about forms of GBV that may have been common in the community before displacement, and potential service entry points. Assessments conducted to inform the design and delivery of GBV services should gather this information.

As you establish your services, you will begin to gain further insight into the range of GBV types and the risk factors in your context, which you can use to adapt your services over time. New information may also prompt you to carry out more specific GBV assessments during later stages of an emergency.

20 UNICEF. (2015). Communities Care Programme: Transforming Lives and Preventing Violence Toolkit. UNICEF, New York.

21 International Rescue Committee. (2012). Gender-based Violence Emergency Preparedness and Response Package. <http://gbvresponders.org/emergency-response-preparedness/>

2.2 MAPPING AVAILABILITY OF SERVICES²²

GBV survivors often need various type of care and support to help them recover and heal and to be safe from further violence. Some of the most common services that survivors have the right to receive are:

- **Medical treatment and health care** to address the immediate and long-term physical and mental health effects of GBV. This can include initial examination and treatment, follow-up medical care, mental health care, and health-related legal services, such as preparation of documentation and provision of evidence during judicial and related processes.
- **Psychosocial care and support** to assist with healing and recovery from emotional, psychological and social effects. This includes crisis care as well as longer-term emotional and practical support for the survivor and her/his family, information and advocacy, case management, and educating family members so that they can support the survivor's healing and recovery. These psychosocial support services are often provided through the case management process, or through other individual and group services provided by the same organization. In addition, through case management a survivor can be supported to identify family members and friends who they can reach out to for support.
- **Options for safety and protection** for survivors and their families who are at risk of further violence and who wish to be protected. This can include safe shelters, police or community security, relocation, or in the case of children, alternative care arrangements.
- **Legal and law enforcement services** that can promote or help survivors to claim their legal rights and protections. This includes criminal investigation and prosecution, legal aid services and court support.
- **Education and livelihood opportunities** to support survivors and their families to live independently and in safety and dignity. This can include referral pathways for existing livelihood and education programmes or services, non-formal education and adult learning options, and targeted economic interventions that can mitigate risks of GBV and foster healing and empowerment.
- **Other protection services, including durable solutions for displaced populations.** In displacement situations, lack of documentation and detention can expose survivors to considerable further risk. Planning for durable solutions, including resettlement, local integration and voluntary repatriation can contribute significantly to a survivor's safety.

In many humanitarian contexts, some or all of these services may not exist or be functioning properly, and/or some affected persons may not have adequate access. **Before setting up case management services, you will need to know what services exist in the community, the extent to which they are functioning, and who has access to them. Where there are gaps, you will need to work with other organizations and community leaders and members to address them.**

Before trying to collect this information yourself,²³ be sure to reach out to other GBV and protection actors and determine what is already known so as to avoid duplication and minimize the number of assessments in a given region or area.²⁴

If this information is not already available, you can collect it through a simple mapping exercise. The mapping should consider both formal services and informal resources for responding to GBV. Formal service providers may

22 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

23 World Health Organization. (2007). WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf

24 International Rescue Committee. (2012). Gender-based Violence Emergency Preparedness and Response Package. <http://gbvresponders.org/emergency-response-preparedness/>

include national and local governments, UN agencies, non-government international, national and community-based organizations. Informal resources, such as family members, friends, community and religious leaders, women's groups and other associations play an extremely important role in providing care, support and protection for survivors. In many contexts, they may be the only source of help survivors feel comfortable and safe accessing, and in some cases are the only resource available in the community.



SERVICE MAPPING TOOL

You can use the *Service Mapping Tool* to compile a list of who does what and where and to collect detailed information about what is offered to create a service directory. See Part VI.

2.3 IDENTIFY GAPS IN SERVICE QUALITY

Once you have completed your mapping, you can begin to look at critical gaps in quality of services. You will want to examine gaps that prevent survivors from receiving a minimum standard of care.

Examples of gaps in quality of services include not having trained staff, not having equipment or supplies at the health centre, or not having a safe place where survivors can go to tell someone what has happened, get information about their options and receive emotional and practical support. This lack of a safe space is particularly common in humanitarian contexts, and especially concerning as survivors can be at risk of further harm from perpetrators, their supporters and even from their own family members and others in the community. There is no one model for ensuring survivor safety—what works in one setting may not be appropriate in another. You will need to work with community stakeholders to identify a range of safety options that take into account the different needs of survivors.

It is important that all actors responding to GBV are familiar with local service gaps so they do not create false expectations about the existence of services that are not available or are not survivor-centered.

When you know about all the gaps in services, you can work with stakeholders to identify and plan ways to fill them. Strategies for filling gaps might include building capacity of existing service providers, coming up with creative solutions to adapt existing resources, or advocating for more resources to close service gaps. You won't necessarily be able to fill all the gaps and fix all the problems immediately, but you can work with other stakeholders to prioritize and develop a plan.



SERVICE GAP ANALYSIS & PLANNING TOOL

You can use the *Service Gap Analysis and Planning Tool* to help identify critical gaps in different sectors and to document the plan for filling them. See Part VI.

2.4 IMPROVE ACCESSIBILITY OF SERVICES²⁵

Even where services are available, they may not be accessible to all survivors. There are many reasons why GBV survivors find it difficult to access services. Some common ones are:

- Distance to services
- Lack of security
- Cost of services
- Lack of trained female staff
- Lack of privacy and confidentiality in services
- Providers' attitudes towards survivors
- Perceptions of services by people in the community
- Community beliefs about sexual purity and family honor
- Family pressure not to seek services
- Family or community repercussions for disclosing the violence
- Administrative barriers, such as requirements to obtain documentation from police before accessing medical treatment, lack of official identity card, etc.
- Services not provided to foreign nationals or people not from the local area
- Perception that services are not available or friendly to certain groups of people (e.g. LGBTI persons).

To plan how to reduce barriers to services and care, you can do a participatory assessment and work with stakeholders to come up with solutions to problems identified. Note that some barriers may be easy to identify through the assessment, while you may not become aware of others until later.²⁶



CONTEXT CLUE

Displaced populations may experience different barriers in accessing services. These barriers can be formal—for example, refugees and asylum seekers may be barred from receiving services without particular documentation (or at all), or may have to pay for access where nationals do not. Restrictions on freedom of movement—for example as a result of police persecution or detention policies—can also affect displaced persons' access. Barriers can also be more informal, for example as a result of language barriers, xenophobia, or a lack of knowledge of services and how to gain access. In some circumstances, internally displaced persons (IDPs) face similar barriers, for example where their access to national services is limited to their area of residency according to their identity documents.



BARRIERS TO CARE ANALYSIS & PLANNING TOOL

You can use the *Barriers to Care Analysis and Planning Tool* to help identify barriers survivors face in getting help and create plans to reduce them. See Part VI.

25 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

26 Read more about how one program in the DRC used service-based data to determine access barriers. GBVIMS. (2016). *Linking Data Analysis with Programming*. <http://www.gbvims.com/wp/wp-content/uploads/DRC-GBVIMS-Linking-Data-AnalysisFinal.pdf>

2.5 ESTABLISH SERVICE COORDINATION²⁷

Case management provides a system of coordination among all actors involved with a survivor so that everyone can work together and understand their role. Regardless of how many or few services are available in the community and who provides them, coordination among everyone is essential. Good coordination involves good communication, understanding of each other's roles and responsibilities and the important links among services, and collective problem-solving and information sharing—which should always be done respecting the safety, security, dignity and confidentiality of survivors.

To build effective coordination, it is best to designate an agency or service provider as the focal point for providing case management services to survivors. This, among other things, can prevent a survivor from being interviewed many times and not getting the right information and help. Which agency is chosen will depend on capacities and resources, as well as existing case management responsibilities. For example, in some settings government agencies responsible for women and children may be the default case management service provider for GBV cases. If a coordination mechanism already exists, be sure everyone is clear who the lead is and what everyone's roles are.

If there is no coordination mechanism already in place, to create one, you will need to:

- Invite relevant GBV actors to join a meeting.
- Share the results of your service mapping with the group. Discuss and decide which organization will be the focal point for providing case management services to survivors. This should be based on expertise and capacity of the organization to provide services in line with good practice.
- If you are the lead case management agency, support the group to develop simple protocols for case coordination and referrals, so that everyone has good information about relevant services and can make appropriate referrals. Developing simple protocols does not have to be a long and complicated process; what's most important is that all actors are informed and on the same page about how to work together.
- You may also need to take some time to provide basic training to these actors on guiding principles and good practices for responding to GBV to ensure they understand why the coordination of services is essential to providing quality care and how they can provide quality care and support. For example, you may want the police to be part of the referral network, but they may not have had training on how to respond appropriately to GBV.



HELPFUL TO KNOW

In many humanitarian settings, there are also often regular humanitarian coordination or sector coordination groups. The function of these groups is different than service coordination. These forums or working groups can be helpful to identify partners for service coordination. They are not forums in which specific cases or specific services are discussed, but rather overall trends in cases, gaps in services, advocacy strategies, etc.



SAMPLE REFERRAL PROTOCOL

You can use the *Sample Referral Protocol* as a guide for developing local referral protocols. See Part VI.

27 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

CHAPTER 3

SETTING UP QUALITY GBV CASE MANAGEMENT SERVICES

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- How to staff your GBV case management services
- Systems, policies and practices that need to be in place to ensure quality
- Modes of service delivery and how to keep them survivor-centred

The quality of care and support that GBV survivors receive, including the way they are treated by the people they turn to for help, affects their safety, well-being and recovery. It also impacts whether other survivors will feel comfortable coming forward for help. Qualified staff and systems in organizations providing GBV case management services are essential to establishing and maintaining quality, survivor-centred care.²⁸

3.1 STAFFING GBV CASE MANAGEMENT SERVICES

As potentially one of the first points of contact with a survivor, caseworkers have a tremendous responsibility to create a safe, supportive and compassionate climate for people receiving services. Negative responses to survivors from those they turn to for help can lead to re-victimization, which is likely to exacerbate existing psychological distress and delay recovery. This major form of harm to a survivor is completely preventable. It should be a priority for all service providers and others to prevent re-victimization, and staffing your programme with caseworkers that have the right qualities, knowledge and skills is a key way to do this.



TRAINING MATERIALS

- Module 8: Guiding Principles and Roles and Responsibilities
- Module 9: Communication Skills
- Module 18: Supervision
- Module 20: GBV Information Management and Case Management

²⁸ Ibid.

3.1.1 QUALITIES OF GBV CASEWORKERS

The nature of the working relationship between a caseworker and a survivor largely determines whether or not the case management process and related services are effective in helping the survivor recover—in other words, a positive relationship is necessary for case management to be effective.²⁹ Research shows that the qualities of warmth, respect, genuineness, empathy and acceptance are most important to people seeking services and are considered necessary for developing trust and safety with survivors.³⁰

- **Warmth.** Helpers who are kind, accepting and non-judgmental are perceived as warm. Warmth can create a climate of safety and trust that encourages survivors to be open. Warmth can be expressed through appropriate facial expressions, giving one's full attention to the survivor, and using a calm, kind tone of voice.
- **Empathy.** 'Being empathic' or 'having empathy' is best described as being able to imagine oneself in another person's situation, including imagining their world views, assumptions and beliefs.³¹ You can be empathic by listening attentively to what survivors are telling you, making every effort to comprehend their experiences from their viewpoint and validating their feelings.
- **Respect.** Respect can be referred to as 'unconditional positive regard'. It is closely linked to acceptance, and as such involves being accepting and non-judgmental of the survivor and highlighting her/his strengths. Blaming, arguing, reacting defensively, and attempting to pressure survivors all indicate a lack of respect.
- **Genuineness.** Genuineness can be expressed by being sincere and authentic. Part of being genuine is accepting and admitting being wrong or making mistakes. Helpers are human and therefore do not know all of the answers and do make mistakes from time to time.
- **Self-awareness.** Helpers are also individuals whose beliefs and values are impacted by culture, ethnicity, religion, gender (or gender identity), sexual orientation, socio-economic status and family and personal history.³² A caseworker needs to be aware of how her/his beliefs and values may bias her/him negatively towards a survivor. In many humanitarian contexts, social norms that lead to blaming, shaming and stigmatizing of survivors are prevalent. It is important that helpers, as organizations and individuals, reflect on their own potentially harmful beliefs and norms, examine how these influence their response to survivors, and recognize how this could deter survivors from coming forward for help.

While qualities are often considered innate (things we're born with), they can also be developed overtime with practice and mentoring.

In Part V, Chapter 2 of this resource, you will find guidance for supervisors to assess caseworker's attitudes and behavior towards survivors. You can use the training materials reference in the beginning of the chapter to help cultivate in staff the positive qualities discussed above.

29 Chang, V., Scott, S., Decker, C. (2009). *Developing Helping Skills: A Step by Step Approach to Competency*. Brooks/Cole Cengage Learning: California.

30 Ibid.

31 Ibid, p. 93.

32 Ibid.

3.1.2 CASEWORKER KNOWLEDGE

Good GBV case management also requires that caseworkers have knowledge to carry out their responsibilities. Knowledge can be taught to and acquired by caseworkers, and it can also deepen over time.

At a minimum, it is important that caseworkers have the following:

- Knowledge about GBV and its causes and consequences
- Knowledge and understanding of social norms and how they affect survivors' help-seeking and decision-making
- Knowledge of what services and supports are available and what survivors can expect from them, in particular, the health and justice systems
- Knowledge of a survivor-centred approach and the guiding principles that underpin this approach
- Knowledge of the steps and tasks involved in GBV case management.

See Part V, Chapter 2 for guidance to assess a caseworker's knowledge. You can use the training materials referenced in the beginning of the chapter to build your staff's knowledge.

3.1.3 CASEWORKER SKILLS

Skills represent the application of knowledge and the expression of qualities. GBV caseworkers should possess the following basic skills and should be given opportunities to refine these skills through ongoing training and supervision.

- Ability to use a survivor-centred approach in their interactions with survivors including following the guiding principles
- Ability to use active listening skills
- Ability to communicate non-judgmentally
- Ability to demonstrate empathy
- Ability to communicate essential information about care options to a survivor
- Ability to empower survivors to make their own decisions about what is best for them
- Ability to identify key issues and needs related to a survivor's care
- Ability to solve problems related to the survivor's care

See Part V, Chapter 2 for guidance to assess a caseworker's skills. You can use the training materials referenced in the beginning of the chapter to build your staff's skills.

3.1.4 STAFFING STRUCTURE

In addition to hiring caseworkers with the right qualities, knowledge and skills, organizations providing GBV case management services must think about how to organize their staff. This includes having qualified senior staff who can supervise and mentor caseworkers.

Below are some benchmarks for appropriately staffing your case management services. It is important to remember that this guidance is based on what is considered ideal for good practice. Every context is different and will have its own set of circumstances that must be considered.

- Enough GBV caseworkers to allow for a caseworker-to-survivor ratio of 1:15 active cases, at the most 1:20. This should be monitored very closely by supervisors with the understanding that some cases require greater involvement depending on the needs and circumstances of the survivor and the stage of the case in the case management process.
- Caseworkers that speak the language(s) spoken by survivors so survivors can communicate in their first language.
- The gender of caseworkers should also be considered. For example, for programmes that are established to specifically address violence against women and girls and where the entry point for case management services is a women's centre, female caseworkers should be hired in order to keep the women's centres 'women-only', to protect the emotional and physical safety of the survivors. In other cases, it may be beneficial to have a mix of female and male caseworkers. These decisions should be based on the context, the types of GBV and your organization's or programme's focus.
- The ethnic, religious and cultural background of caseworkers should also be considered, and caseworkers should be hired to create a staff mix that is proportional to the makeup of the population being served.
- A supervisor to caseworker ratio of 1:5 and no larger than 1:8.
- Ongoing training, learning, support and other capacity building opportunities for caseworkers to further develop core qualities and skills and for supervisors to advance their technical and management abilities.



CONTEXT CLUE

In contexts where there are not enough resources to maintain the 1:15 or 1:20 ratio, organizations may have to develop a triage system that focuses on providing crisis intervention services to survivors with immediate safety and health needs.



CONTEXT CLUE

In contexts where caseworkers are working through interpreters, it is important the interpreters are trained on the GBV guiding principles, are clear on organizational case management policies and protocols, understand that they are bound by the same confidentiality practices, and understand that their role is to translate word for word what the survivor says. The parameters of the role of the interpreter should be communicated clearly to the survivor.

See Part V, Chapter 2 for guidance on establishing a supervision system for GBV case management.

3.2 CASE DOCUMENTATION, STORAGE AND SHARING

Documentation is an important part of any case management practice. It helps you keep track of what you and the survivor discussed, of what you and the survivor have determined is needed to help her/him, and what steps are being taken to help address the survivor's needs.

In humanitarian contexts, you must be very cautious in deciding if and when to begin collecting data and maintaining case files on survivors. Whether you should do so depends on the specific context and your ability to ensure safe, confidential storage of all information. All programme data containing information about survivors should be collected and stored in adherence to international standards that prioritize survivors' confidentiality, safety and security.

In the absence of specific information storage systems, you must assume your data is not secure and may be subject to unauthorized access and dissemination. With this in mind, the following are recommended procedures for keeping survivor data safe.³³

If you are maintaining paper copies of case information:

- Only print information if it is absolutely necessary. Where possible, promote a paper-free working environment to reduce the amount of information that is printed. In most cases, however, caseworkers will not have access to computers or hand-held data devices and will thus use paper forms to document cases. If information is printed, register each copy by applying serial numbers (or coding) and track them on a spreadsheet. Ensure that only those authorized to access these documents in your organization are aware that they are accountable for the security of them.
- In line with your organization's data protection and archiving policies, destroy all printed material that is no longer needed. You can do this by shredding or burning (if safe to do so).
- Store printed material in a locked file cabinet or other secure container, and limit access to the combination or keys.
- Have a plan in place for destroying all information in the case of an emergency or evacuation.



HELPFUL TO KNOW

GBV Information Management System (GBVIMS)

The GBVIMS is a robust system for collecting, storing and sharing key information on GBV incidents. It was created to harmonize data collection on GBV in humanitarian settings, to provide a simple system for GBV project managers to collect, store and analyse their data, and to enable the safe and ethical sharing of reported GBV incident data. The GBVIMS is intended to both assist service providers to better understand the GBV cases being reported, and to enable actors to share data internally across project sites and externally with other agencies for broader trends analysis and improved GBV coordination. GBVIMS+ is the latest iteration of the classical GBVIMS incident recorder. It is part of the umbrella application called Primero. More information on the GBVIMS and GBVIMS+ can be found in Part VI of this resource. In addition, guidance and tools to support the implementation of the GBVIMS can be found at <http://gbvims.com>.

³³ International Rescue Committee. (2012). Gender-based Violence Emergency Preparedness and Response Training Package. <http://gbvresponders.org/emergency-response-preparedness/>

If you are maintaining electronic case information electronically:

- Do not email information unless absolutely necessary. When you do send an email, include instructions for the recipients so that they are aware the information in the email and its attached files is sensitive. This could include caveats such as “Limited Distribution: Do not disseminate this email or attachments without permission from...”
- Store electronic data on a single computer or removable storage device, such as a flash drive, and keep limited backup copies.
- Secure backup copies in a locked, safe or room, or keep flash drives with you at all times.
- Access to information should be controlled. This includes establishing protocols for all staff accessing or using survivor information, and limiting access to computers used to store confidential data.
- Information stored electronically should be password protected. Use a series of passwords, establishing a different one for each level of information. Maintain security by ensuring that each user knows only the passwords to the information for which she/he has legitimate need.
- Use identifiers to mask personal identities. Develop a system of codes to assign unique identifiers to each survivor, using numbers, letters from their last name or other codes. Only the person who first assigns the identifier and enters the information into the computer should know the identity of the client.

Additional resources on good practices for GBV data management are available on the GBVIMS website:

<http://gbvims.com>.

3.2.1 CASE MANAGEMENT FORMS AND CASE FILES

If you determine that it is safe to put a system in place for collecting survivor data, you should develop and use a consent form and basic assessment tool. Other forms that can be part of case documentation include a case action plan, a written safety plan, case notes, a referral form, a case follow-up form and a case closure form. These can be added as your case management system becomes more developed. If case management services existed prior to the emergency, you should consult these service providers about the tools they use and determine whether they are standardized tools that should be used across agencies.

Each survivor should have a separate case file that includes all relevant completed case management forms. A code should be assigned to and marked on the front of each case file. Names should never be recorded on the front of case files. To protect confidentiality, a list linking the case file codes to the survivors' names should be stored in a different location, or stored electronically through a password protected file.

Information collected about survivors belongs to them, and they should have access to review and read the information at any time as part of their meaningful participation.



SAMPLE REFERRAL PROTOCOL

Sample case management forms can be found in Part VI.

3.2.2 INFORMATION SHARING PROTOCOL

In most contexts, there are multiple agencies working together to provide different services to GBV survivors. This necessitates sharing information about cases and using referral forms with sensitive client data. As discussed in the previous chapter, actors involved in a referral network need to agree what information about survivors should be shared, when and with whom. How this information will be shared—verbally, electronically or through a paper system—also needs to be agreed upon and appropriate procedures put in place to ensure that the confidentiality of the survivor is protected at all times. This can be documented in an information sharing protocol.³⁴

If you are using the GBVIMS, you will also need a separate information sharing protocol on sharing aggregated GBV incident data across agencies. Guidance on developing information sharing protocols for the GBVIMS is available at <http://gbvims.com>.

3.3 ORGANIZATIONAL POLICIES AND PROTOCOLS FOR GBV CASE MANAGEMENT

Written policies or protocols that outline the case management process can help staff understand what is expected of them with day-to-day case management work. A GBV case management protocol can include:

- **The maximum caseload.** The maximum caseload a caseworker can take on should be clearly stated.
- **How cases are assigned.** It should be clear to all casework staff how and when cases are received or assigned (i.e. walk-in, referrals, transfers). In addition, if organizations have a system for triaging cases, this system should be outlined in the protocol.
- **How ‘high-risk’ cases will be handled.** A high-risk case is usually one in which there is an immediate threat to the survivor’s safety or health. It is important to have a policy specifying what is considered to be a “high-risk” case and the procedures for handling such cases, including when a caseworker should bring such a case to a supervisor’s attention.
- **Mandatory reporting requirements.** Many countries have laws that require service providers to report to police or other government authorities any acts that are believed to be criminal offences. In addition, in humanitarian settings, all organizations are mandated to have protocols in place for responding to sexual exploitation and abuse by humanitarian workers. Procedures are not the same for all mandatory reporting requirements, thus it is important that your organization outline its mandatory reporting procedures. This should include detailed guidance on how such policies are explained to survivors, when the caseworker should inform a



CONTEXT CLUE

Mandatory Reporting

All response actors need to understand the laws and obligations on mandatory reporting as they relate to GBV cases. While mandatory reporting is often intended to protect survivors (particularly children), in some cases following mandatory reporting procedures conflicts with the guiding principles for working with survivors, including confidentiality and self-determination. It can also result in actions that are not in the best interest of the survivor. For example, mandatory reporting of cases of sexual violence or intimate partner violence to the police can put the survivor at great risk of harm from the perpetrator, family members or community members. Every organization must decide how they are going to handle mandatory reporting when it is not in the best interest of the survivor.

³⁴ For more information on the Information Sharing Protocol template and best practices, visit <http://www.gbvims.com/wp/wp-content/uploads/ISP-Package-August-2014.pdf>

supervisor, the responsibility of the supervisor, to whom (other than the supervisor) a report will be made, and what information will be needed if a report to an external entity is necessary. Note that UN organizations enjoy privileges and immunities that exempt them from prosecution where mandatory reporting laws are not followed. In addition, whether you are a national or international organization may determine the extent to which you are obligated to follow mandatory reporting practices outlined in national laws.

- **How different types of GBV will be handled.** For example, organizations need to make clear their policy on mediation of intimate partner violence cases, such as not allowing GBV caseworkers to carry out mediation or work with perpetrators (see **Part III, Chapter 1** for more guidance on this). Organizations that have child protection and GBV programmes need to be clear about which programme is the primary focal point in cases of child sexual abuse, and should decide how intimate partner violence cases that pose risks for children and require the involvement of a child protection expert will be coordinated.
- **List of forms.** A checklist of the forms a caseworker should complete for each case management step.
- **Instructions for case filing and safe data storage.** Clear instructions for how the paperwork in case files should be organized and how the case files should be stored.
- **Referral networks.** Information about the various service providers in the community, what services they provide, and who the focal point is for referrals for each service provider.
- **Staff safety protocols.** Working with GBV survivors can be dangerous for staff, particularly if they are part of and known in the community. Organizations need to identify and think through the situations that are likely to put a caseworker at risk of harm and put clear policies in place for how the organization will support staff in mitigating risks, including deciding when a case needs to be transferred because of the risk it poses to a staff member. It should also be clear what staff should do if they are in a harmful situation.

Every context and organization will have unique circumstances. Some examples of protocols and policies to consider developing are: staff should not work with perpetrators because of the safety risks involved for the staff member (and the survivor); creating a staffing structure and policy that ensures staff never work alone, whether in the community or the service centre; provide staff with a mobile phone with phone credit for use in an emergency.

3.4 WHERE AND HOW CASE MANAGEMENT SERVICES ARE PROVIDED

In humanitarian contexts, the most common entry points for GBV survivors to begin receiving services are usually 'safe spaces', women's centres and health clinics. However, not all such institutions have the resources to provide GBV response services, and in some contexts this may not be the most effective way to reach survivors. Some organizations provide services directly in the community, using semi-private indoor and outdoor community spaces, including mobile approaches.

Regardless of the mode or physical infrastructure your organization uses to provide services, it is important that the space—even if it is outside—is somewhere the survivor feels comfortable and safe speaking with you. Ideally, this would be a private place where a survivor can speak one-on-one without being heard or identified. However, this will not be possible in some settings, particularly during acute emergencies. The most important issue to consider in determining how you will provide services is safety. This includes the safety of the survivor, as well as the safety of staff and other community members accessing services. Some things to keep in mind are:

- If you set up a separate physical location, do not call it a "GBV centre" or anything that suggests that anyone going there has experienced GBV—that would make it unsafe for both survivors and staff. Offering a variety of services that are not necessarily related to GBV allows survivors to access services more safely and discreetly.

- If you are providing services in a centre or health clinic, be sure to create a private safe space— a separate room or a space separated by a partition. It is important that the person cannot be seen or heard by others as they speak to you.
- If your organization operates centres for women and girls where GBV survivors can receive services, it is important to keep the centre a women only space. This is to protect both the psychological and physical safety of all of the women and girls who go to the centre. Centre-based models that offer a broader range of services to women and girls facilitate disclosure and help-seeking and also allow for the provision of more holistic psychosocial care.

Such organizations should have a clear policy on responding to disclosures from male survivors—making sure staff know of relevant services in order to make referrals, and if there are none, how to respond in a way that is safe and respectful towards that person without compromising the safety and integrity of the centre.

- If your organization provides services for particular groups at risk, such as LGBTI persons, it is essential to consult with these groups on whether and how to provide services separately or as part of existing services. Depending on the context, there can be significant security risks for these groups, so it is important to establish how to operate services safely.
- If your organization provides services outside of a centre or health clinic, it is important to do safety mapping in the community with your target population. For example, you can gather women and ask them to identify spaces in the community they consider to be generally safe, or even protective, for them.
- Regardless of where your organization provides services, thinking about and planning for child care options may also be important in order to facilitate help-seeking among mothers and caregivers.

Of course, every context is different and every survivor’s situation will be different. What is most important is finding a way to speak to a survivor that will not expose them and put them at risk of further harm from the perpetrator or community members.

3.4.1 HOME VISITS

In some humanitarian settings it is common for organizations to use home visits as part of their service delivery approach because it is an easy way to access individuals and families. In particular, home visits are often used by health and protection services to assess an individual’s or family’s situation, and/or to follow-up on services that have already been provided as a way of monitoring well-being and progress.

Home visits are also used to access individuals and families who live far from service centres or who cannot easily reach services because of a disability or lack of timely and affordable transportation. **While there are several benefits to using home visits as part of case management, for GBV cases, this approach is usually not recommended because of the challenges in maintaining survivor confidentiality and safety, as well as risks to staff safety.**

The potential risks of home visits for survivors are:

- If it is not a common practice for organizations to carry out routine home visits, the very act of a staff member visiting one household in an area may signal that the household is receiving some kind of special service that others are not. This may stir curiosity and prompt discussion among neighbors who may eventually confront someone in the household, which could expose the GBV survivor.
- If your staff are known to provide GBV case management services or talk about GBV in the community, you immediately jeopardize a survivor’s confidentiality by visiting the her/his home. In such situations, your caseworkers are also putting their lives at risk of harm from perpetrators and/or community members.

- When you visit a survivor's home as part of a follow-up service and do not know who will be in the home at that time, you are putting the survivor's life, and your own, at risk of harm from the perpetrator, particularly in cases of intimate partner violence or child sexual abuse.
- Usually when perpetrators, particularly of intimate partner violence, discover a survivor has sought help from someone (even if it is not clear that the person sought help related to the abuse), the perpetrator will feel that his power has been threatened and there is thus potential for an escalation of violence.

To the extent possible, GBV caseworkers should not carry out home visits. In most situations it would be better to identify a safe space in the community that is easily accessible for survivors and would still allow for some privacy and safety. However, recognizing that in some places, due to general security concerns, home visits may be the only way to reach survivors, there are strategies to you can put in place to minimize risk to survivors and staff.

How can you minimize these risks?

- Home visits should never be used to 'identify GBV cases'. Organizations responding to GBV should not go out in communities to actively identify GBV cases. Outreach teams may visit homes to provide information about services in the community, but these visits should never include any questions or discussions about personal experiences of violence in the household.
- If you absolutely need to carry out home visits as part of your programme, remember to do the following:
 - Develop a strategy for visiting multiple households at a time in a small geographic area to provide information or some other type of service not related to GBV. You can visit a survivor's household in that area during this time, which should not draw attention.
 - Discuss with the survivor what time of day and which days fewer community members will be around, and when the perpetrator will not be in or near the house. To the extent possible, set aside a specific time with the person so they know when to expect you.
 - Make a plan with the survivor to have a code or signal that they can use to let you know that it is no longer safe for you to come to their house. This could be a message sent through a mobile phone, something that the person puts on or near the home (cloth of a certain color, a stick), or something that is changed within the home so that if you do enter, you will know that it is not safe to speak with the person.
 - In the event that the survivor is confronted about your visit, discuss with the person what they can say to others about who you were and why you were visiting so that they do not expose themselves.

3.4.2 COMMUNITY-BASED CASE MANAGEMENT COMMITTEES

Organizations may set up community committees to help with the identification, response to and prevention of certain protection issues and concerns. **In the case of GBV, case management committees or community-based protection groups are not recommended because of the difficulty in protecting the identity and confidentiality of the survivor, the likelihood of re-traumatization if community members are not well-skilled in responding to disclosures, and the safety risks associated with poor confidentiality practices.** Such entities can still play an important role in creating awareness about GBV services and in prevention programming, but they should not be involved in direct provision of support or services to survivors.

PART II

THE STEPS OF GBV CASE MANAGEMENT



Peter Biro / International Rescue Committee

CHAPTER 1

STEPS OF GBV CASE MANAGEMENT

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- The overall steps of GBV case management
- Caseworkers' responsibilities in the case management process

G BV case management is a process that can be broken down into steps, each with tasks, as outlined in the table on the next page.

You will usually follow the steps of case management in order. However, some steps and tasks are ongoing. For example, as part of your follow-up, you will reassess and perhaps need to provide further support or referrals. **The diagram on the next page demonstrates the continuous return to steps and tasks throughout the case management process.**

The responsibilities of GBV caseworkers are:

- Apply knowledge of GBV to their work and provide information to survivors about the violence they experienced that may help in their recovery.
- Communicate with survivors in a way that builds rapport and trust and promotes their healing and recovery.
- Carry out case management steps and procedures with survivors. This includes:
 - Follow informed consent/assent procedures, including modifying informed consent/assent procedures according to local laws.
 - Follow confidentiality protocols, including modifying confidentiality protocols to reflect the limits of confidentiality in your context.
 - Work in partnership with the survivor to assess health, safety, psychosocial, and other relevant needs and determine a course of action to address them.



TRAINING MATERIALS

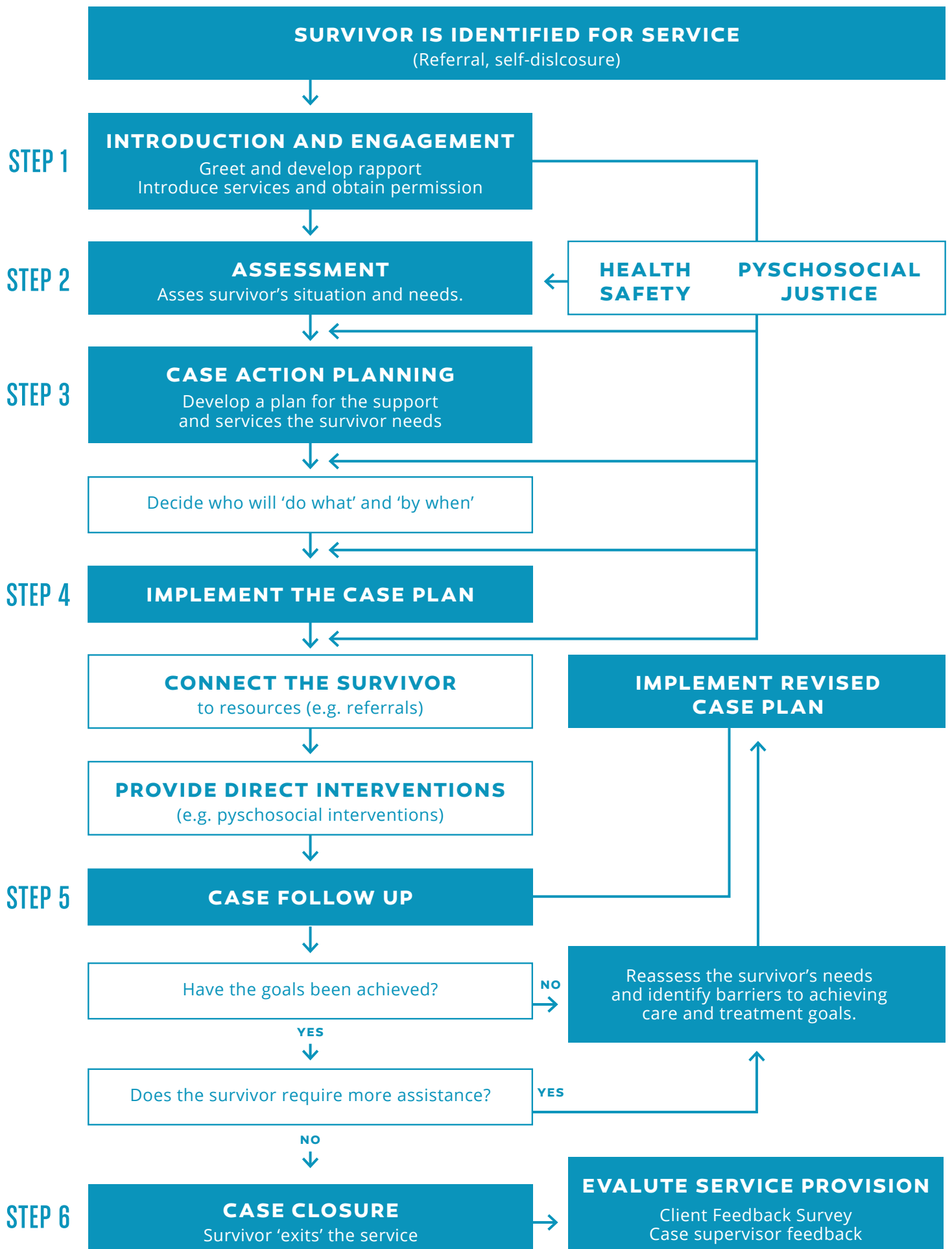
- Module 8: Guiding Principles and Roles and Responsibilities
- Module 10: Overview of GBV Case Management

- Conduct ongoing safety assessments and safety planning.
- Make referrals and coordinate a survivor's care.
- Follow up on referrals and organize case conference meetings.
- Identify strengths and assets the survivor has to cope with the consequences of their experience and support the person in using those throughout your work together.
- Nurture, comfort and provide emotional support to survivors throughout the case management process.

These responsibilities will be further explained in the coming chapters.

THE STEPS OF GBV CASE MANAGEMENT

CASE MANAGEMENT STEP	TASKS
<i>Step 1: Introduction and Engagement</i>	<ul style="list-style-type: none"> • Greet and comfort the survivor. • Build trust and rapport. • Assess immediate safety. • Explain confidentiality and its limits. • Obtain permission (informed consent) to engage the person in services.
<i>Step 2: Assessment</i>	<ul style="list-style-type: none"> • Understand the survivor's situation, problems and identify immediate needs. • Provide immediate emotional support. • Give information. • Determine whether the survivor wants further case management services.
<i>Step 3: Case Action Planning</i>	<ul style="list-style-type: none"> • Develop a case plan based on assessment with the survivor. • Obtain consent for making referrals. • Document the plan.
<i>Step 4: Implement the Case Action Plan</i>	<ul style="list-style-type: none"> • Assist and advocate for survivors to obtain quality services. • Provide direct support (if relevant). • Lead case coordination.
<i>Step 5: Case Follow-up</i>	<ul style="list-style-type: none"> • Follow up on the case and monitor progress. • Re-assess safety and other key needs. • Implement a revised action plan (if needed).
<i>Step 6: Case Closure</i>	<ul style="list-style-type: none"> • Assess and plan for case closure.





HELPFUL TO KNOW

What is the role of non-GBV specialists in responding to GBV?

All humanitarian actors play a crucial role in ensuring survivors gain access to GBV-focused community-based care services. The IASC GBV Guidelines highlight the importance of humanitarian actors across all sectors to provide information to survivors in an ethical, safe and confidential manner about their rights and options to report and access care. Humanitarian actors should work with GBV specialists to identify systems of care (i.e. referral pathways) that can be mobilized if a survivor reports exposure to GBV. For all humanitarian personnel who engage with affected populations, it is important not only to be able to offer survivors up-to-date information about access to services, but also to know and apply the principles of psychological first aid. Even without specific training in GBV case management, non-GBV specialists can go a long way in assisting survivors by responding to their disclosures in a supportive, non-stigmatizing, survivor centred manner. For more information on the role of non-GBV specialists, see the IASC Guidelines *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* at <http://gbvguidelines.org>. A companion guide to the GBV IASC Guidelines that outlines the supportive actions these actors should take when receiving a disclosure of GBV is forthcoming in 2017.

CHAPTER 2

STEP 1: INTRODUCTION AND ENGAGEMENT

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- How to greet and comfort a survivor
- The process for informed consent

The first step of the case management process—Introduction and Engagement—begins when you first meet a survivor. This is your first chance to develop rapport with a survivor and build a foundation for a good helping relationship. This step involves making the person feel safe and calm and giving them information about who you are and what help you can offer. It also involves getting consent from the survivor to work with her/him.



TRAINING MATERIALS

- Module 9: Communication Skills
- Module 11: GBV Case Management Step 1: Introduction and Engagement

2.1 GREET AND COMFORT THE SURVIVOR, BUILD RAPPORT

- To the extent possible, make sure that the physical space you are in is private. Be sure the survivor feels safe speaking with you there.
- Greet the person as you normally would greet a stranger in your culture.
- Invite the person to sit down. If you are in an office, avoid having a desk or table between you. Ask the person if they are comfortable.
- Be warm, calm and open. Be sure that your body posture begins and remains open and facing the person, so that you give the sense that you are inviting the person to tell their story and that you are ready to listen.
- Introduce yourself and explain who you are in simple terms. Ask the person if they are comfortable sharing their name.



SAMPLE SCRIPT

To introduce yourself, you can say:

Hello, my name is [name] and I am a [role] for the [name of organization]. I am glad that you came here today. I am here to listen and help you.

2.2 ENGAGING THE SURVIVOR IN SERVICES³⁵

After greeting the survivor, you must determine whether the survivor wants to receive your case management services. Doing so involves obtaining informed consent from the survivor. **Informed consent is the voluntary agreement of an individual. It is a term that is widely used in health and social services and is intended to protect the rights of the survivor and ensure that they are fully aware of the limitations, risks (and benefits) of receiving services.**

Getting informed consent is an ethical obligation, and it is a survivor's right that must be protected. In GBV case management, getting informed consent is also an important part of building trust with a survivor. It is a way to promote the person's self-determination and start restoring their power and control. The process for informed consent is:

- Explain what will happen if you work together.
- Explain confidentiality and its limitations (see below for more information).
- Explain collection, use and storage of the survivor's information (if you are collecting client data).
- Explain the survivor's rights throughout the helping process.
- Ask the person if they have any questions.
- Ask the person if they would like to continue with services.

Each part of the informed consent process is described further on the next page.



HELPFUL TO KNOW

Why is there no "identification" step?

In GBV case management, there is no "identification" step, as there is in child protection case management, even in cases of GBV that involve child survivors. This is because it is dangerous for both survivors and staff if staff are out in the community identifying actively GBV cases. Organizations carrying out GBV case management should instead work on cases that have been referred to them with the survivor's consent, or those in which the survivor has directly disclosed. Some organizations may have outreach teams that understand the issues women, girls and other vulnerable populations face that put them at risk of GBV; such teams can play a critical role in providing information about services can receive disclosures and can make appropriate referrals. They should be trained on how to handle disclosures, and must be clear on the parameters of their role (i.e. they should not be doing case management).

³⁵ When working with child survivors, follow the informed consent procedures outlined in the *Caring for Child Survivors of Sexual Abuse Guidelines*, pgs. 113-117. <http://gbvresponders.org/response/caring-child-survivors/>
Informed consent/assent procedures for adolescent girls are discussed in Part III of this resource.

2.2.1 EXPLAIN WHAT WILL HAPPEN IF YOU WORK TOGETHER

After you introduce yourself, you can explain to the person what the case management process will entail using simple language. Explain that you will ask the person to share what brought them to you, and that you will talk together about what help the person may need and the options for support and services. This is done to provide information to the survivor about what will happen during the case management process.

2.2.2 EXPLAIN CONFIDENTIALITY AND ITS LIMITS³⁶

Survivors have the right to keep information about themselves private in the same way we that we all have the right to privacy with regards to our own personal information, such as our health status. As discussed in **Part I, Chapter 1**, protecting a survivor's right to confidentiality is a key guiding principle. It is an important aspect of restoring the dignity of the survivor and reducing social stigma and blame.

You should explain:

- What confidentiality means with regards to you sharing information about the survivor's case
- What the limits to this are, including any mandatory reporting laws (if any exist in your context)
- What you will do if/when you have to break confidentiality.

Sometimes people think that confidentiality means never telling anyone anything about a case—but this is not what confidentiality means. **Confidentiality means that you do not share information about a survivor's case unless you have their permission to do so.** For example, you might discuss issues related to a case with your supervisor. You need to do this to make sure you are taking the right actions and providing the best possible service. You may also need to discuss case details with other actors involved in helping a survivor in order to ensure adequate coordination and that all of a survivor's needs and rights are met. At all times, you need to make sure that you let the person know who will be involved in a case and why and get their permission on what information can be shared with whom, while always protecting the identify of the person. If they object, you will need to look at why they are objecting—perhaps they have a good reason, and you need to listen and find out more.

'Limitations to confidentiality' refers to situations in which there may be legal or other obligations that override the individual's right to confidentiality. **'Limited confidentiality' applies in the following circumstances:**

- There are concerns about the immediate physical safety of survivors or co-survivors, such as the physical safety of children or in cases when you may be concerned that a survivor may harm themselves.
- There are mandatory reporting laws that obligate service providers to report to police or other government authorities. In such situations, legal requirements override the question of the survivor's permission. Survivors (and caregivers) should be made aware of these legal requirements as part of the informed consent process.
- There are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers. In these situations, organizations need to be clear on what the inter-agency protocol is and inform the survivor as to whom the case would be reported, what information would be shared, and what the expectations would be regarding the survivor's involvement (i.e. Will the survivor have to file a report, and if so to whom? Will the survivor have to be interviewed, and if so by whom?).

36 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

You never want to “promise” confidentiality. While it may seem like an important way of building trust, it is not acceptable to make promises to survivors that you know you might not be able to keep. This person has already been betrayed and would only feel worse. **Instead, from the very beginning be very clear what confidentiality means and what the limits are in your context.**



SAMPLE SCRIPT

To explain confidentiality and its limitations, you can say:

It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during our meetings. This means that I will not tell anyone what you tell me, or share any other information about your case, without your permission.

There are only a few situations when I may have to speak with someone else without asking your permission.

If you tell me you that you may hurt yourself, I would need to tell my supervisor or others who could help keep you safe.

If you tell me that you plan to hurt someone else, I would have to tell [relevant protection authorities] so we could prevent that action.

If a UN or humanitarian worker has hurt you, I would need to tell my supervisor and report what this person has done, so he/she can't hurt anyone else.

If... [Explain mandatory reporting requirements as they apply in your local setting].

Sharing information during these times is meant to keep you safe and get you the best help and care you need. Other than these times, I will never share information without your permission.

2.2.3 EXPLAIN HOW THE PERSON'S INFORMATION WILL BE SAFELY AND SECURELY STORED

If you are documenting survivors' data either in writing or electronically, be sure to explain to the person that part of the case management process includes documenting and storing some of the information they share with you. Explain that you do this so you can remember important information about the case that will help you best help the survivor, including by following up on services and other issues. Explain the safety and security measures your organization has in place to make sure that written information is non-identifiable and inaccessible to outsiders. If you are using the GBVIMS or another information management system, you will also need to explain that and get consent accordingly.



SAMPLE SCRIPT

To explain how the person's information will be safely and securely stored, you can say:

There are some forms that I need to fill out where I write down the information you have shared with me. These forms are not shared with anyone else—I use them to help me remember things about your case. These forms are kept in a locked file in a secure place, and will not be kept with any personal information that would link you to the case file.

2.2.4 EXPLAIN THE PERSON'S RIGHTS

In addition to their right to confidentiality, survivors have other rights when they work with you. Explain to the person that she/he has the following rights that you will protect:

- ✓ The right to request that their story, or any part of their story, not be documented
- ✓ The right to refuse to answer any questions
- ✓ The right to stop at any time
- ✓ The right to ask questions at any time
- ✓ The right to request to work with a different caseworker
- ✓ The right to refuse referrals, without affecting your willingness to continue working with the person
- ✓ The right to request to see their case file or other data collected about them, and to ask for changes to be made to it.



SAMPLE SCRIPT

To explain the person's rights, you can say:

I also want to be sure you know that you have rights as we work together. For example,

- *It is okay if there is something you want to tell me, but you'd rather I not write it down. You just have to let me know.*
- *You do not have to answer any questions that you do not want to. Also, you can always ask me to stop or slow down if you are feeling upset, worried or scared.*
- *You can ask me any questions you want to, or let me know if you do not understand something I say.*
- *You can also tell me that you prefer to work with someone else either here or with another organization.*

2.2.5 OBTAIN PERMISSION TO PROCEED

The last step in the informed consent process is to ask if the person if they have any questions and if you have their permission to proceed with services.



SAMPLE SCRIPT

To get permission from the survivor to proceed, you can say:

Do you have any questions about anything that I explained to you?" [Allow for time to answer any questions]. If I have answered all of your questions, may I have your permission to continue our conversation and begin working with you?"

- **If YES**, you can proceed with case management services.
- **If NO**, remind the person that what happened to them was not their fault, provide information about other services in the community that may be helpful, and tell the person that they can come back at any time.

In most situations, survivors will be willing to give their consent to participate in case management services. However, they may have questions about confidentiality, mandatory reporting and written documentation. You should listen carefully to these questions, try to understand and validate the person's concerns, and then provide choices. For example, a survivor may say that they do not want to have a case file created or do not want you to write anything down. You can let them know that their concern makes sense, provide clarification about how case files are kept anonymous and secure, and offer options that may make the person feel more safe. For example, you can give the survivor the option to read any of the notes you take or offer to read the notes back to them. If the person remains concerned, you should set aside the procedures and focus on providing help. While documentation is helpful for you and your organization, it is not required to help the survivor.

2.2.6 WHEN TO GET INFORMED CONSENT

Conversations with a survivor about informed consent are ongoing throughout the case management process. There is no consent process or form that serves as all-encompassing permission from the survivor for services, referrals or information sharing. You should get informed consent:

- ✓ **Before you begin assessment**, that is, before listening to a survivor's story, gathering or documenting any information about the person's case.
- ✓ **Before making case referrals**. Any time you share information with other service providers who can help the survivor meet their needs. **You must seek permission to share information for each new referral.**
- ✓ **Before you take any other actions on behalf of the person**. For example, carrying out advocacy or case coordination.

Are there any instances when you do not need to obtain informed consent?

If a person comes to you in need of immediate lifesaving help—for example, because they are in imminent danger (the perpetrator or someone else potentially dangerous has followed them) or requires urgent medical attention—you will likely not be able to go through the entire informed consent process. In such cases, if you are going to take actions that require involving others, try to get the survivor's verbal consent before acting.



HELPFUL TO KNOW

Why is informed consent so important?

Sometimes caseworkers skip the process of getting informed consent. You may think that if a survivor comes to your centre, you can assume she/he wants help from you and that you do not need to get consent. Or sometimes a survivor may start talking right away about what happened, and you worry that interrupting would be rude. While these are reasonable concerns, it is potentially more harmful to your relationship with the survivor if they share their story without understanding the full risks and benefits of doing so. Caseworkers should approach the informed consent process as a way of building rapport and trust with the survivor.



TOOLS

A sample *Consent for Service Form* and the *GBVIMS Intake and Assessment Form* can be found in Part VI.

CHECKLIST STEP 1: INTRODUCTION AND ENGAGEMENT

- Greet and comfort the survivor in a warm and open way
- Introduce yourself and your role
- Discuss all aspects of informed consent (including confidentiality, mandatory reporting, etc.)
- Answer questions
- Get permission from survivor to continue

CHAPTER 3

STEP 2: ASSESSMENT

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Listening to a survivor's story
- Responding to a survivor's story
- Assessing specific needs
- Determining how a survivor wants to proceed

Providing good case management services rests on conducting a good assessment as well as having a good relationship with the survivor. In social work case management, **assessment is defined as the act of gathering information about a client and using it with the client to make decisions about the client's care.** In GBV case management, this step involves listening to the survivor to find out what has happened and what the current situation is, and giving information and helping the person identify their needs and problems.



TRAINING MATERIALS

- Module 9: Communication Skills
- Module 12: GBV Case Management Step 2: Assessment

3.1 FACILITATING THE SURVIVOR'S DISCLOSURE

As explained in the previous chapter, our goal during Step 1: Introduction and Engagement is to begin building rapport and trust with the survivor. This is very important in order to be able to move into assessment. A person is unlikely to tell us what happened to them if they do not sense that they can trust us. This is even more so for someone who has experienced GBV, which can shatter a person's trust in all people.

Asking the survivor to talk about what happened to them is likely to feel difficult and scary for them. Some ways you can make the person feel more at ease during this conversation are:

- Using an open-ended question to invite the person to begin, e.g. “Would you like to tell me about what happened?” or “Can you tell me what brought you here today?”
- Listening carefully to the story as the person tells it.
- Watching the person’s body language closely for any signs of discomfort, such as crying, staring into space, mumbling, giving one-worded answers, turning away, or changing the topic.
- Actively check in with the person along the way—Are they okay with continuing to talk about this? Do they need to take a break?
- If the person verbally or non-verbally expresses that they are not comfortable answering questions or sharing information with you, respect their wishes and stop. Forcing a survivor to tell their story is harmful. **You should not do this under any circumstances.**
- Take notes if needed, but keep your focus on the survivor.
- As the person tells you what happened, encourage and empathize through both verbal and non-verbal communication. Phrases such as “continue”, “go on” or “I am listening” can be helpful.
- Once the person has disclosed, respond to the disclosure with compassion, validation and reassurance. See section 3.1.3 for examples.
- Ask clarifying questions only after you have let the survivor speak and have responded to their disclosure. Avoid unnecessary questions; only ask questions that will give you information to help the survivor.

As you begin this step, you will continue to build trust by fostering a safe environment in which the person feels listened to, not judged and not blamed for what happened.

3.1.1 GATHERING BACKGROUND INFORMATION

Before you begin your conversation with the survivor about what happened to her/him, you may want to gather basic information about their background. This may help the person feel more comfortable and safe, and it gives you more time to build rapport with them.

Instead of asking a list of questions, begin with an open question that invites the person to tell you about her/himself. You can then ask follow-up questions if necessary. Information that is helpful to know includes:

- The survivor’s age (can be approximate if the person does not know)
- Current living situation
- Family situation
- Occupation or role in the community.



HELPFUL TO KNOW

Before you begin, find out if other service providers have already been involved.

Before the survivor begins sharing the details of their story, ask whether they have spoken to any other organizations. Explain that this is to avoid having them repeat their story, which may be painful or frustrating. You can give them the option of giving you permission to get information from that/those organization(s).

You should always take your cue from the survivor. If they seem eager to speak about what happened to them, allow them to do this first and you can go back to gathering background information later on in your conversation.

3.1.2 UNDERSTAND WHAT HAPPENED

The following information is important for you to understand about what happened to the person:



CONTEXT CLUE

In a refugee setting, it can be important to gather information about the person's legal status in the country of asylum—for example, whether they are a recognized refugee, an asylum seeker awaiting a decision on refugee status, or a rejected asylum seeker. It may be a good idea to ask what documentation they have. This can also influence their access to particular services in certain settings.

- **Nature of the violence or abuse.** What kind of violence did the person experience? Although you do not need to ask many details about what happened, there are some things that are important to know because they may indicate the need for lifesaving medical care. For example, knowing if physical force and weapons were used, whether there is any severe pain (especially head injuries) or bleeding, and whether there was vaginal/anal penetration.
- **Who the perpetrator is and what access they have to the survivor.** Gathering information about the perpetrator helps evaluate a survivor's risks for future harm by the perpetrator and/or friends and relatives of the perpetrator. For example, if the person has been raped or assaulted by a close neighbor or member of the survivor's family, they may not be able to return home. If the person is experiencing intimate partner violence, they will need to think through safety options carefully. Key areas for assessment include:
 - Relationship of the perpetrator to the survivor and their family. Does the closeness of this relationship have implications for immediate safety or longer-term psychological effects?
 - Where the perpetrator is now (if the survivor knows).
 - Whether the perpetrator can access the survivor easily.
 - The occupation or role in the community of the perpetrator. Does the perpetrator's position and level of power raise further safety concerns?
 - The number of perpetrators.
- **When the last incident took place.** Knowing when the last incident took place is essential to analysing the urgency of a medical referral and for accurately informing the person about medical options. Depending on when the last incident took place, different medical treatments are available.
- **Frequency.** If the person has a history of recurring abuse, focus the assessment on the most recent incident so that you can understand the current needs. This does not mean that the most recent incident is the most significant, but the person should not be asked to recount every incident of abuse at this time.

3.1.3 RESPONDING TO A SURVIVOR'S DISCLOSURE

After a survivor has shared what has happened, it is important to communicate compassion, validation and reassurance. In addition to thanking the person for sharing something very difficult, there are a few simple statements you can say that can be very powerful and supportive for the person to hear. These statements, called "Healing Statements" can be an important part of a survivor's healing.

- Validate and empower the survivor by saying, "You were very brave for sharing that with me."
- Continue to build trust by saying, "I believe you."
- Express empathy by saying, "I am sorry this happened to you," or "I am so sorry you are going through this."

- Provide reassurance that what happened was not their fault by saying “You are not to blame” or “What happened was not your fault.”



HELPFUL TO KNOW

Healing Statements

Hearing these statements frequently can be an important part of a survivor’s healing. You should use them (or similar ones) throughout your work with a survivor. Remember that, once they leave the safe space you have created with them, survivors go out into a world that does not believe them, blames them and judges them. Communicating these basic but powerful messages may help survivors begin to feel less shame, self-blame and stigma and more supported.

- Validate and empower the survivor by saying, *“You were very brave for sharing that with me.”*
- Continue to build trust by saying, *“I believe you.”*
- Express empathy by saying, *“I am sorry this happened to you,”* or *“I am so sorry you are going through this.”*
- Provide reassurance that what happened was not their fault by saying *“You are not to blame”* or *“What happened was not your fault.”*

Specific strategies for communicating with survivors can be found in the training materials that accompany this resource.

3.2 ASSESSMENT OF NEEDS

Assessment of a survivor’s needs begins with listening. While you may develop a sense of the person's major concerns through their recounting of the GBV incident, it is also important to ask the person directly how they see the situation and what they want to happen next. This will help you understand their priorities for help and support.

In the immediate aftermath of an incident, the survivor’s life may be at risk either because of health complications or threats to safety. In such cases, it is important to prioritize these areas in your assessment of needs. In addition, caseworkers do not need to carry out a complete assessment or gather all demographic information the first time they meet with a survivor. This can and should be done in a phased manner as appropriate to the survivor’s case, priority needs and context.

3.2.1 SAFETY NEEDS AND STRATEGIES

While the person is telling you what happened, you should listen for situations, circumstances and people that are continuing to harm them or put them at risk of harm. You will also want to discuss strategies for mitigating those risks. Listen and assess for:

- ✓ **The person’s sense of safety in their home and in the community**
 - Identify with whom and where the survivor does not feel safe and why. You can do this by asking the person or by mapping it with them visually, i.e. conducting a mapping of places in the community where the person does not feel safe.

- ✓ **The person's existing safety and support systems and strategies**
 - Identify what the survivor has been doing since the incident to keep themselves safe from the perpetrator or others who might harm them. Discuss if what they have been doing is something they can continue to do, and identify what resources or support they might need to continue using these strategies.
 - If there are particular places that are unsafe, discuss whether there are strategies for avoiding those places or for mitigating the associated risks (such as having a friend or family member with them).
 - Discuss what other support systems the person may have—family members, community members, community leaders—and how they may rely on them for safety and protection. Are there family members they have not had recent contact with but with whom they could reconnect? Do others know what happened? Would they be supportive and help protect the person if they knew?
- ✓ **Other resources that may be available or mobilized**
 - If the survivor does not have a support system or existing helpful strategies, discuss what other resources may be available to them in the community. For example:
 - Is police protection a safe option? (This will depend on a lot of factors, such as the context, the capacity of the police, who the survivor is, who the perpetrator is, and the person's past experiences with the police.)
 - In an emergency, is there a hospital or health clinic the person can easily access as a temporary safe space?
 - Is there a public or private place that the person can go to as a temporary safe space (e.g. a market, a church)?
 - Does the person have access to a phone they could use to call someone for help?
 - As a last resort, a survivor may want to move out of their home or area. This should always be the survivor's choice, and should not be pushed on them. In this case, it is important to fully discuss the options and implications for relocation or placement in an emergency shelter or alternative housing.

The most important thing to remember is that the strategies you discuss with the person will only be helpful if she/he can actually put them in place. It is always best for the survivor to come up with their own strategies. You can help them think through how their ideas would work and what else they may need for effective implementation—but giving them your ideas about what will work is not helpful. They know their situation best, and if the strategies do not come from them, they may agree to something that is simply not practical, feasible or safe.

3.2.2 HEALTH NEEDS AND SERVICES

For a recent GBV incident, it is important to determine whether a medical referral is required. This is particularly important for incidents of rape, sexual assault or any form of non-sexual physical assault that may have resulted in acute injury, pain or bleeding.

You can understand a survivor's health needs primarily by listening to their story of what happened and determining the medical implications.



CONTEXT CLUE

Health Services

It is important that you know the availability, accessibility and quality of health services in the community. This will all depend on your context. Even if services exist, you will need to think carefully about whether the person will be able to access them and what the financial costs may be. You will also want to be sure of and discuss with the survivor any mandatory reporting requirements that health service providers may have in your context and the associated safety risks.

You may also have to ask clarifying questions—the goal of which is to understand:

- ✓ Nature of the incident (i.e. if it was a rape or sexual assault, medical treatment is highly recommended)
- ✓ Date/timing of the last incident (i.e., for sexual assaults that happened within 72 or 120 hours, lifesaving treatments can be provided as described below)
- ✓ Presence of and/or complaint of pain or injury.

Clinical management of rape

If the last incident was within 72 (3 days) to 120 hours (5 days) and/or the survivor is injured or experiencing physical pain, she/he may be able to receive the following treatments:

- **Prevention of HIV:** The risk of HIV can be reduced if a survivor is referred for medical care to receive HIV post-exposure prophylaxis within 3 days (72 hours).
- **Prevention of pregnancy:** The risk of unwanted pregnancy can be reduced if a survivor is referred for medical care to receive emergency contraception within 5 days (120 hours).
- **Medical stabilization/treatment of acute injury or pain:** Depending on the severity and nature of the injury (i.e. broken bones, wounds or internal injuries), immediate medical attention may be necessary. *Some serious and life-threatening injuries are not easily detected as they may not be physically visible or associated with pain.*
- **Forensic evidence collection:** In contexts where this is a safe option and the survivor requests it for legal purposes, the medical examination must be arranged and recorded as soon as possible (within 48 hours) with a qualified professional. Organizations should also understand if there are legal requirements for a survivor to have a forensic exam in order to access other services.

Sharing information

Be sure to share information with the survivor about the health consequences of GBV, particularly in the case of sexual violence. Doing so will help the person understand the reason for a medical referral and help them determine if it is something that they need. You should share the following with them:

- Rape, if there was vaginal penetration, can lead to unwanted to pregnancy.
- Rape or attempted rape can put the person at risk of HIV or other STIs.



CONTEXT CLUE

Clinical Management of Rape

In many humanitarian contexts, the resources and capacity for the clinical management of rape are not widely available, or there may be laws that require a survivor to have a police report to receive services. The services may also cost money. Before offering these as an option, you need to think about:

- Are there hospitals and clinics that have the right medications in stock? Do they have the personnel to administer them? Where is the hospital/clinic located?
- If there is a hospital or clinic, how will the person access it? Does it require a police report? Does it cost money? Is it too far away? How will the survivor get there?
- For forensic evidence collection—are there qualified and designated professionals to carry out this exam? Does the survivor have to pay?

Non-urgent Care

As with the clinical management of rape, in some contexts, exams, medications and procedures (e.g. abortion services) may not be available or legal. It is important that you know what the relevant laws are and the availability and accessibility of such medical treatment.



HELPFUL TO KNOW

Clinical Care for Sexual Assault Survivors (CCSAS) Resource

The Clinical Care for Sexual Assault Survivors (CCSAS) multimedia training tool was created to improve the clinical care of sexual assault survivors in low resource settings by encouraging competent, compassionate, and confidential care, in line with international standards. It is intended for all medical and non-medical clinic workers who interact with sexual assault survivors.

The CCSAS multimedia tool resource package includes:

- CCSAS Multimedia DVD
- CCSAS Facilitator's guide
- CCSAS Psychosocial toolkit

The CCSAS resources are available in downloadable versions in English, French and Arabic from <http://www.IAWG.net/CCSAS>.

- Rape and sexual assault could result in injuries, including tears to reproductive organs.
- There may be helpful prevention medication and treatment available. Some of these are time sensitive.
- You will also want to share with the survivor what to expect from a visit to the health clinic or doctor, so that they can weigh the benefits and risks of a visit.
- Options for accompaniment to the health clinic or doctor.

Because health services within 120 hours of an incident of rape can be lifesaving, if a survivor of rape decides not to get such care, it is important that you respectfully and carefully discuss the reasons for that decision, and see if any of the survivor's concerns can be allayed. For example, you may be able to arrange for the service in another location outside of the community, or with another provider, etc.

Non-urgent health needs

If the person is physically free of injury and pain, the sexual assault occurred more than 120 hours earlier, and/or the nature of the assault did not include physical violence, touching or penetration, a medical referral may be useful but not urgent. Survivors seeking care more than 120 hours after sexual assault may still require treatment and should not be delayed or discouraged from seeking medical care. For example:

- Sexually transmitted infections, including chlamydia, gonorrhea, and syphilis, should be treated with antibiotics; if left untreated, they may cause chronic illness or infertility.
- Incontinence of urine or stool may indicate severe complications resulting from injury, such as fistula- or rectal-sphincter damage, requiring surgical attention.
- Pregnancy resulting from a sexual assault may be safely terminated up to 22 weeks.

In these cases, a survivor can receive the following medical treatment:

- Physical and genital exam: A physical and/or external genital exam may be necessary to assess injuries. A physical exam may also reassure the survivor that they are fine physically, not internally injured, and free of infections.
- Laboratory tests: Tests can be done for sexually transmitted infections and pregnancy following sexual assault. HIV testing can be done as early as 6 weeks after the assault and should be repeated 3-6 months after the incident. Pregnancy testing can be done one week after the assault.

3.2.3 PSYCHOSOCIAL NEEDS AND SUPPORT

Experiences of GBV have a great impact on a person's emotional well-being, their ability to keep up with day-to-day tasks, their overall sense of safety in the world, and their ability to trust others. You can begin to understand the survivor's psychosocial state from the very first meeting with them. The person's emotional state, their facial expressions, body language and other behavior can indicate signs of distress. The key assessments areas for psychosocial needs and support are:

- Get a basic sense of how the person is feeling
- Observe the person's appearance and behavior
- Assess changes in the person's feelings or behavior
- Assess opportunities for education and livelihoods
- Identify protective factors and strengths

Each of these are described in more detail on the next page.

Remember, It may not be possible in your first meeting to do a thorough assessment of the person's psychosocial needs. In your first meeting, prioritize providing information to the survivor about the potential impact of GBV on a person's emotional and psychological state. This does not mean that the person needs to be "educated" about what they are feeling. Rather, trauma work indicates that survivors may experience many feelings at once, and this can be overwhelming and confusing. Shame and stigma may limit them from telling us exactly how they feel. Providing information about the impact of GBV is a way to help them clarify, as well as normalize, their feelings. Some examples of what can you say are provided in the Sample Script box on this page.



SAMPLE SCRIPT

To provide information about the emotional and psychological impact of GBV, you can say:

- *You may be experiencing many different feelings right now. The different feelings can be confusing and hard to understand. You can often feel opposite feelings at the same time. It's ok to have a lot of different feelings about what happened and the [perpetrator], especially if it someone you knew well and trusted.*
- *You may feel that you cannot trust anyone anymore and this may be hard and discouraging and scary. It makes sense that you feel them given what you have gone through.*
- *All of the feelings you have--whether anger, guilt, fear, love, hope, hopelessness, sadness, shame, confusion-- are common and okay for you to feel.*
- *Sometimes these feelings affect how you behave. You may feel scared all of the time and feel like you cannot trust anyone. You may feel sad all of the time and want to cry. You may feel nothing or feel 'numb.' And you may not want to talk to anyone. All of that is ok.*

Get a basic sense of how the person is feeling

Once you have shared some basic information with the survivor, you can ask them to share with you how they are feeling. If the person is struggling to explain, you can ask them if any of the feelings you mentioned—anger, guilt, fear, love, hope, hopelessness, sadness, shame, confusion—feel familiar to them. If it seems that these feeling words are difficult to understand, you can also use pictures that express a range of emotions, such as emotion faces, to help the person identify what emotions they are feeling.

Observe the person's appearance and behavior

How would you describe the person's appearance? This isn't intended to be a judgment about the person's clothes or attractiveness, it's meant to get a sense of whether the person has been able to maintain a certain level of routine functioning. Does the person look disorganized or frazzled, or does she/he seem fairly poised and intact?

How would you describe the person's behavior? Are there any signs of being erratic, aggressive, extremely sad or numb (i.e. someone who does not talk at all or show any feelings). All of these emotions are also normal responses to an experience of GBV. You are trying to identify extremes.

Assess any changes in the person's feelings or behavior

This helps to determine if the survivor's feelings and behavior have changed significantly following their experience. You should listen for any indications that the person:

- Has stopped doing their daily activities
- Has stopped leaving the house
- Has stopped talking with or seeing family and friends
- Is having trouble sleeping or is sleeping too much
- Complains of physical aches (stomachaches, body aches, headaches)
- Has changed their eating habits (eating too much or too little)
- Feels sad most of the time
- Expresses feelings of hopelessness about their situation or about life.

You can also ask the person directly if they have recently experienced any of the above.

Understanding how the person's feelings and behavior have changed since the incident can help you understand how they are functioning and what support they may need. For example, survivors who answer "yes" to many of these questions may be experiencing depression or anxiety and may require benefit from more advanced psychosocial services or mental health care.



HELPFUL TO KNOW

Survivors with Suicidal Thoughts

Caseworkers need to be watchful for warning signs that a survivor is at risk of self-harm or suicide. If a survivor is expressing thoughts about ending their life, it is important to address them immediately and to understand whether they are just thoughts or there is an intent to act on them. This kind of assessment requires extensive training and supervision. If you have not had such training, it is important that you bring in a supervisor who has been trained to support you. If it is not possible to do this in your setting, you should make an in-person referral to a mental health service provider immediately. If that is not available, go to the nearest hospital or health clinic for emergency care. **Do not to leave the person alone until you have been able to ensure that they are in appropriate care. Instructions for carrying out a suicide risk assessment can be found in Section 3.4 at the end of this chapter.**



SAMPLE SCRIPT

To assess changes in the person's feelings and behavior, you can say:

Sometimes, what happened to you can cause you to act differently and feel differently than before. I'd like to ask you some questions about how you have been feeling and what you have been doing recently. Since [the incident] happened, have you / do you. . . [draw from examples provided as relevant]

Assess opportunities for education and livelihoods

For many survivors, a source of income and a meaningful activity can be a considerable source of both emotional and practical support, helping them build self-esteem as well as economic independence. Education can also be important for survivors, both adults and children, providing them not only with valuable knowledge and skills, but also with a daily routine and potentially a supportive social group.

Keep in mind the following important considerations when assessing for education and livelihoods opportunities:

- **Understand whether the survivors' education/livelihood activities played a role in the GBV they experienced.** In some cases, survivors are exposed to violence as a result of their work or education activities, for example in school or on the way to the marketplace. This could deter them from continuing these activities, making them potentially more vulnerable in the long term. It is important to talk through this in the safety assessment.
- **Understand whether education/livelihood activities play a role in the survivor's life goals.** A survivor's dream to finish school or to start their own business can be an important part of their life goals and action plan. They may feel that the incident or their situation after the incident will not allow them to pursue their ambitions. It is also important to understand that education/livelihoods may not be part of a survivor's goals and that their needs may not be met in this area. As such, referral to such services should not be automatic, but rather based on expressed need. Avoid suggesting that education or livelihoods activities will somehow be a solution for survivors.
- **Identify a survivor's opportunities, barriers and supports related to accessing education/livelihoods.** What were the survivor's education/livelihood activities before the incident? Can they go back to them, or transfer those skills to new endeavors? Are there other skills they would like to apply or alternative business ideas they'd like to explore? Are there training programmes in the area that the survivor might be interested in? Is there a childcare centre or a supportive friend or relative who could help them with their children while they attend classes?
- **Before beginning a conversation with the survivor, ensure you are well-informed about the existing supports and services in education/livelihoods in your context,** so you can provide accurate information to the survivor about their options. Do not create false expectations. You should also be informed about and discuss the potential risks of such activities with a survivor.
- **Identify a range of options in education/livelihoods for survivors. Do not assume that one size will fit all.** Support for younger survivors to continue or return to formal schooling is important, and may involve referral to accelerated learning programmes or catch-up classes. Where formal schooling is not an appropriate option, life-skills, literacy and numeracy classes may be a good way to provide both adolescent and adult survivors with important knowledge, skills and a meaningful activity. Livelihoods activities should also be carefully developed to suit the market, the capacities and the family situation of survivors. Vocational training, small business education and start up, and employment schemes could all be good options for survivors, depending on their situation.

- **Coordinate with education/livelihoods providers to find appropriate ways to involve survivors in their activities.** It is usually not a good idea to have programmes that specifically target survivors, as these could become stigmatizing. Furthermore, there are likely many people who may be at risk of GBV who would also benefit from such programmes. Ideally, there would be safe, confidential ways to make referrals to existing programmes that can incorporate survivors without disclosing what happened to them or creating a perception that survivors of GBV get special treatment.
- **It may be important to provide additional support to survivors who are involved in education/livelihoods activities, especially adolescents.** In addition to childcare solutions, survivors may need additional financial or psychosocial support and coaching in order to successfully complete training or learning programmes. If a survivor is referred to an activity without additional support, it may lead to their dropping out and coming away with a greater sense of failure, which can affect their willingness to try again. Referrals should not be made without having thought through whether the activity is appropriate and how the survivor will be supported. Such support could be provided as part of case management or as part of the education/livelihoods programme.

Identify protective factors and strengths

Gathering information about the survivor's family, social and spiritual life and strengths can help you determine the extent to which the survivor has protective factors that may support their healing and recovery.

- **Family and living situation.** You should already have information about this from the beginning of your assessment. Here you are trying to identify if the survivor has family relationships that are supportive. It is helpful to know who the survivor considers to be their family and where those people are physically located.
- **Social support.** It is helpful to know with whom the survivor spends time. Does the person have friendships? People whom they can trust? Who are sources of emotional support? Has the person been able to access these social supports since the incident? How have they helped the person?
- **Spiritual/religious.** Does religion and/or faith play a role in the survivor's life? Has the person been able to draw upon their faith and/or religious practice since the incident? How has doing so helped them?
- **Positive coping mechanisms.** Does the person have positive coping mechanisms? What are they?

When you are listening to the person's story, you can listen for some of these protective factors. You can also ask the person direct questions that help you understand the degree to which they have these protective factors in their life. For example:

- **What do you do when you are scared?** This helps the person think about people, places or actions they call upon in times of danger.
- **What do you do when you are sad?** This helps the person think about people, places or actions they call upon when feeling sad.



- **Who are people that give you hope and strength?** This helps the person identify supportive people, such as family members, friends and neighbors who can be part of their recovery and healing.
- **What are your interests?** This can help the person identify activities they enjoy and make them feel good, which can help them heal.

The information you gather will help you form goals with the survivor related to psychosocial support when you do case action planning.

3.2.4 LEGAL RIGHTS³⁷

The decision whether to pursue justice is an important one, and survivors need to have access to full information to think through such a decision. It is important for you to understand if what happened to the person is a crime within the legal framework of your setting, and if so, whether the person wants to take legal action.

Sometimes people working with GBV survivors assume that the person should report to the authorities because they think the perpetrator should be punished. While this may be what you want, you have to understand that there are great risks for a survivor in reporting to formal authorities. Often, responses from the police and legal systems can put the person at risk of harm from the perpetrator, family members or community. The process of taking legal action can also re-victimize the survivor. It may also take a long time and cost money.

Instead of pushing a survivor to make a decision, you should inform the person of their legal rights in this situation (if any) and provide them with information about what they can expect if they report to the police (i.e. who will interview them, who determines if it proceeds to court, what happens if you make a report and the police do not press charges) and what will happen if the matter proceeds to court (how much will it cost, how long it will take, what the survivor will need to do). Sharing accurate information about the likelihood that a case reported to the police will actually proceed to court and/or result in conviction is also important. This information will help the person analyse the benefits vs. costs or risks of reporting to the police.

Some organizations providing GBV case management services have found it helpful to have legal counselors as part of their programme who can accurately explain legal options in a survivor-centred way. Supporting survivors to access legal services, including attorneys who can help them report and pursue their case, is important if that is the survivor's wish.



CONTEXT CLUE

Legal Services

In the early stages of an emergency, it may not be feasible to link survivors with justice actors—such as the police or courts—in part because justice systems and structures may have disintegrated as a result of the emergency. In such settings, staff may address issues of impunity through national and international advocacy efforts, including supporting national efforts to reform or create laws and policies that support the rights of women and girls. Ensuring redress for GBV survivors also entails working to build the capacity of existing national and traditional legal actors to enable them to appropriately carry out their responsibilities.

³⁷ UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.



CONTEXT CLUE

Other Protection Solutions and Services

In some situations, a survivor's risks may be compounded by other protection issues such as lack of documentation, legal status or family separation. This is particularly likely in displacement settings. Bear in mind that some survivors may not know that services and support are available in these areas, and therefore may not raise all of the issues themselves. It is thus important to be aware of the issues that may affect those at risk of GBV in your context, and to ask survivors for the relevant information. For example, in a refugee setting, it could be important to ask whether a survivor is an asylum seeker or a recognized refugee, and what documentation they have, in order to understand what services are available to them.

- **Documentation:** In some cases, survivors may be lacking documentation that can serve to protect them. This could range from individual identity documentation, civil documentation for themselves or their children, or proof of their legal status as an asylum seeker or a refugee. Supporting survivors to access such documentation can be essential to their protection, especially to avoid arrest or detention, or to access particular services and benefits. In some settings, this may involve helping survivors to approach relevant authorities or fill out necessary forms. In refugee settings, UNHCR can usually assist refugees and asylum seekers in obtaining documentation of their status in the country of asylum.
- **Legal status:** A person may have different access to health, accommodation and material support, legal, psychosocial, education, livelihoods and other services depending on their legal status in the country. In refugee settings, it may be possible to accelerate Refugee Status Determination (RSD) for particularly vulnerable individuals where this affects their access to protection and assistance. It is a good idea to coordinate with the national authorities responsible for RSD and/or the UNHCR in order understand which persons may be eligible for accelerated procedures.
- **Re-establishing family links and family reunification:** Where a survivor has been separated from family members, this can contribute to their vulnerability to GBV-related risks. Putting survivors in touch with organisations that can help them to find, contact and potentially reunite with husbands, wives, children, parents or other loved ones can be critical to their safety and well-being. In displacement and disaster settings, the International Committee of the Red Cross and National Red Cross and Red Crescent Societies will typically provide these types of services, and, in displacement settings, UNHCR also supports family reunification.
- **Durable solutions:** UNHCR has a mandate to identify durable solutions for refugees, including local integration, voluntary repatriation and resettlement to third countries. Depending on the context, survivors may have access to prioritized assistance to access particular durable solutions. Many survivors experience GBV-related risks as a direct consequence of their displacement, for example due to continuing security risks in the host area. Coordinating with UNHCR on durable solutions for refugees and appropriate referrals can be an important part of ensuring survivors' safety.

3.2.5 OTHER PRACTICAL AND MATERIAL NEEDS

It is likely that survivors will also need practical and material support. For example, they may need money, clothes, food, phone credit, transportation, etc. These are likely to be needs that the person identifies on their own as a priority because they are critical for survival. If your organization does not provide such assistance, it is important to connect them with an organization that does or to help them identify sources of support in their family and community (e.g. family members, friends, religious groups and leaders, community associations and leaders).

3.3 DOCUMENTING INFORMATION FROM THE ASSESSMENT

If you have a case management system and are using forms, you should document the information from your assessment. The most important information to document is the survivor's description of what happened, what the survivor identified as concerns, and what you identified together as needs. Documentation of the incident should be based on fact and professional judgment rather than on personal opinions. It is important to remember that the assessment form is only a tool. Sometimes caseworkers make the mistake of thinking it is more important to fill in the forms than to concentrate on listening to the survivor. If possible, it is best to listen to the survivor's story first and fill in the form after your meeting so you are not distracted by the form while the survivor is speaking. If you are a new caseworker and feel that you need to take brief notes during the session, be sure to ask the survivor's permission before doing so, explaining that the notes will be safely and securely stored in the person's case file.

If you are using the GBV IMS, you will use the Intake and Assessment Form to document the assessment. If your organization does not have a specific form, you can document what happened in case notes that should be safely and securely stored. Again, be sure to ask the survivor's permission to take notes during the session.



TOOLS

The *GBVIMS Intake and Assessment Form* can be found in Part VI. Only organizations using the GBVIMS should use this form.

3.4 SUICIDE RISK ASSESSMENT AND SUPPORT

One of the most serious consequences of GBV is a survivor's risk of suicide. It can be expected that survivors will have feelings of wanting to die, end their life or "disappear." If a survivor is expressing such feelings, it is important that a more in-depth assessment be carried out. The main task is to determine whether or not this is a feeling only, or a **feeling with an intention to act** (i.e. the intention to actually take one's life). Some staff worry that if they ask a person whether they are having suicidal thoughts, they may encourage the person to think about suicide. There is no evidence to suggest this is true.

Organizations will need to have clear policies on how suicide risk cases are handled, which should be based on the staff's and supervisors' own capacity to carry out suicide risk assessments. If staff have not been specifically trained how to do this, then a supervisor should be notified immediately, and a referral to more specialized mental health services should be considered, if available.

If it is within your organizational policy and you have been properly trained, you should follow the suicide risk assessment guidance that follows, which includes the following steps:³⁸

Step 1: Assess current/past suicidal thoughts

Step 2: Assess risk: lethality and safety needs

Step 3: Address feelings and provide support

Step 4: Develop a safety agreement

Before beginning, you should reassure the person that it is okay to have feelings of sadness or wanting to die, and that whatever they are feeling is normal. In many cultures and religions, suicide may be looked upon as “weak” or may even be forbidden. To feel safe and comfortable to talk to you about what they are feeling, the person will need to know that you will not judge them.

STEP 1: ASSESS CURRENT/PAST SUICIDAL THOUGHTS

Explain to the person: *“I’m going to ask you some questions that may be hard for you to answer, but I am worried about you, so I want to know that you are going to be ok.”*

Ask the person questions that can help you assess their current and past suicidal thoughts. Some examples of questions you can ask are below. Keep in mind that these will need to be adapted based on the cultural context.



SAMPLE SCRIPT

To assess current or past suicidal thoughts you can say:

- *That sounds like a lot for one person to take. Are you feeling so bad that you’re considering suicide to escape?*
- *Do you think about dying? Or wish you were dead?*
- *Are you or have you ever thought about hurting or killing yourself?*
- *Has all that pain you’re going through made you think about hurting yourself?*
- *Do you ever wish you could go to sleep and just not wake up? How often? Since when?*

Based on the person’s responses, you may or may not need to continue with the suicide risk assessment.

- If the person answers “no”,** and there are no signs that they intend to harm or kill themselves, it is likely the risk of suicide or self-harm is low. In this case, you can likely discontinue the assessment. Again, this is determined on a case-by-case basis and depending upon whether there are other signs that the person may be suicidal.
- If the person answers “yes”** to either of the questions, say to the survivor, *“Please tell me more about these thoughts”,* and then proceed to the next step.

³⁸ International Rescue Committee and UNICEF (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.* <http://gbvresponders.org/response/caring-child-survivors/>

STEP 2: ASSESS RISK: LETHALITY AND SAFETY NEEDS

You will next need to understand if the person has a plan. You should also **assess past suicide attempts** because they signal higher risk. Examples of questions you can ask to assess these risks are below.

- If the person is unable to explain a plan for how they would take their own life and/or has no history of attempts, the risk is less immediate. At this point, you should support the person by exploring strategies for coping with difficult feelings and thoughts, and if needed, develop a safety agreement with the survivor (see Step 4 of the suicide risk assessment).
- If the survivor is able to explain a plan and/or indicates they have already attempted suicide, the risk is more immediate. You should continue to the next step.

SAMPLE SCRIPT

To assess if the person has a plan, you can say:

"Tell me about how you would end your life. [Allow survivor to answer]. What would you do? When did you think you would do it? Where did you think you would do it? Are (guns/pills/other methods) (at home/easy to get)?"

To assess past suicide attempts you can say:

"Have you ever started to do something to end your life but changed your mind? Or have you ever started to do something to end your life but someone stopped you or interrupted you? What happened? When was that? Tell me how many times that happened."

As with any part of the assessment, be sure to give the survivor time to answer and pause before asking another question. Always take your cue from the person as to whether they need to go more slowly or take a break.

STEP 3: ADDRESS FEELINGS AND PROVIDE SUPPORT

It is critical that you stay calm if the person expresses suicidal thoughts and a plan. It may be the opposite of your instinct, but do not try to talk the person out of it nor offer advice about what they should do. The feeling they have is serving a purpose for them—it is their last attempt to feel that they are in control of something. Instead, you should validate their feelings and acknowledge the courage it took for them to share such information with you and communicate your concern for their safety and well-being.

SAMPLE SCRIPT

To address feelings and provide immediate emotional support, you can say:

"I understand that you are feeling this way and I am sorry. I know that it was hard for you to share that. You are very brave for telling me. It is very important to me that you do not hurt yourself. And I would like us to come up with a plan together for how we can help you to not do this. Is this okay with you?"

STEP 4: DEVELOP A SAFETY AGREEMENT

Developing a safety agreement with the survivor is a way for you to help them identify their own mitigation and prevention strategies. In this step, you will explain the purpose of the agreement. Then you will help the person identify:

- Warning signs
- Strategies to feel better
- A safety person

First help the person identify warning signs:

- Ask the person to describe their experience
 - *“Tell me what happens when you start to think about killing yourself or wanting to hurt yourself? What do you feel? What do you think about? How will you know when you are going to need to use these strategies?”*
- Identify the warning signs (thoughts, images, thinking processes, mood and/or behaviors) using the survivor’s own words.

Next help the person identify strategies to feel better:

- **Explain to the survivor, that you want to find other things the person can do to make themselves feel better.**
 - *“When you have thought about killing yourself before, what prevented you from doing it?”*
 - *“Tell me some things you can do to help yourself feel better when you start to think about hurting yourself or wanting to end your life. What has helped you feel better in the past? Is there someone you can talk to or go to?”*
- Based on what the person says, agree that they will use these strategies/do these helpful things instead of hurting themselves.
- Ask the person what might get in the way of them using these strategies to feel better. In other words, you want to identify strategies that are practical and feasible for the person to do.

If the person is not able to identify any strategies, you should confer with a supervisor and discuss the potential for a referral to mental health services, or if not available, to emergency medical care.

Identify a safety person:

Explain to the person that in addition to the strategies they have identified, a friend or another family member must be notified to act as a “safety person” for the survivor. This should be someone who can be with the person all the time for at least the following 24 hours. You will need to try to get in touch with this person, explain to them what is happening and arrange for them to come meet the survivor or for you to bring the survivor to them.

SAMPLE SCRIPT

To help the survivor identify a safety person, you can say:

“I want to help you stay safe. Can you think of someone in your family or a friend who could stay by your side? Can we work together to get that person to agree to stay by your side in order to keep you safe?”

If the person cannot identify anyone, you should confer with a supervisor and discuss the potential for an immediate referral to mental health services, or if not available, to emergency medical care. You or a supervisor will need to accompany the person, as it will not be safe to leave them alone. You will need to explain to the referring agency that this person is in crisis and should not be left alone. You do not need to disclose that the person is GBV survivor.

Document the safety agreement:

You can document the safety agreement you have made with the survivor, which may be helpful for the person to keep with them as a reminder in times of crisis. As with any documentation, only provide it to the person if they will find it helpful and if it is safe to do so.



TOOLS

A Sample *Suicide Safety Agreement* can be found in Part VI.

CHECKLIST STEP 2: ASSESSMENT

- Determine if other responders are involved
- Understand who the survivor is
- Invite the survivor to tell you what happened
- Listen well
- Respond with validation, compassion and information
- Identify the survivor's concerns and key needs
- Document relevant information on a form or in case notes if you have a safe case documentation and storage system

CHAPTER 4

STEP 3: CASE ACTION PLANNING

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Planning with the survivor how to meet needs, set personal goals and make decisions about what will happen next
- Developing a simple written plan specifying what actions need to be taken, by whom and when

In this step, you and the survivor will plan how to meet her/his needs, solve problems and make decisions about what will happen next. You will:

- Summarize your understanding of the survivor's key needs.
- Give information about what services and supports are available and what can be expected from them.
- Plan together how to meet needs, set personal goals and make decisions about next steps.
 - Obtain informed consent for referrals to other services.
 - Discuss how the survivor will access other actors and whether accompaniment is needed.
- Develop a case action plan—a simple written plan specifying what action needs to be taken, by whom and when.



TRAINING MATERIALS

→ Module 9: Communication Skills

→ Module 13: GBV Case Management Step 3: Case Action Planning

4.1 SUMMARIZE KEY NEEDS

Case action planning builds from your assessment. You can transition into this step by summarizing for the person what you understand to be their key needs according to your discussions with them. Check whether they agree with your summary and whether there is anything you missed or they would like to add.



SAMPLE SCRIPTS

To help transition the assessment to case cation planning, you can say (below is based on a case example):

“Based on our conversation, my understanding is that you are worried about your safety when you return home... that you do not need medical attention at this time... that you aren’t sure yet about any legal process... and that you are feeling worried, sad and scared right now. Is this right, or is there anything we need to add?”

4.2 PROVIDE INFORMATION ABOUT AVAILABLE OPTIONS

Provide information to the survivor about what services and supports are available and what can be expected from them as follows:

- What will happen as a result of the referral, including what support will be available, and whether there are any mandatory reporting requirements associated with the referral (for example, whether referral for medical treatment will require the doctor or nurse to report the case to the police)
- The benefits and risks of the service
- That the person has the right to decline or refuse any part of an intervention provided by the caseworker and/or referral agency
- What information will be shared about the case in the referral process and with whom.

4.3 DISCUSS AND PLAN HOW TO MEET NEEDS AND SET PERSONAL GOALS

Plan with the person how to meet needs, set personal goals and make decisions about what will happen next.

- **Determine whether they want to be referred to a service, and get informed consent.** Once you have provided information to the survivor about the services available (as described in Section 4.2 above), ask the survivor if they have any questions. Do your best to answer the questions, and if you can’t, determine if/how you can get the information requested. You can ask the person if they would like to be referred to any of the services you have discussed—this is the process of getting informed consent for the referral.
- **Identify who will be responsible for facilitating the intervention or service.** For example, will you be responsible for making referrals for survivors as well as providing direct services (e.g., psychosocial)? Who will be responsible for medical care if it will be provided? The survivor may also agree to be responsible for taking certain steps to manage their safety and well-being (e.g. as part of safety planning or psychosocial support).
- **Discuss accompaniment for the referrals.** The survivor may want someone to accompany them to the other agencies or actors they will go to for help. You should talk this through carefully with the survivor, always thinking about safety risks. In some settings, GBV caseworkers are known in the community, so walking a survivor to a medical facility or a police station automatically raises curiosity and may inadvertently put the survivor at risk. If you will not accompany them, is there someone else they trust who can?

- **Discuss and set personal goals with the survivor.** A significant part of a survivor’s healing and recovery depends on their own sense of empowerment. It is important to also identify short-term and realistic goals that the survivor can reach that will contribute to their own well-being. These should be related to the assessment you did, particularly the psychosocial assessment, in which you discussed the survivor’s emotional state, feelings and functioning as well as sources of support and strength. You can use this information to help the survivor formulate concrete goals and strategies for achieving them. For example, if a survivor discussed feeling alone or isolated, you can talk about creating a goal to make a routine appointment with a friend or family member. Or agree that the survivor will return to certain routines that help bring them joy or stability, or spiritual practices that bring them strength. As much as possible, allow the survivor to identify these goals on their own—you can offer your support by bringing the person back to the information you discussed during the assessment.

4.4 DOCUMENT THE PLAN

If you have a case documentation system, you can document the plan you and the survivor discussed in a simple way—by writing down what actions need to be taken, by whom and when. Having this written down will be helpful when you follow up with the survivor so you can remember what actions you were responsible for, monitor the services the survivor was referred to (if any) and make sure they were provided in a timely manner. You and the survivor can both sign it, so that it’s clear that they provided their consent.



TOOLS

If you do not have a form already, you can adapt the sample *Case Action Plan* form provided in Part VI.

4.5 DISCUSS HIGH-RISK CONCERNS WITH YOUR SUPERVISOR

If urgent concerns arise regarding the safety or health of the survivor during the course of your assessment and action planning (e.g. they are suicidal, decline lifesaving health services or there are issues related to mandatory reporting) and you require further support, be sure to discuss this with your supervisor **before** you complete the session with the survivor. If a supervisor is not available, confer with a colleague for support.

4.6 IDENTIFY A TIME AND PLACE FOR A FOLLOW-UP MEETING

If it will be possible in your context to follow-up with a survivor, you should discuss options for a follow-up visit and be very specific about where it will take place and when. Explore with the survivor how follow-up will be safest for them. Possible options include:

- Make appointments for the survivor to come to your centre.

- Meet the survivor inside another organization’s office if that better protects their privacy (e.g. health clinic).
- Visit the person at home if this does not compromise confidentiality and safety (see **Part I, Chapter 3** for information on home visits).
- Call the survivor by phone if one is readily accessible to them and safe for them to use.

Discuss follow-up options carefully with the survivor, keeping in mind the options that will be safest and easiest for them.



CONTEXT CLUE

Facilitating Follow-up

In some humanitarian settings, following up with a survivor may not be possible due to insecurity or the transient nature of the population. If you already know that the context is going to make follow-up very unlikely, be sure that the survivor has the information and/or a plan in place to get the support they need before you end your session. If there are safety risks, be sure that you have carried out safety planning.

If you are in a context where follow-up is possible, it is useful to discuss with the person what obstacles—emotional or physical—could prevent them from being able to make a follow-up appointment. It is easy for survivors to agree to follow-up appointments when they are in the room with you, but once they leave, many issues may arise that will prevent them from returning. Brainstorming with the survivor about what the obstacles may be—transportation, child care, time, safety or feelings such as fear, stigma, shame, worry—and identifying possible solutions to those obstacles, mobilizes the survivor’s thinking and problem-solving skills and makes it more likely that they will return.

CHECKLIST STEP 3: CASE ACTION PLANNING

- Summarize your understanding of the survivor's key needs
- Give information about what services and supports are available and what can be expected from them
- Plan with the person how to meet needs, set personal goals and make decisions about what will happen next
- Develop and document a case action plan
- Discuss concerns with your supervisor
- Discuss options for follow-up

CHAPTER 5

STEP 4: IMPLEMENT THE CASE ACTION PLAN

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Making referrals
- Helping survivors access services
- Case coordination
- Case advocacy
- Providing direct interventions

Implementing the case action plan entails helping the survivor implement the plan and making sure they receive the care, support and assistance they need. Tasks involved in this step can include:

- Making referrals, e.g., for health care, to police, for legal advice, to other services and helpers
- Support, e.g., accompanying the person to services, appointments, etc.
- Advocacy—speaking on behalf of survivors if they need and want this help to access quality care
- Coordination of services
- Providing direct services, e.g., emotional and practical support, providing education to families, etc.



TRAINING MATERIALS

- Module 9: Communication Skills
- Module 14: GBV Case Management Steps 4, 5 and 6: Implementation, Follow-up and Case Closure

5.1 MAKE REFERRALS AND SUPPORT SURVIVORS TO SAFELY ACCESS SERVICES

Based on the action plan developed, you will need to contact the relevant service providers to refer the survivor's case. You can also assist the survivor with accessing those services by:

- Accompanying the person to service providers
- Advocating on behalf of the survivor. Some common examples of advocacy include:
 - With police and security personnel regarding protective measures
 - For compassionate and quality medical care and treatment
 - For survivors' views and opinions to be followed and their rights upheld
- Meeting with service providers (with the consent of the survivor) to explain what happened and provide information about the incident (as agreed with the survivor) so the survivor does not have to repeat their story.

5.2 LEAD CASE COORDINATION

A key role of a caseworker is coordinating care for the survivor. This means acting as a liaison between the survivor and service providers, advocating for timely and quality care for the survivor, and working with service providers to reduce obstacles to accessing services. This requires regular communication and follow-up with other actors working with a survivor.

One aspect of case coordination is **case conferencing**. Case conferencing is a planned, structured meeting convened by the caseworker to discuss a particular case with other service providers involved in the survivor's care and treatment. Case conferences allow you to: 1) review activities, including progress and barriers towards goals; 2) map roles and responsibilities; 3) resolve conflicts and strategize solutions; 4) adjust current action plans. Case conferences can be effective venues for addressing any problems with services not being provided in a timely way, or to get clarity on who is doing what to avoid duplication of efforts in complex cases involving many actors. **You should always get consent from the survivor before holding a case conference.** Case conferencing is done on an ad hoc basis and is distinct from ongoing service coordination and other coordination forums.

5.3 PROVIDE DIRECT SUPPORT

If some cases, your organization may also provide direct support to the survivor as part of or in addition to case management. Some of the interventions you can implement directly are:

Provide emotional support. You can provide emotional support by continuing to listen, comfort, validate and



HELPFUL TO KNOW

Complete Mandatory Reporting Procedures

As discussed earlier, depending on the mandatory reporting requirements in your context, you may be obligated to share information about the survivor's incident with others. This should have already been discussed with the survivor during Step 1: Introduction and Engagement, when you obtained consent for services. However, it is during this step of the case management process that you will need to carry out mandatory reporting. Make sure you follow these guidelines when doing so:

- Always inform the survivor of your obligation to report (before the person shares their story, to the extent possible).
- If the survivor shares information that you must report, explain what information you must share, who you will share it with, and what is likely to happen next.
- Discuss any protection needs associated with mandatory reporting.
- Discuss the situation with your supervisor first before reporting to the required authorities.

reassure the survivor. Reinforce that the violence the person experienced was not their fault, that the person is strong and can heal, that the person did the right thing by speaking up, and that you support and believe them.

Facilitate the survivor's reconnection to sources of strength and support. Survivors may feel shame about returning to their home, circle of friends, place of worship or "being seen" in the community generally, or they may have other personal issues. One of the best ways for survivors to heal is to resume their daily activities, take time for activities that bring them hope, strength and courage, and connect with people in their lives who are supportive and encouraging. Caseworkers can work with survivors to develop strategies to help them reconnect with supportive relationships in their life.

Refer the survivor to specific interventions that your organization offers, such as group support sessions, vocational programmes, etc.

CHECKLIST STEP 4: IMPLEMENT CASE ACTION PLAN

- Make referrals**
- Advocate for and support survivors in accessing services**
- Lead case coordination**
- Provide direct services if relevant**

CHAPTER 6

STEP 5: FOLLOW UP AND STEP 6: CASE CLOSURE

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Following up on a case and monitoring progress
- Determining when to close a case
- How to close a case

6.1 STEP 5: CASE FOLLOW-UP

Following up on cases is an important part of helping survivors with their needs. During case follow-up, you will:

- **Monitor** the case.
- **Make sure the survivor is safe** and getting the help they need, and identify and overcome barriers or problems.
- **Identify new problems** and solutions.



TRAINING MATERIALS

- **Module 9: Communication Skills**
- **Module 14: GBV Case Management Steps 4,5 and 6: Implementation, Follow-up and Case Closure**

6.1.1. HOW TO DO FOLLOW-UP

Meet with or contact the survivor as agreed. During case action planning, you should have already agreed with the survivor on when and how case follow-up will happen. Follow-up meetings should take place in a location where the survivor is comfortable and in which confidentiality can be protected. You and the survivor should have a specific time, date and place that is best for the survivor.

Reassess safety. Survivors' risks of harm often increase once they have disclosed the incident. Therefore, caseworkers should assess a survivor's safety during every visit with a survivor. During follow-up visits, you should ask specific questions about the survivor's safety in their home and community and what has changed since the last meeting. Based on the outcome of the safety reassessment, you should follow up on safety referrals or make an updated safety plan if necessary.

Reassess psychosocial state and functioning. If, overtime, a survivor's well-being is not improving or seems to be deteriorating (e.g. they are not caring for themselves or their children, further isolating themselves) more specialized psychosocial or mental health care may be considered, if available. Supervisors should be consulted in such cases to determine whether or not to make such a referral.

Review the case action plan with the survivor. Discuss whether the survivor has accessed the services to which they were referred and whether they experienced any challenges. Identify whether any new needs have emerged that should be addressed.

Revise the case action plan. Document the outcomes of referrals and any new needs that emerged on the case action plan form or a follow-up form. Schedule another follow-up visit.

Implement revised case action plan. If new referrals are required, additional informed consent procedures must be followed.

While the case management process involves steps, you need to recognize that survivor's lives are rarely so straightforward and most often involve a complex mix of ongoing needs. You may have to go through some of the steps several times during your work with a survivor. When cases are very complex, and especially where risks are very high, it is likely that a case will remain open for a long time. This is ok.

It is important to remember that it may be very difficult to meet all of a survivor's needs, and that while you can continue to support the person for as long as they want to receive help, you are not expected to find solutions to all of the person's problems.



TOOLS

A sample *Follow-up Form* can be found in Part VI.

6.2 CASE CLOSURE

The length of time a case may be open will vary greatly depending on the survivor's needs and the context in which you are working. Because of these variables, it is important to have criteria for case closure so that you know when it is time to close a case. You can close a case as follows:

- **When the survivor's needs are met and/or their (pre-existing or new) support systems are functioning:**
 - ✓ Follow up with the survivor and discuss their situation.
 - ✓ Review the final action plan and the status of each goal together.
 - ✓ Explain that it is time to close the case, but reassure the survivor that they can always return if they encounter new issues or experience GBV again.
- **When the survivor wants to close the case.** Sometimes survivors may feel that they do not want to continue with you even if they haven't had all their needs met. Our goal is to respect the survivor's wishes, and thus the case is closed at their request.
- When the survivor leaves the area or is relocated to another place.
- When you have not been able to reach the person for a **minimum** of 30 days.

Once you have determined that a case should be closed, you should:

- **Document when the case is closed and the specific reasons for doing so.**
 - ✓ Complete a Case Closure Form if your organization uses one.
 - ✓ Review the case with a supervisor and obtain approval to close it.
 - ✓ Review all the forms in the survivor's file and make sure the file is complete.
- **Safely store the closed case file.** Move the file to a "closed case" cabinet if your programme has one. Do not include the consent form in the closed file.
- **Administer a client feedback survey.** If you close the case in person and your organization uses client feedback surveys, you can administer the survey to the survivor after closing the case. **See Part V, Chapter 1 for more information on using client feedback surveys.**



TOOLS

A sample *Case Closure Form* can be found in Part VI.

CHECKLIST STEP 5: FOLLOW-UP AND STEP 6: CASE CLOSURE

STEP 5

- Meet with or contact the survivor as agreed
- Reassess safety
- Review and revise the case action plan
- Implement the revised case action plan

STEP 6

- Determine if/when the case should be closed
- Document the case closure
- IF possible, administer client feedback survey
- Safely store the closed case file (move the closed file to a new cabinet)

PART III

GBV CASE MANAGEMENT WITH WOMEN AND ADOLESCENT GIRLS



Meredith Hutchison / International Rescue Committee

INTRODUCTION

WOMEN, GIRLS AND GBV IN HUMANITARIAN SETTINGS

Global statistics estimate that one in three women will experience physical and/or sexual violence by a partner, and/or sexual violence by a non-partner, at some point in their lifetime.³⁹ Among women 15 to 44 years old, violence causes more death and disability than cancer, malaria, traffic accidents and war combined.⁴⁰

Adolescent girls are among the most marginalized within vulnerable populations around the world. Beliefs that girls have less value and are less capable than boys result in their being denied education and married off at an early age. Nearly half of all sexual assaults worldwide are against girls aged 15 and younger.⁴¹

Widespread discrimination and gender inequality often result in women and girls being exposed to multiple forms of violence throughout their lives, including 'secondary' violence as a result of a primary incident (e.g. abuse by those they report to, honor killings following sexual assault, forced marriage to a perpetrator, etc.).⁴²

It is well documented that women's and girls' risk of various forms of violence increases in humanitarian settings due to the worsening of existing inequalities between men and women and the overall instability and violence that comes with conflict or natural disasters. Some of the specific risks are:

- Women and girls are at risk of sexual assault and rape during emergencies, especially if food, water or fuel sources are far from settlements or located in unsafe areas.
- Women and girls are at risk of sexual exploitation—including the exchange of sex for essential goods and services, trafficking and sexual slavery.
- Women and girls can suffer systematic sexual violence by soldiers or members of armed groups.
- Violence by intimate partners and male family members can escalate during emergencies. This tends to increase as crises worsen and men lose their jobs and status—particularly in communities with traditional gender roles and where family violence is normalized.
- Girls are vulnerable to forced and early marriage during emergency situations.

In the chapters that follow, additional information and considerations will be highlighted for case management responses to the key forms of violence that women and girls experience in humanitarian settings: intimate partner violence, sexual violence and child, early or forced marriage.

39 World Health Organization. (2013). <http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>

40 UN Women. (2011). *Facts and figures on violence against women*. <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>

41 Women's Refugee Commission. (2014). Adolescent Girls Fact Sheet.

42 Interagency Standing Committee. (2015). *Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action*. Geneva, IASC. <http://gbvguidelines.org>

CHAPTER 1

GBV CASE MANAGEMENT FOR INTIMATE PARTNER VIOLENCE

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- What intimate partner violence is
- How intimate partner violence affects women and girls
- Specific ways to support women and girls experiencing intimate partner violence

As discussed in the Introduction of this resource, there is increasing attention in humanitarian settings to the risks of intimate partner violence women and adolescent girls face. Intimate partner violence (IPV), which is also often called domestic violence, is a pattern of abusive behavior in an intimate relationship that is used by one person (who is usually a man) to gain or maintain power and control over the other person (who is usually a woman). It can be in the form of physical, sexual, emotional, economic, reproductive, spiritual or psychological actions or threats or stalking/monitoring. This includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound. Because the majority of IPV situations involve a husband or boyfriend abusing their female partner, this chapter will focus on providing support to women who are experiencing IPV, including married or partnered adolescent girls.



TRAINING MATERIALS

- **Module 15: GBV Case Management Responses to Intimate Partner Violence and Sexual Violence For Women and Adolescent Girls**

1.1 DYNAMICS OF IPV

Working on IPV cases is complex because of the ongoing exposure the survivor has to violence and how this impacts her physical and psychological safety and well-being. Understanding the dynamics of IPV and its consequences for women can help you provide non-judgmental and compassionate care. Some of the key aspects it is important for you to know are:

- IPV is deeply rooted in social norms and gender roles and expectations. In many communities, social and cultural norms as well as religious beliefs dictate that men own their wives and that it is acceptable to control, punish, humiliate and beat them.
- IPV is about power and control. Abusers find different ways—physical, emotional, psychological, reproductive, spiritual and economic—to control and dominate their wives and girlfriends and exploit the power they have as men in society and the family. An abuser makes threats, uses intimidation, coercion and often physical violence to instill fear in their wife/girlfriend so they can continue to control her.
- IPV is characterized by an ongoing cycle of violence that typically combines several types of abuse (such as physical and emotional) the abuser uses to achieve control over their partner. It is rarely a one-time event, but rather a continuum of connected incidents.
- There are many factors that contribute to or make it more likely for men to abuse. Abusers make calculated choices about with whom, when and where they are violent. It is important to remember: 1) these same men know how to control their aggression with other people; 2) there are many men who drink alcohol and who are under stress who **do not** abuse their partners. Abusers can control their behavior; they choose to be violent.
- Abusers will exploit a survivor's tendency to blame herself by telling her that it is her fault. This is a tactic abusers use to further control the survivor and stop her from getting help.

1.2 SAFETY ASSESSMENT AND SUPPORT

Survivors in IPV situations are at continuous risk of harm. In most humanitarian contexts, there will be few safe and sustainable options for a woman to permanently leave an abusive husband or partner. Traditional cultural and social norms and lack of resources make it unlikely that there will be a safe shelter or other permanent option for women to relocate safely. Furthermore, many women may not even consider leaving because they have been socialized to believe that being abused is normal and part of life as a woman.

Even if they want to leave, there are many barriers to doing so. Escaping an abuser is likely to be extremely dangerous for the survivor and others in her life. Perpetrators often stalk the survivor, track them down and make threats to anyone who may support them.⁴³

As such, you should never assume or communicate that leaving is going to be better for the survivor; do not advise her to leave. As a caseworker, your primary role in working with IPV survivors on safety is to focus on ways they can reduce their risk of physical violence and to help them think through what they would do if they had to leave temporarily or permanently.

At the same time, organizations and communities also have a responsibility to establish safety options for women and their children who are at risk of harm. This is part of the work that your organization can do through other aspects of its programme—such as advocacy through coordination groups, capacity building with community and government institutions that can play a role in the safety and protection of women and children, and longer-term social change interventions.

⁴³ Campbell, J. et. Al (2007). *Intimate partner homicide: review and implications of research and policy*. Trauma, Violence and Abuse. Jul;8(3):246-69.

1.2.1 IDENTIFY THE CIRCUMSTANCES IN WHICH THE SURVIVOR IS MOST IN DANGER

Each perpetrator has different patterns of abuse. Part of your safety assessment should be to identify and understand those patterns. Doing so can help the survivor better plan, avoid or respond to them. Some women will already know what the patterns are, others will need your help to think through the situation and uncover them.

You can use open-ended questions (such as those below) to encourage the survivor to carefully think through past instances of violence.

- Can you tell me about some of the times you have felt most unsafe around your husband/partner?
- What have you noticed about your husband/partner during those times when you feel unsafe? (What is he doing? What is his state of mind like?)
- What is happening around you during those times when you feel unsafe? (Are you in a particular place? Is it a certain time of day? Are you alone with him? If not, who is with you?)
- Have you noticed anything in particular that comes before the violence?

1.2.2 ASSESS RISKS OF ESCALATED VIOLENCE

Understanding the profile and past violent behavior of the abuser can help you and the survivor assess her current risk of danger. This is particularly important because of the increased risk a survivor is in once she reaches out for help. The risk assessment tool below can be helpful for assessing the level of present danger. It is a list of questions about the survivor's exposure to physical violence and risks of violence. Any item that the survivor answers "yes" to could put the survivor at increased risk of severe physical violence. With each additional "yes", the potential danger level increases. You must consider these factors when doing safety planning because it means that any action the survivor takes (including coming to see you) is extremely risky. You should only use this tool if you have been properly trained how to use it.

SAMPLE SCRIPT

To introduce the risk assessment, you can say:

I'd like to ask you some questions about the violence you have been experiencing and about your husband's behavior. Some of these questions may be hard for you to answer—just do your best and let me know when you need to take a break or if you don't want to answer something. Please tell me, 'yes,' 'no' or 'I don't know' when I ask the question.

IPV RISK ASSESSMENT

QUESTION	RISK
<i>Have you had serious injuries from the perpetrator in the past week?</i>	If the perpetrator has caused life-threatening injuries in the past, he is more likely to kill. (i.e. beating until the survivor loses consciousness, hitting abdomen during pregnancy, deep cuts, injury requiring hospitalization, etc.)
<i>How often is the violence happening?</i>	If violence is frequent (more than once per week) and/or starts to escalate and become more severe, the survivor may be in greater danger.
<i>Has the perpetrator threatened to kill the survivor or himself?</i>	Perpetrators who threaten suicide or homicide must be considered very dangerous. If the perpetrator has killed before, in or out of combat, he may be more dangerous as well.
<i>Is he obsessive, jealous or isolating? (e.g. says he can't live without her, is very jealous and accuses her of seeing other men, closely monitors her and stalks her when she tries to do her own activities)</i>	Survivor is likely to be more isolated, have fear of reaching out to anyone for help and be at extreme risk if she does.
<i>Does the perpetrator own or have access to items that may be used as weapons (knife, rope)?</i>	A perpetrator who owns or has access to weapons and has used them or threatened to use them in past assaults is more likely to use them again.
<i>Does the perpetrator use drugs or often drink too much?</i>	This is likely to impair his judgment.
<i>Does the perpetrator seem very sad or depressed?</i>	This may mean he feels hopeless and could increase risk or threats to his own life or the survivor's.

1.2.3 PLANNING FOR SAFETY

Once the survivor has identified potentially dangerous situations, she needs to develop an idea of how to react in those situations. Safety planning enables the survivor to proceed with a pre-determined course of action when she is in a life-threatening situation. Safety planning can help her minimize the harm done by the perpetrator by identifying resources means to avoid harm and places she can go temporarily for safety.

Usually survivors have some safety strategies already in place. The key is to find out what is already working for the survivor and build upon it. You can use the following questions to develop the safety plan together:

Identify her existing responses:

- **What do you do when you are in danger?** Discuss with her if and how this is working.

Identify her existing resources (people, money, materials):

- **Where could you go?** Help the survivor to think of at least one safe place she can get to quickly in an emergency. She should arrange things with that place ahead of time.
- **Whom do you trust?** Think about anyone (neighbors, friends, family members, an organization) that the survivor can trust. For example, discuss having a signal with helpful neighbors. Upon seeing this signal from the survivor, neighbors would plan to visit in a group.
- **What financial resources do you have?** Can she save money and hide it somewhere the abuser will never look or keep it in a designated safe place.
- **What material resources do you have?** Can any of these be moved out of the abuser's reach? Can any of them be used to support the survivor if she needs a means of income?

Explore potential safety strategies:

- **Who already knows about your partner's abuse?** The survivor may not be embarrassed to enlist the help of these people.
- **Is there anyone who can talk to the perpetrator at a non-violent time to try to discourage his violence?** There may be someone whom the perpetrator respects that could work with him to stop his use of violence. Even if temporary, it may give the survivor some respite.
- **What local authorities or police might you involve, and under what circumstances would you involve them?** Discuss with the survivor at what point she would report the perpetrator and involve authorities.
- **How can you involve your children?** If the survivor has children, what do the children do when the survivor and they are in danger? How can the survivor involve her children in safety strategies?

Discuss what would happen if she needed to/ decided to leave:

- **If you have to leave, what will you bring?** Consider important documents such as identification for her and the children, clothing, food, and money and how they will be carried.
- **If you have to leave, what will happen to your children?** If the survivor has children, what will be their role in the escape? Survivors almost always flee with their children, so it is important for the survivor to think about their safety and how much they are able to handle. If they will not go with her, what are the arrangements for their care?

- **Who else might be in danger if you had to leave?** Consider whether the perpetrator would take out his frustration on anyone else if the survivor left.

As the survivor begins to identify potential responses and resources, help her to plan exactly what she would do in dangerous situations. After she has identified all the resources she has, you can begin to discuss how they can be appropriately applied to these situations. Usually a survivor will have a more moderate plan for less threatening situations and a more drastic one for life-threatening situations. It is important to remember that the most dangerous time for any survivor of IPV is when she tries to leave, so having a plan already in place for the point at which she is going to leave, where she is going to go and who is going to be involved is critical for minimizing safety risks.

In summary, to assess and plan for safety with a survivor of IPV, you should:

- Get a sense of a survivor's perception of safety in her household.
- Find out the exact circumstances in which the survivor (and her children, if relevant) are in the most danger.
- Determine if the survivor is at risk of life threatening physical harm.
- Find out what existing strategies and resources the survivor has and develop a plan for safety that incorporates those resources.
- If relevant, help her identify strategies to include her children in safety planning.

1.3 PROVIDING INFORMATION AND SUPPORT

One of the most important ways you can help an IPV survivor is to provide accurate information about the causes and dynamics of IPV and the normal responses and feelings that a woman in an abusive relationship may have. Providing such information is helpful because it may reduce self-blame and shame about the violence she has been or is experiencing as well as validate and normalize her reactions to it. Be sure to adapt these messages as appropriate to your context and the survivor's situation.

1.3.1 KEY MESSAGES ABOUT INTIMATE PARTNER VIOLENCE

- *Intimate partner violence is a pattern of behavior in an intimate relationship (for example, in a marriage or dating relationship) that is used by one person in the relationship to gain or maintain power and control over the other person in the relationship.*
- *This type of violence or abuse can be physical, sexual, emotional, spiritual, reproductive, economic or psychological. It includes any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure or wound you.*
- *Intimate partner violence is all about power and control. Abusers (who are usually men) find different ways—physical, emotional, psychological, sexual, reproductive and economic—to control and dominate their wives/girlfriends and exploit the power they have as men in society and in the family. An abuser makes threats, uses intimidation, coercion and often physical violence to instill fear in their wife/girlfriend so that they can continue to control her.*
- *While it may seem like the abuser's use of alcohol or the stress that he is under are what is causing the abuse, they are not. Drinking alcohol may contribute to or escalate a violent episode, but it is important to remember that this is also a part of the abuser's methods to terrorize you. There are many men who drink alcohol and who are under stress that DO NOT abuse their wives.*

- *All types of women experience abuse from their husbands/boyfriends. It does not matter whether you're rich or poor, educated or not educated, old or young, or what ethnicity or religion you are.*
- *Women who have gone through what you are going through often blame themselves for the abuse and violence that is happening to them. It is common to think that if you changed your behavior or your appearance the abuse would stop. You may put the blame and responsibility on yourself. But it is important to know that the abuse does not happen because of anything that you did or anything you need to change. It is never your fault.*
- *This is really important to remember because the abuser will tell you things to make you think that it is your fault, but he is doing this to further control you and stop you from getting help. You may find that you are trying to change what you do to avoid an episode of violence. The reality is that there is nothing you can do to change his behavior and actions towards you. The abuser is the only one that can control his behavior.*

1.3.2 KEY MESSAGES ABOUT COMMON REACTIONS A SURVIVOR MAY HAVE

- *Women have many different feelings when they are in an abusive relationship. The different feelings are confusing and hard to understand. You can often feel opposite feelings at the same time. It's ok to have a lot of different feelings about what happened and about the person who has been abusing you or assaulting you, especially if it is your husband, or someone you knew well and trusted.*
- *It is common to feel a sense of shame, guilt and helplessness. You may feel that you cannot trust anyone anymore, and your view of the world and feeling of safety in it may have changed. These feelings can be really difficult. It makes sense that you feel them given what you have gone through.*
- *You may be feeling scared for your life and your children's. You may feel a lot of stress from living with this fear all of the time, and this can be harmful to your body and your mind.*
- *Because you may be in a constant state of fight, flight or freeze, it can become more difficult to make decisions and believe in your own ability to find safety. You may feel like you are unable to move. This is normal.*
- *Living with abuse all of the time may also make you feel badly about yourself. You may feel sad and not trust yourself anymore. You may feel isolated and that you do not have others in your life that love and support you. These are normal feelings to have because the abuser's words and actions are meant to make you feel this way.*
- *All of the feelings you have—whether anger, guilt, fear, love, hope, hopelessness, sadness, shame, confusion—are common and okay for you to feel.*
- *Sometimes these feelings affect how you behave. You may feel scared all of the time and feel like you cannot trust anyone. You may feel sad all of the time and want to cry. You may feel nothing or feel 'numb.' And you may not want to talk to anyone. All of that is ok.*
- *Talking about the feelings you are having and how they are affecting you with someone who is a good listener and can comfort you can be helpful.*

1.4 HOW TO APPROACH MEDIATION IN CASES OF IPV⁴⁴

Mediation is a process that is frequently used in customary law to solve disputes between community members, families and family members. In some cultures and contexts, cases of IPV are regularly 'settled' by traditional or religious leaders, as it is considered a private family matter. In general, mediation is **not recommended** as a response to IPV because of the safety risks that it poses for the survivor. Survivors seeking help from organizations responding to GBV may want their cases to be handled through mediation because they want the violence to

⁴⁴ International Rescue Committee (2015). *Women's Protection and Empowerment Case Management Guidelines*.

stop and may perceive mediation as a way to facilitate this. In some cases they may request that you, as their caseworker, carry out the mediation. Therefore, it is important that organizations have clear guidelines on how to respond to these requests in a way that is survivor-centred.

1.4.1 RISKS ASSOCIATED WITH MEDIATION

Mediation is not a recommended response for IPV cases because it is unlikely to stop the violence from happening in the long term and it has the potential to escalate violence, causing more harm to the survivor. Below are some risks that are important for you to understand:

- The mediation process itself maintains and contributes to the abuser's ongoing power and control over a survivor. The process of mediation presumes that both parties can speak freely, confidently and safely. However, given the tactics an abuser uses to maintain power and control over a survivor, and social norms that may not enable women to speak freely or consider their views to have equal weight or worth, it is unlikely that a survivor is going to feel that she can speak freely and without fear of consequences. It is also likely that just making a referral to mediation can cause harm to the survivor. The abuser may get angry that she has told others about the violence.
- Mediation rarely results in an end to the abuser's violence, and can actually lead to an increase in violence.⁴⁵ The violence will only end if the perpetrator chooses to stop being violent. A survivor cannot control the abuser's behavior, actions or choice to be violent. There is nothing the survivor can do to make the violence stop—only the perpetrator can do that.
- Those who are likely to 'mediate' within traditional justice mechanisms often hold prejudices against survivors and in favor of perpetrators due to social and cultural norms; this makes it unlikely that the survivor's rights will be respected.
- There is a high risk of survivor-blaming within the mediation process. The perpetrator, who is used to blaming the survivor, will have a platform to articulate his position, and given the cultural and social norms in place, and the fact the survivor may feel intimidated or scared to answer back, he may sound convincing. The survivor may be asked to change her behavior as a condition for violence reduction.

1.4.2 WHAT IS THE ROLE OF A CASEWORKER?

Despite the many risks associated with mediating IPV cases, in many settings this is the only potential recourse a survivor might have, and she may ask you for support in facilitating or carrying out mediation. While we can explain the risks associated with mediation, ultimately if the survivor still wants to continue, your goal is to support her in reducing her risk of further abuse or harm. This can be a difficult situation to handle, and understanding your role in these circumstances is incredibly important.

- **Never mediate a case.** Even if a survivor requests that you do this, you should never mediate. Your role is always as an advocate for the survivor—trying to play an 'impartial' role and negotiate with the abuser compromises your relationship with the survivor. It is also a safety risk for you and your organization.
- **Understand how such a process works in your context.** Gather information about who is involved in mediation and what the process is likely to be. Be aware of local laws and procedures regarding mediation. Local authorities are not always up-to-date on new regulations that may prohibit mediation or restrict the role of the mediator to a trained judge or other official in cases of IPV. Also try to understand what the likely outcomes will

45 Dunnigan, A (2003). Restoring Power to the Powerless: The Need to Reform California's Mandatory Mediation for Victims of Domestic Violence, 37 U.S.F. L. REV. 1031, 1052.

be—for example, paid compensation or a written agreement to stop the violence. Getting this information will help you determine if/how you can influence the situation and will help you prepare the survivor for what to expect.

→ **Provide information to the survivor.** Discuss with the survivor how mediation works, risks linked to mediation, her rights, and other options available to her.

→ **Influence key actors.** As GBV caseworkers, you may be able to influence mediators or mediation mechanisms that operate in your area and build better processes for survivors. Always assess the safety risks for both you and the survivor of doing any of the below:

- Work with mediators in advance of the session to ensure the survivor’s needs and wishes are taken into account, including pre-mediation meetings between the survivor and the mediator.
- Work with mediators to ensure they understand the complexities of IPV, and the risks associated with the mediation process. Make them aware of the power imbalance between the abuser and the survivor and encourage them to manage the behavior of the abuser. It will be important for them to understand how experiences of violence might affect the agreement the survivor considers making with the perpetrator. Even if the survivor appears to agree in front of the abuser, this does not necessarily mean that the mediation process was free from fear or intimidation.
- Work with community leaders, if appropriate, so they also understand the complexities of IPV and the role they can play in protecting the survivor in a mediation process.

→ **Support the survivor.** You should expect to support the survivor before, during and after the mediation process.

- Make sure she knows how the mediation process works and what information she will need to share.
- Discuss the options available in mediation that can make the process fairer, for example:
 - Limiting community participation, having a private session, and/or choosing a few support people to join her.
 - Allowing the option of a public setting if the survivor wishes. Having others know about the violence and mediation resolution could help her feel safer. However, this may also make the perpetrator angrier (if he feels he is shamed in public), so this needs to be thought through carefully.
 - Allowing the survivor to prepare a written statement to share as her opening statement. This way the survivor can speak more clearly in the mediation session and feel less intimidated.
- If you can attend the mediation session, check in with the survivor during it to ask how she is feeling, whether she needs a break, whether she would like to stop the mediation process, etc. If you cannot attend, help her identify a supportive person who can be there for her during the process.
- Assist the survivor with safety arrangements. For example, ask influential community leaders (at the survivor’s request) to attend the mediation process if she thinks it will make it safer. Discuss whether she wants to arrive to and leave the mediation without the perpetrator.
- Plan with her what she will do if she is unhappy with the agreement or is worried that the agreement will only lead to more harm for her.

1.5 IDENTIFYING AND RESPONDING TO RISKS FOR CHILDREN IN IPV SITUATIONS

Children living in families where there is intimate partner violence may also experience violence or be at risk of violence from the abuser. In addition to direct safety risks, they can also be deeply impacted emotionally, psychologically and developmentally. Abusers may also manipulate and use children as part of their abuse and control tactics with the survivor.

If an IPV survivor seeking your services has children, it is important for you to understand whether the children are also being abused and to discuss options with the survivor for their immediate and longer-term safety. You will need to approach this conversation with care, being careful not to blame or judge the survivor if you discover that the children are also being abused. It is important to remember that she is likely doing all that she can to protect her children from being harmed. Some considerations for responding to the needs of children are:

- Understand the mandatory reporting laws and requirements in your context with respect to identifying child abuse. Laws may require that you report the existence of abuse in the household to child protective authorities. You will need to understand what is likely to happen to the children and the survivor if you make such a report. You will need to explain all of this from the beginning when you discuss mandatory reporting with the survivor during the informed consent process.
- Understand the short- and long-term safety and protection options for children and families in your context. Are there services or options that exist only for children? What about for the mother and children to stay together? Be sure to get information on the processes for securing such services and protections (criteria, how long it takes, whether it costs money) as well as the safety risks of pursuing such options.
- Incorporate questions and strategies related to the survivor's children into safety planning. This does not mean that safety planning becomes focused only on the children, but it will be important for the survivor to think through what options exist to keep her children safe and what she would do if their risk of harm should escalate.
- Discuss with the survivor the option of referring her children to a child protection agency or program that can engage the children in services to support their physical and mental health.
- If you make a referral to a child protection agency or other group, be sure to coordinate your services closely to avoid duplicating questions, providing different information, or overburdening the survivor with follow-up sessions or discussions.



HELPFUL TO KNOW

Understand Trends in Intimate Partner Violence

Reviewing data on the services you provide, for example data from the GBVIMS can help you understand important trends in IPV in your setting. Knowing the age group of the survivor, relationship to the perpetrator, incident location, time elapsed between incident and report, referral pathway (paying particular attention to declined services), and stage of displacement may help you improve your services. For example, it may help you understand if your outreach is those most affected by IPV at the most convenient times or improve your services by making sure they are accessible and safe for the survivors you are seeing or help you think about how to increase accessibility for those your services are not currently reaching.

1.6 ORGANIZATIONAL ROLES IN RESPONDING TO IPV

Because of the complexity of IPV, its ongoing nature, and the continuous safety risks it presents for both survivors and staff it is important that organizations are very clear on their roles and responsibilities in responding to IPV.

Ensure staff have in-depth training on IPV

- As discussed, IPV is an incredibly complex problem with deep psychological and emotional consequences for the survivor, and ongoing safety risks for the her, possibly her children and sometimes for staff. Organizations providing GBV services have a responsibility to ensure that their staff and volunteers are well trained on the causes, consequences and dynamics of IPV before assigning cases to staff.
- This includes training other staff in the organization who are not GBV caseworkers but who may become involved in such cases through other programs and services such as health, mental health or child protection. Organizations should ensure that there are clear, agreed-upon internal protocols on how IPV cases will be managed and coordinated.

Staff safety

- In addition to having policies that create clear boundaries and mitigate risks for GBV caseworkers, organizations need must put practices in place for emergency situations in which a caseworker may be at risk of harm from a perpetrator, family member or community member due to the support they are providing to the survivor. It should be clear that staff are expected to consider their own safety as well as the survivor's when they are planning for accompaniment, follow-up, and other actions with and on behalf of the survivor.

Policies and protocols on mediation and working with perpetrators

- Organizations providing services to GBV survivors should have a clear policy on mediation. The policy should state that GBV caseworkers should not carry out mediation or any similar practices that involve working with the survivor and perpetrator together.
- In addition, some caseworkers may determine that it is not safe for them to provide advocacy support for a survivor who is going through a mediation process (i.e. liaising with community or family members involved in the mediation). They may know the perpetrator, perpetrator's family or the mediator and thus be worried about their own and their family's safety. Supervisors should support caseworkers in prioritizing their safety and work with the survivor to provide alternative options (e.g. identify someone else who can help).

CHAPTER 2

GBV CASE MANAGEMENT WITH WOMEN AND ADOLESCENT GIRL SURVIVORS OF SEXUAL VIOLENCE

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- How sexual violence affects women and adolescent girls
- Specific ways to support women and adolescent girls who have experienced sexual violence

Sexual violence is any sexual act that is forced, including forcing someone to do something they do not want to do or when they do not want to. There are many forms of sexual violence, including sexual harassment, sexual exploitation, forced or unwanted touching, attempted rape and rape. Sexual violence has serious long-term consequences on women's physical, sexual and reproductive health and mental health. It is a deeply violating and painful experience for the survivor. Depending on the form of sexual violence, women and adolescent girl survivors are likely to need support that addresses the life-threatening health consequences, as well as support to help them cope with the aftermath of the incident. This chapter will highlight information that is important to consider when working with women and adolescent girl survivors of sexual violence.



TRAINING MATERIALS

- **Module 15: GBV Case Management Responses to Intimate Partner Violence and Sexual Violence For Women and Adolescent Girls**

2.1 BARRIERS TO CARE

Survivors of sexual violence will face many barriers to accessing care and support. They may not tell anyone what happened because they:

- Feel shame and embarrassment
- Blame themselves or fear blame by others

- Want to protect the perpetrator
- Think what happened is normal
- Fear harm from perpetrator or his family
- Know there is a possibility that the response from family, community and authorities could be so negative that they could be blamed, stigmatized, ostracized, punished and, in extreme cases, even killed
- Fear they will not be believed or will not be treated well
- Lack proof that the incident/s occurred
- Do not think what has happened is a crime or that it is serious enough to report to the police
- Do not know how to report
- Doubt that the justice system will provide redress.

In addition, women and adolescent girls in humanitarian settings may face considerable practical barriers to accessing care and support even if they do disclose, including:

- Lack of transportation
- Lack of money to pay for services or transportation to access services
- Lack of childcare
- Lack of awareness of services
- Isolation

These barriers are magnified for adolescent girls, who may already be significantly isolated or controlled within their families or by their spouses if married.

2.2 PROVIDING INFORMATION AND CARE

2.2.1 HEALTH INFORMATION AND CARE

In sexual violence cases for women and girls, the primary health concerns are related to incidents of rape, sexual assault or forms of non-sexual physical assault that may result in acute injury, pain and bleeding. Women and girls may be at risk of HIV/STIs, unwanted pregnancy and injuries. The health services that should be available in response to rape and sexual assault are described in **Part II, Chapter 3**. They include medication to prevent HIV, emergency contraception, testing and treatment for STIs, and treatment of injuries or wounds.

Be sure to share information about the health consequences of GBV with the survivor, particularly in the case of sexual violence. Doing so will help the person understand the reason for a medical referral and help them determine if it is something that they need. You should share the following with them:

- Rape (if there was vaginal penetration) can lead to an unwanted to pregnancy.
- Rape or attempted rape can put the person at risk or HIV or other STIs.
- Rape and sexual assault could result in injuries or tears to reproductive organs.
- There may be helpful prevention medication and treatment available. Some of these are time-sensitive.

Facilitating access to other health services. Women and adolescent girls may also benefit from other sexual and reproductive health services. While the primary concern should be to address the immediate health consequences of rape or sexual assault, once the survivor's medical situation is stabilized and if you continue to work with her, you may be able to assess other needs and facilitate access to care.

Other health needs and services may include:

- Menstrual health and hygiene:
 - Providing information about menstrual health and hygiene, particularly for adolescent girls who may not yet have an understanding of menstruation.
 - Ensure access to menstrual hygiene materials. Find out if the survivor has access to these materials. If not, provide her with sanitary kits or facilitate her access to them through other services. Women's and girls' safe spaces should maintain a basic reserve of menstrual hygiene materials.
- Information on family planning and access to family planning methods.
- Facilitating access to safe abortion services or post-abortion care, depending on the laws related to abortion and the availability of safe services in your context.
- Pre- and post-natal care.

2.2.2 SAFETY SUPPORT

Women and girls who disclose sexual violence may be at high risk of further violence or harm from perpetrators, people protecting perpetrators, or members of their own family due to notions of family 'honor'. Unmarried adolescent girls and unmarried women may be at particular risk of violence from family and community members due to norms related to virginity and a woman's purity and value. As with any GBV survivor, you will want to assess safety needs, carry out safety planning, and facilitate access to any services that may keep the survivor safe. You should work closely with the survivor to:

- Assess what her concerns are related to safety, paying close attention to whether the perpetrator has access to her, who knows about the incident, who knows that she has come for help, and what the reactions of family members are likely to be.
- Help her identify the risks of further harm and whether there are ways for her to mitigate those risks.
- Provide her with information about safety services that may be available in the community and facilitate her access to these services.

2.2.3 INFORMATION ABOUT COMMON REACTIONS TO SEXUAL VIOLENCE

Survivors of sexual violence may have the following responses after an experience of sexual violence:⁴⁶

- Shock, fear and feelings of helplessness and powerlessness
- Feelings of personal safety are shattered
- Physical symptoms (trembling, headaches, feeling very tired, not being able to eat or drink, not being able to sleep)
- Confusion, disorientation

46 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

- Feelings of detachment and being outside one's body
- Sadness and crying
- Being withdrawn
- Not speaking at all
- Not being able to care for themselves or their children.

Psychological distress can be very high in the first few weeks, particularly if the incident was an assault.

Understanding that survivors of sexual violence may have these reactions is important in order to support them with empathy and non-judgment. It is also important that survivors understand these responses are normal and common.

Providing survivors with accurate information about sexual violence and its impact can help reduce their self-blame and shame, and can help them better cope with what happened. It will be helpful to provide the following information:

- An explanation of what sexual violence is, why it happens and who perpetrates it
- How survivors may feel after the incident(s), common reactions and normalizing these reactions
- Survivors' tendencies to remain silent about abuse

Key messages you may want to share with survivors are provided below. Remember that this is just suggested language; you will have to adapt the messages according to your context, the type of sexual violence experienced and the age of the survivor.

What sexual violence is:

- *Sexual violence is any sexual act that is forced or that someone is made to do when they do not want to. There are many forms of sexual violence, for example, harassing comments made towards you that are sexual, being exploited for sex, being forced to do something sexual that you do not want to do, having parts of your body touched without your consent, and being forced to have sex when you did not want to (rape).*

Why sexual violence happens:

- *Sexual violence happens because of the perpetrator's need to control, humiliate and harm. Perpetrators use sexual violence as a weapon to hurt and dominate others.*



HELPFUL TO KNOW

A survivor will react differently depending on:

- Their age (for example, children of different ages and levels of development will react differently)
- The nature and context of the violence (for example, was the perpetrator known and trusted, was the abuse ongoing, was violence used, were there multiple perpetrators, did the survivor fear for her life?)
- The level of social stigma or acceptance (for example, whether she was blamed for what happened)
- Whether the person is believed and taken seriously (for example, whether she was accused of lying)
- Whether she has support and resources to meet her needs (for example, if she needs medical care, is she able to access it?)
- If there is a safe environment in which she can recover
- Whether she can exercise some control and choice in responding to the violence
- Whether the violence happened on top of previous abuse or trauma

- *Sexual violence does not happen because men have sexual urges they cannot control.*
- *The perpetrator can be someone you know, like your relative, a close family friend or someone trusted in the community. Or it could be a complete stranger. Most of the time it is someone you know and trust. Perpetrators take advantage of the fact that you may already know and trust them in order to bring you closer to them and to keep you silent. It is part of the abuse.*
- *It is important to remember that sexual violence also happens in intimate relationships, including marriage. It is often one of the ways abusers humiliate, torture and control.*
- *Sexual violence can happen to all types of people—rich or poor, educated or not educated, married or unmarried.*
- *The important thing to remember is that being sexually assaulted is not your fault; it's not about what you look like, what you wore, or anything that you did or did not do.*

How you may feel:

- *You may have many different feelings. The different feelings are confusing and hard to understand. You can often feel opposite feelings at the same time. It's ok to have a lot of different feelings about what happened and about the person who has abused or assaulted you, especially if it is your husband or someone you knew well and trusted.*
- *It is common to feel a sense of shame, guilt and helplessness. You may feel that you cannot trust anyone anymore and that the world is not safe. These feelings can be difficult. It makes sense that you feel them given what you have gone through.*
- *It is common to be in shock, and you may not be able to fully grasp what has happened.*
- *All of the feelings you have—whether anger, guilt, fear, love, hope, hopelessness, sadness, shame, confusion—are common and okay for you to feel.*
- *Sometimes these feelings affect how you behave. You may feel scared all of the time and like you cannot trust anyone. You may feel sad all of the time and want to cry. You may feel nothing or feel 'numb.' And you may not want to talk to anyone.*
- *You may also feel very distrustful of others and like you are always vulnerable to something else bad happening.*
- *Talking about the feelings you are having and how they are affecting you with someone who is a good listener and can comfort you can be helpful.*

Why many survivors do not tell someone what happened:

- *There are many reasons why people do not tell anyone they have been assaulted.*
- *Sometimes the perpetrator threatens you and says things like, "If you tell anyone, I'll hurt you," or they threaten to hurt your children or other people in your family. And so you may be afraid of more violence or abuse if you do tell someone.*
- *The abuser/perpetrator may tell you that no one will believe you if you tell. And you may begin to believe that this is true.*
- *Sometimes you don't tell anyone because you are ashamed, embarrassed or afraid that you may get in trouble.*
- *Telling someone about what has happened to you takes a lot of courage and strength. It is a brave step that can also feel scary and confusing. The first step in getting help is to tell someone.*

2.3 CONSIDERATIONS FOR ADOLESCENT GIRLS

The principles, skills and interventions outlined in this chapter apply to working with adolescent girls who have experienced sexual violence. However, you will need to alter your engagement and work with adolescent girls based on their level of development and maturity and her situation. In-depth information on this can be found in the *Caring for Child Survivors of Sexual Abuse Guidelines*.⁴⁷ Below are some helpful reminders:

- Use simple, clear language. Do not use professional jargon, terms or phrases. Some organizations have communication materials such as videos and pamphlets that describe their services. If these materials are available, use them to introduce the idea of individual services. If not, you can speak with the girl using simple language to describe services.
- The need to work with parents, caregivers or other trusted adults and the issues this raises related to safety and confidentiality.
- Informed consent processes for engaging an adolescent girl in services or referring her to other services will also be different than with adult women. The consent process will be different depending on the age of the girl. If the girl is between the ages of 6 and 11, you will obtain informed assent—an agreement from the girl that she wants to receive services. You will then have to get informed consent from the girl's caregiver. If the caregiver is not supportive or if reaching out to the caregiver is deemed to not be in her best interest, another trusted adult or the girl's caseworker can provide written consent for services. The same process applies to girls aged 12 to 14. However, depending on the maturity of the girl, her consent for services can be given 'due weight', meaning that consideration can be given to her views and opinions based on factors such as her age and maturity. For girls ages 15-17, informed consent must be obtained from the girl and, if possible, from her caregiver.
- Understand any mandatory reporting laws that exist for children in your context and how they apply to adolescents and what the potential safety risks may be if followed.
- Use best-interest principles to guide decision-making and actions.
- Age-appropriate referrals and the capacity of service providers to work with adolescent girls.
- If girls are married, the need to potentially advocate with husbands (if they are not the perpetrator and it is safe to do so) to allow them to access services.



HELPFUL TO KNOW

The Best Interests Procedure

Where UNHCR and partners support national governments in protecting refugee children, the Best Interests procedure is often used in case management for children at risk. As such, in refugee settings, it may be appropriate (and in some cases necessary) to use the Best Interests procedure for cases of GBV involving children. This particularly applies to cases where children may need to be separated from their parents against their will, but it can be a useful process for other complex cases involving children. For more information on the Best Interests procedure, see UNHCR, *Guidelines on Determining the Best Interests of the Child*.

<http://www.unhcr.org/protection/children/4566b16b2/unhcr-guidelines-determining-best-interests-child.html>

⁴⁷ International Rescue Committee and UNICEF (2012). *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. <http://gbvresponders.org/response/caring-child-survivors/>

CHAPTER 3

GBV CASE MANAGEMENT FOR CHILD/EARLY MARRIAGE

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- The risk adolescent girls face of child/early marriage
- How caseworkers can support girls at risk of child/early marriage and girls who are already married

Adolescent girls who come to our centres for services or with whom we work in targeted programming may be at risk of or already involved in child, early or forced marriages (referred to in this resource as early marriage). The international definition of an early marriage is based on the international definition of a child, which is under the age of 18. The Universal Declaration of Human Rights recognizes the right to “free and full” consent to a marriage, acknowledging that consent cannot be “free and full”

when one of the individuals involved is not sufficiently mature to make an informed decision about a life partner. **Thus, early marriage is defined as a formal or an informal union between two people in which one or both parties is below the age of 18.** Most countries around the world have laws that set a minimum age of marriage, usually age 18. However, many countries provide exceptions to the minimum age of marriage, for example, if parents consent or with authorisation of the court. Other exceptions allow customary or religious laws that set lower minimum ages of marriage to take precedence over national law.

In many settings, early marriage is deeply embedded in cultural and social practices. In humanitarian settings, families may also be more inclined to marry their girls at young ages for financial reasons, or to “protect” the girl from risks of sexual violence in the community. Working on cases of early marriage requires an incredibly sensitive and careful approach that supports the girl and does not put her at risk of harm.



TRAINING MATERIALS

→ **Module 16: Case Management Responses to Adolescent Girls and Child/Early Marriage**

3.1 WHAT IS THE ROLE OF A CASEWORKER?

While it may be difficult to accept, it is **not** the immediate role of a GBV caseworker to directly intervene to stop an early marriage from happening. Such an approach can have harmful unintended consequences for the girl you are trying to help and is potentially dangerous. When you identify girls in your day-to-day work who may be at imminent risk for early marriage or who are already in such marriages, the best response is to understand their situation and what they want to happen, assess and plan for safety, provide information and support, and connect the girl to people and services that will be supportive and useful. Depending on the context, there may be community or other actors or services that could help to prevent the marriage if that is what the girl wants. Furthermore, just as with all GBV case management responses, you must always prioritize the girl's safety. If a girl is facing an immediate safety threat because of the marriage or because she is trying to escape the marriage, connect her with services that can provide short-term protection and potentially lead her to a longer-term protective option.

3.2 APPROPRIATE CASE MANAGEMENT RESPONSES

Just as with any case management response, it is important to begin the process by getting consent/assent from the girl to work with her. Follow the guidance from the previous chapter for your informed consent procedures. The process you follow thereafter will depend on the girl's situation— whether she is already married or whether she is currently at risk of an early marriage. The next sections outline appropriate case management responses for both of these situations.

3.2.1 FOR 'IMMINENT RISK' CASES

"Imminent risk" refers to girls who are not yet married but whose parents are in the process of negotiating her marriage or are actively planning it. The recommended case management response for these cases is:

Understand how the girl feels about the marriage

Some girls initially feel excited about getting married because they get to have a celebration and they often think that they will have more freedom when married than under their parents' care. Some girls may specifically ask you to help stop the marriage, and you will need to be clear that while you cannot directly intervene, you will discuss strategies and options with her and develop a plan that will promote her safety.



CONTEXT CLUE

Early marriage within the national legal frameworks

It is important that you understand the legal framework for early marriage in your context. In contexts where early marriage is against the law, organizations may be required to report an early marriage case to the authorities. You and your organization must understand whether you are obligated to report in your context, because it will have legal and safety implications for the girl and her family and could impact your own safety.

Where the legal framework allows child marriage, for example from the age of 16 with parental consent, it is also important to understand the implications. For example, understanding what rights are afforded to the girl if the marriage is legally registered and facilitating that legal registration may be important to create protections for her in the future. You may be able to advocate with parents to wait until the girl has left school or turns 18, for example.

Provide information

It's important that girls are educated about the longer-term impacts of early marriage for them. You can discuss this information, or use any communication materials your program has available. The purpose of sharing this information is to prepare her for the reality of being married at her age. You may want to start with an open-ended question such as *"How do you think getting married will impact your life?"* or *"What do you think will change for you once you are married?"*

The key pieces of information that you should sensitively share with her in an age appropriate manner are:

- Getting married at her age will likely restrict her freedom. Girls who get married young usually do not get to see their friends as much and are not allowed to attend school anymore.
- Many girls who get married will be expected to have sex before they want to, and because of power dynamics within the relationship, sex will likely not be based on their own willingness or consent—and it may well be physically forced. Given that most often the men to whom girls are married are older and sexually experienced, this could put the girl at increased risk of HIV and other STIs, particularly when there is physical force.
- Many girls give birth within the first year of marriage, when their bodies are not fully matured. There can be serious health consequences from this.
- Girls in early marriages are more likely to experience intimate partner violence.

Sharing this information with an adolescent girl should be done sensitively and with compassion. The information is not intended to scare her, but rather make sure she has accurate information about the consequences.

Organizations working with or planning to work with adolescent girls should think about how they can share information with girls in an age appropriate way and invest in equipping staff with the skills to do so.

Determine whether there is a supportive family member or other trusted adult in her life

Work with the girl to try to identify an adult in her family, close to her family or another adult whom she trusts and with whom she could safely share her feelings about the marriage. This could be a parent or caregiver, or someone else.

You can support her to do this by role-playing with the girl so she can practice how she would speak to this person, what she would say, etc. Be sure that you thoroughly assess with her the risks that may be involved if she shares her feelings with this person (e.g. How will this person react? What would happen if family members knew that she spoke to this person?). Help her plan for when she will have the conversation with this person. Identify a time and place to follow up with her to see how the conversation went.

→ If the supportive person identified is the parent, and you assess it is safe to do so, engage the parent.

If the parent with whom the girl speaks has a supportive and caring response, and you assess that it will be safe to do so, you can engage the parent in a joint or one-on-one session. Again, this should be approached with caution by assessing with the girl what would happen if you speak to her parent.



HELPFUL TO KNOW

Understanding Trends in Early Marriage

If you are reviewing service-based data, like the GBVIMS, for trend analysis on adolescent girls and early marriage, there are several points to consider. First, it may be helpful to look at data points on age at time of incident, if the survivor was age 10-18 or 10-24 (depending on context), married, type of violence reported, relationship to the perpetrator, referral pathways, and stage of displacement. It may also be crucial to look at time elapsed between incident and report, as this can give clues about movement restrictions, or knowledge or willingness to seek services. Reviewing these trends may provide clues about the context of violence for early marriage.

If you proceed, explain to the parent that you understand that they are planning to marry the girl, and you want to make sure that you provide information that will help keep her healthy and safe in the future. The conversation must be held in a completely non-judgmental manner. You want to make the parent feel comfortable so that you can better understand the circumstances influencing their decision to marry their daughter at an early age. Once you have been able to establish rapport with the parent, some of the ways you can directly engage are:

- **Understand the family and environment circumstances that are contributing to the early marriage decision. Assess and listen for:**
 - What are some of the reasons for the marriage?
 - At what stage are they in the process?
 - How did the family choose the groom? Do they know his reputation and history?
 - Who is the ultimate decision-maker on the marriage?
 - Who in the family is supportive of the marriage?
 - How does the parent view the marriage?
 - Is she/he able to identify both positive and negative consequences of the marriage?
- **Support the parent in thinking through the pros and cons of the early marriage.** For example, in some contexts, the fact that the girl skipped years of school after displacement is often used as a rationale for early marriage—the alternative being that she is kept at home waiting. What would be the advantages of her restarting school, even if she missed a few years? Are there advantages for the family (e.g. is she fed at school or can she learn a skill that can help her earn money for the family)? Are there any success stories in the community of girls who stayed in school that the parent knows or that you can share with them?
- **Provide information** to the parent about health, safety, and psychosocial consequences of early marriage. If they find this information useful, work with them to identify the best way to share the information with other members of their family who have decision-making power and influence. Key pieces of information for the parent are:⁴⁸
 - Early marriage restricts girls' freedom, isolates them from peers and ends their education prematurely.
 - Girls are often wed to men who are older and more sexually experienced; young brides lack power and are more likely to experience intimate partner violence.
 - They risk exposure to HIV and other STIs. Eighty percent of unprotected sex among adolescent girls in the developing world occurs within marriage.
 - Because girls married young are likely to give birth within one year of marriage and their bodies may not be fully developed, they are more likely to experience complications in childbirth.
 - Information on the legal framework, where relevant. This should be provided in a non-threatening way so that the family is not encouraged to marry the girl in another location or clandestinely. It is intended to serve as an argument for waiting until the girl is older, when more protections will be afforded her and her family members.

→ **If the person the girl identifies is not the parent, but a trusted adult, engage that person.**

If the adult with whom the girl identifies she can speak with is not a parent, but has a supportive and caring response, and you assess that it will be safe to do so, you can engage this adult in a joint or one-on-one session. Again, this should be approached with caution by assessing with the girl what would happen if family members knew that she or you spoke to this person.

48 Interagency Youth Working Group (2011). Addressing Early Marriage of Young and Adolescent Girls. <https://www.iywg.org/sites/iywg/files/y134e.pdf>

- With this person, carefully assess the family relationships and this person’s degree of influence over decision-makers in the family.
- Explore with this adult whether he/she thinks one of the girl’s parents or caregivers would be willing to speak with you, and if so, what the best process would be for doing so. **It is very important that you carefully assess the risks of doing this. If the supportive adult has any concern that speaking to the parent or caregiver will negatively impact the girl, then you should not do it.**
- Instead, continue to work directly with the supportive adult, supporting her/him to have conversations with the parent or caregiver. **Be sure to get the girl’s consent before having the supportive adult speak with the parent or caregiver, and determine whether she wants to be present for this discussion.** As always, carefully assess whether this will be safe for the girl. Support this person in having a conversation with a decision-maker in the family about the girl’s marriage, providing accurate information about the consequences for the girl. You can review with the person what they would say and role play with her/him.

You can also identify any respected community leaders or people close to the family who support delaying or stopping the marriage and feel comfortable speaking to family members with decision-making power. This person needs to be very careful how they approach the discussion and should not mention that the girl spoke with anyone about her marriage. Be sure to discuss any unintended consequences of such an intervention with the parent, caregiver, or supportive adult whom you have engaged (i.e. think through any potential negative reactions that could result in more harm, how to handle these risks, etc.).

Remember to always discuss with and get consent from the girl before you take any of the above actions.

3.2.2 RISK REDUCTION

If, following your engagement of the girl and a parent or other trusted adult, it remains likely that the marriage is going to move forward, your goal must be to prepare the girl to navigate her new relationship and environment in a way that minimizes her risk of violence and health complications. To focus on risk reduction, you should:

- **Assess:**
 - What are her feelings now about the marriage?
 - What are her questions/concerns?
 - What are the potential risks for her, particularly related to safety and health? This should include questions about the person she will be marrying, and whether she recognizes any signs that he may be abusive.
- **Carry out safety planning.** You will want to do safety planning with the girl if you identify together that there are current or potential safety risks from either her future husband, family members or community members. Follow the steps for safety planning that are provided in **Part II, Chapter 3**.
- **Provide information and make potential referrals.**
 - **Reproductive health.** It is incredibly important that you discuss and help the girl understand her sexual and reproductive health. If you feel that you do not have the appropriate skills or knowledge to do this, be sure to identify a reproductive health expert who can provide this information, and get the girl’s consent to have this person speak to her. It will be important that she understands pregnancy and contraception methods. You also want to make sure that she understands that sex, even within a marriage, should be consensual. You or the reproductive health expert can practice with her how she will communicate with her new husband about having sex. If your organization has group activities or information sessions for adolescent girls that provide information on reproductive health, you can also refer her.

Or your organization could arrange for a reproductive health expert to come to your centre to provide an information session to groups of girls, on a regular basis.

- **Legal information/support.** Depending on the context, you may also want to provide her with legal information or make a referral to an organization that can. She should be provided with accurate legal information about her rights and protections under national and customary law, including if she wants to stop the marriage from happening, or if once she is married she wants to escape the marriage or get an official divorce.
- **Keep or get the girl involved in supportive services** so that you (or your organization) can maintain a relationship with her and provide opportunities for her to be around other girls, make friends and build a social support system.
- **Help the girl identify a supportive person in her life.** It is best if this is someone that she can see on a regular basis and who she can talk to about her worries, fears and problems.
- **Help her identify positive coping strategies.** Ask the girl what she is currently doing to help herself when she feels sad or upset. Help her connect to those existing practices and help her identify new ones that build on her sources of support in her life, activities that bring her joy or calm and that build on her strengths.
- **Advocate for the girl.** If it is safe to do so, speak with the parent, caregiver or supportive adult about ways to take into account the girl's best interests within the marriage negotiation such that her right to access education and health care is preserved.
- **Continue to engage a supportive adult.** If the marriage is going forward, it is even more important that the girl have a supportive adult in her life. If it is safe to do so, you can discuss with a parent, caregiver, or other trusted adult to ensure that she/he knows the consequences of early marriage, some of the safety risks, and how to support the girl moving forward.

3.2.3 RESPONSES TO EXISTING EARLY MARRIAGES

Girls who are already married and not currently seeking your services as survivors of violence also require our support. If your organization is already working with adolescent girls or is planning to, create the opportunity and space for married girls to become engaged in your group services, which may eventually allow for individual engagement with them such that you can provide support regarding their situation as a young wives and mothers.

Once a girl consents to individual services, individual responses should be focused on understanding and responding to the girl's current needs and supporting her to minimize her risk of violence and health complications. With these cases, you can use a standard survivor-centred approach to case management, focusing the assessment on safety, health, psychosocial status, and economic well-being. Some key assessment points to which you want to be particularly attuned are:

- **Sexual relationship:** Is there forced sex within the marriage? Is she in any pain because of sexual intercourse? Is their risk for HIV?
- The girl's understanding of reproductive health and her own body.
- **Pregnancy:** Is the girl pregnant? If so, what does she want to do? Has she had appropriate medical care? Does she have anyone helping her through the pregnancy? Does the girl have other children and/or know how to provide care to a newborn?
- Is there intimate partner violence?
- Is there violence from other family members?
- **Access to money:** Who is earning it? Who is controlling it?

- Is she still allowed to attend school?
- Does she have a social support system?
- How does she feel about the marriage in general?

Your assessment will inform the development of an action plan with a range of responses. You should also:

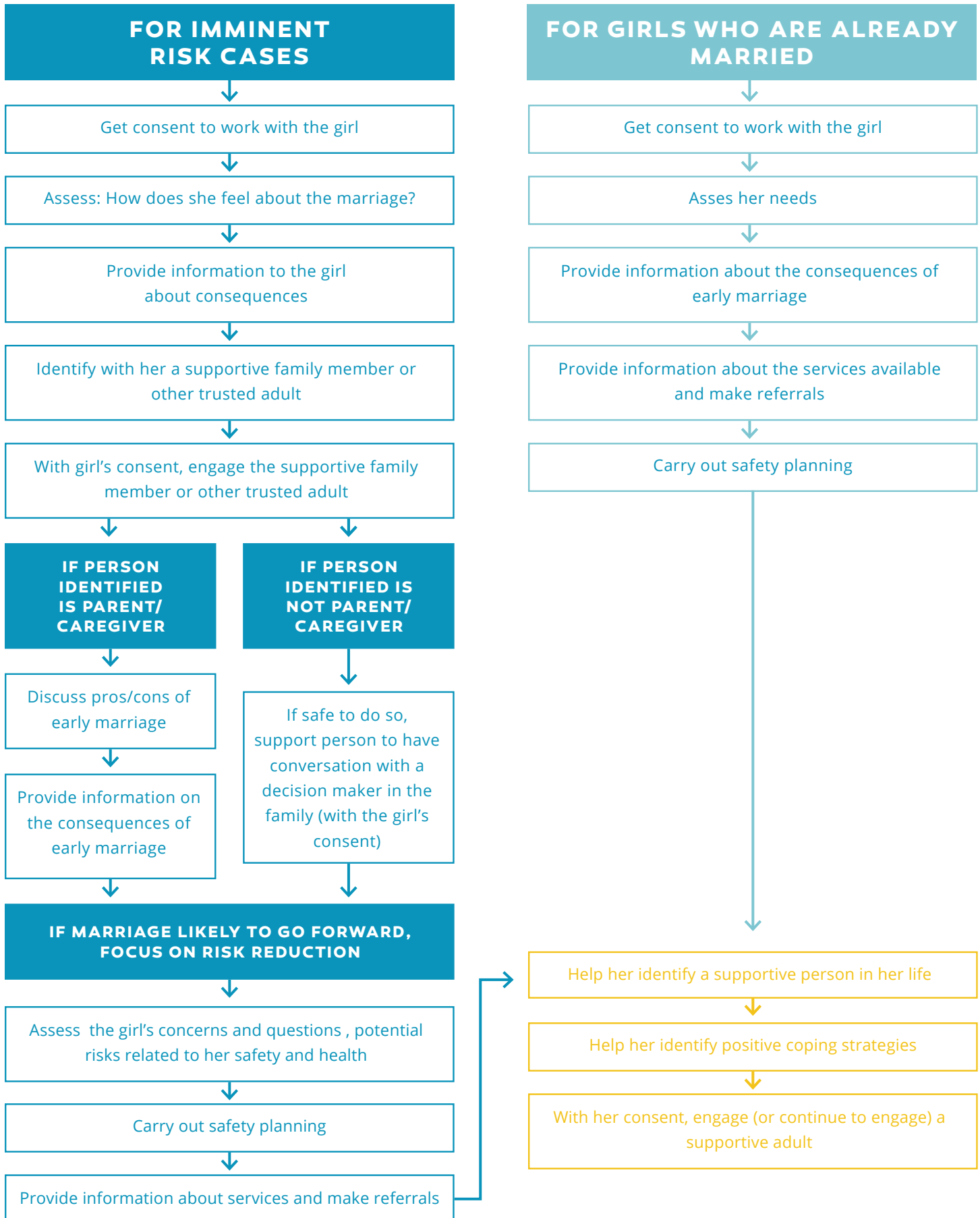
- **Provide information to the girl about:**
 - The health, safety and psychosocial consequences of early marriage
 - Health and reproductive health services, safety and protection and psychosocial services and any other relevant support available
 - Legal counseling or services so that she can understand her rights within the marriage and options should she want to leave.
- **Carry out safety planning.**
- **Help the girl identify a supportive person in her life.** It is best if this is someone she can see on a regular basis and who she can talk to about her worries, fears and problems.
- **Help the girl identify positive coping strategies.** This can be as simple as asking her what she likes to do, what brings a smile to her face, or what helps calm or soothe her. Discuss with her if she is doing these things now and if/how they are working. Discuss with her how she may be able to use these strategies when she is feeling down or upset.
- You can still try to work with a supportive adult to ensure that the girl has a positive and caring adult in her life and that you have some contact with this person.

There may be cases in which girls cannot identify a supportive adult in their lives. You may be the only person she trusts. In such cases, it is best to focus on preserving the girl's access to you and your programme's services rather than trying to directly engage another person. If you engage a caregiver or other adult who does not react well to you discussing the early marriage with her/him, they may decide they do not want their daughter to attend your activities. You do not want to jeopardize the girl's freedom to come to a place and be with people who are supportive of her.

Responding to early marriage cases, whether they involve imminent risk cases or girls who are already married, requires strong case management skills and knowledge on how to work with adolescent girls. These are often complicated cases and caseworkers should always bring in a supervisor for support when needed.

The chart on the following page provides a summary of the appropriate case management responses to early marriage discussed in this chapter.

CASE MANAGEMENT RESPONSES TO EARLY MARRIAGE



PART IV

GBV CASE MANAGEMENT WITH OTHER VULNERABLE GROUPS



Meredith Hutchison / International Rescue Committee

CHAPTER 1

GBV CASE MANAGEMENT WITH LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX SURVIVORS

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Terms and definitions that are important for working with survivors who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI)
- Barriers these survivors may face to accessing care
- Providing care and support in a safe and welcoming manner for LGBTI survivors

In many societies, people who identify as lesbian, gay, bisexual, transgender, or intersex (LGBTI) are at risk of persecution, discrimination and violence as a result of their real or perceived sexual orientation, gender identity or gender expression.⁴⁹ UNHCR has documented that in refugee situations, LGBTI refugees frequently face additional hardships, persecution and harm. Often, LGBTI individuals are specifically targeted in their home countries due to their sexual orientation and gender identity. Once in refugee camps, LGBTI refugees may be among the most isolated and marginalized individuals in the camp due to their fear of being further ostracized and harmed. They may be at risk of sexual violence that is specifically perpetrated as a hate or bias crime. They can also be at risk of sexual violence and/or intimate partner violence. This chapter provides information and guidance on providing care and support to an LGBTI person who has experienced sexual violence or intimate partner violence. It is intended to support organizations that are already or actively planning to provide GBV services to the LGBTI community and should be accompanied by appropriate training.



TRAINING MATERIALS

→ **Module 17A: GBV Case Management with LGBTI survivors**

49 UNHCR. (2011). *Working with lesbian, gay, bisexual, transgender & intersex persons in forced displacement*.

1.1 IMPORTANT TERMS AND DEFINITIONS⁵⁰

Having a basic understanding of common terms and definitions is an important first step in being able to provide supportive services to people who identify as LGBTI.

The concepts of sexual orientation and gender identity are important to understand. All people have a sexual orientation and a gender identity. But sexual orientation and gender identity are not the same thing.

Sexual orientation tells you about a person's sexual and romantic attractions. Common words to describe sexual orientation are below.

- **Heterosexual** describes someone who is attracted to people of a different sex or gender. For example, a man who is attracted to women; a woman attracted to men.
- **Homosexual or gay** describes someone who is attracted to people of the same sex.
 - **Gay** is often used to describe a man whose physical, romantic and/or emotional attraction is to other men, although the term can be used to describe both gay men and women. While the term "homosexual" may be used in some places, note that, in English, many people consider this an outdated term that should be avoided.
 - **Lesbian** describes a woman whose physical, romantic and/or emotional attraction is towards other women.
- **Bisexual** describes people who have the capacity for physical, romantic and/or emotional attraction to person(s) of the same sex or gender, as well to person(s) of a different sex or gender.
- Some people describe their sexual orientation in other ways. For example, some may use the term "queer" instead of lesbian, gay or bisexual. This term is considered inclusive of a wide range of sexual orientations and gender identities.

Gender identity refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond to the sex assigned at birth or the gender attributed to them by society. It describes whether individual people think of themselves as a man, a woman, or in some cases, another gender.

Transgender is an umbrella term used by people whose gender identity, and in some cases gender expression, differs from what is typically associated with the sex they were assigned at birth, including people whose gender identity is neither 'male' nor 'female' as traditionally defined. Transgender people may undertake 'transition', which is the process of changing one's external gender presentation in order to be more in line with one's gender identity. This is a complex process that typically occurs over a long period of time. Transition includes some or all of the following personal, medical and legal steps: telling one's family, friends and co-workers; using a different name and new pronouns; dressing differently; changing one's name and/or sex on legal documents; hormone therapy and possibly (though not always) one or more types of surgery. The steps involved in transition vary from person to person. Many transgender people do not undertake transition, so it is important not to make assumptions based on a person's appearance alone.

Transgender people can have any sexual orientation. For example, a transgender woman can be attracted to men, and might therefore consider herself heterosexual. But this person may also consider herself gay. Sexual orientation and gender identity are two distinct concepts, and only the person themselves can identify and confirm their sexual orientation. Never assume you can tell someone's sexual orientation based on their appearance.

Gender queer is a blanket term used to describe people whose gender identity falls outside the male-female binary. It can also describe persons who identify as both male and female (bigender), don't identify with any gender (agender) or identify as a mix of different genders (e.g. male, female and agender on different days).

⁵⁰ National LGBT Health Education Center. (2015). *Providing Welcoming Services and Care for LGBT People*.

Intersex is a term used to describe a person with bodily variations in relation to culturally established standards of maleness and femaleness, including variations at the level of chromosomes, genitalia or secondary sex characteristics. Intersex is sometimes termed “differences in sex development.”

These terms are important concepts to learn. But, not every LGBTI person will fit neatly into one of these categories. In addition, some people may identify as one of these categories but not with these particular terms.

1.2 BARRIERS TO CARE⁵¹

Many of the barriers an LGBTI survivor of GBV may have to accessing care are similar to those of other survivors, but they may be experienced slightly differently. There are also some unique barriers to care.

- **Safety.** In contexts where LGBTI identity, expression and/or association are criminalized or where there is prevalent homophobia, biphobia and transphobia that could likely lead to more violence, an LGBTI person is unlikely to seek help out of fear they will be harmed.
- **Shame and self-blame.** An LGBTI survivor may experience familiar and natural survivor reactions, such as feelings of embarrassment, guilt, self-blame or vulnerability. The person may feel like they did not “defend themselves enough” or should have been able to “take care of themselves”. This reaction can be particularly strong for male-identified (transgender, bisexual, and gay men) and masculine-presenting survivors, who may feel that their gender has been challenged or threatened by the assault. These feelings may prevent them from seeking help.
- **Fear of being “outed”.** LGBTI survivors may fear that in the process of seeking help, they may be “outed” — meaning that other people will find out their sexual orientation or gender identity, which may result in further stigma, shame or re-victimization.
- **Lack of support network.** People who identify as LGBTI may already be isolated from family/friends/ community. This could be because their family, friends or community knows of their sexual orientation or gender identity and does not support them, or it could be that their family and friends do not know and so the person is unlikely to seek help from them. In situations of IPV, the abuser may also use threats to “out” the person as a means of keeping them from seeking help. The abuser/perpetrator may share a support system, common friends, social spaces and connections to the same organizations, events, etc. as the survivor, making it difficult for the survivor to disclose without the abuser/ perpetrator knowing.
- **Fear of being blamed.** Family, law enforcement, medical and social service providers may blame the survivor’s gender identity and/or sexual orientation for what happened.
- **Previous negative experiences.** If the person has had negative experiences with helpers and other service providers in the past, they will be unlikely to seek care again.
- **Lack of awareness.** The lack of visibility of issues regarding LGBTI sexual violence or IPV can result in a lack of awareness, information, education and resources.
- **Lack of specialized services.** In most humanitarian settings, particularly those that are low-resource, emergency settings or in countries where LGBTI identity, expression and/or association is criminalized, it is unlikely that there will be specialized services. This makes it more difficult for survivors to feel that they will be safe and supported when they access care.

51 Anti-Violence Project. *Working with LGBT Victims of Violence*. http://www.avp.org/storage/documents/Training%20and%20TA%20Center/GAGV_Working_with_LGBT_Victims_Handout.pdf

1.3 PROVIDING CARE AND SUPPORT: SPECIAL CONSIDERATIONS⁵²

As a caseworker working in an organization that is already providing or planning to provide specialized services to LGBTI survivors, your job, just as with all survivors, is to listen, convey warmth, non-judgment and empathy, and provide information and support to the person. However, there are some specific ways that you can make your support and services more welcoming and safe for an LGBTI survivor.

- **Deal with your own feelings about LGBTI people.** You will find it difficult to help a survivor if you have not thought about and addressed your own biases surrounding LGBTI people and violence perpetrated against them. If your own personal beliefs or biases are getting in the way of being non-judgmental, you should not be doing direct services with them. Supervisors will need to assess this with staff before they start working with LGBTI persons to ensure that their services do not do harm.
- **Do not assume the survivor's gender or sexual orientation.** LGBTI survivors may not initially (or ever) disclose their gender identity, sexual orientation or intersex status with you. It is easy to slip into gendered and heterosexual-specific assumptions and, for example, recommend a women's support group to a survivor with a feminine voice but who does not identify as a woman. As much as possible, take cues from the person, and if you are not sure, ask them what resources they think would be best for them.
- **Use language carefully.** Using the right words can help establish a trusting relationship; the wrong ones can make a bad situation worse by building new barriers to care. Take cues from the person. If you are unsure of which pronouns to use (for a survivor or their partner/s), you can ask the person what their preference is.

Suggestions include:

- Avoid assuming that people have an opposite sex partner or spouse. For example, instead of: "Do you have a boyfriend or husband?" Ask: "Are you in a relationship?"
- Use the terms that the survivor uses to describe themselves and their partners. For example, if someone calls himself "gay," do not use the term "homosexual." If a woman refers to her "wife," then say "your wife" when referring to her; do not say "your friend."
- It is also important to use the right pronouns if you will be talking about the person (for example, if you are making a referral over the phone or in person). Use the pronoun that the individual prefers. If you do not know, ask the person.
- **Do not ask unnecessary questions.** Before asking any personal questions, first ask yourself: "Is my question necessary for the person's care, or am I asking it out of my own curiosity?" If it's for your own curiosity, it is not appropriate to ask. Think instead about: "What do I know? What do I need to know? How can I ask for the information I need to know in a sensitive way?" You should be careful not to create a situation where the survivor is educating you on LGBTI issues.
- **Do not "out" the survivor to other staff, support group members, etc.** It is up to the survivor to decide who and when to tell others about their sexual orientation and/or gender identity. Ask permission before disclosing to another staff person, which you should only do if it is clearly relevant for the care and support of the survivor.
- **Reassure the survivor that their reactions are normal.** Let them know that their responses and feelings are okay. Many survivors feel afraid and alone, wondering if they are normal. Offer continued assurance that you will support the survivor and that you are able to hear their story.
- **Support the survivor.** Just as with all GBV survivors, the support you provide may be the only safe haven in which this person can begin to heal. Let them take the lead; do not press for details if they seem reluctant or unwilling to disclose them. Offer support, and if the assault occurred within an intimate partner relationship,

52 Scott et. al (2012). *Supporting Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI) Survivors of Sexual Assault*.

discuss a safety plan. If appropriate and available in your context, help the survivor to locate services that are designed for LGBTI people or that are LGBTI-friendly. If the assault occurred in the context of a hate/bias crime, help them access protection or to report if they are interested, but do not push them to do so.

1.4 SAFETY

Safety will be a key consideration for LGBTI survivors, particularly in contexts where there are laws that criminalize LGBTI identity, expression and/or association. Even in countries where identifying as LGBTI is not illegal, negative social norms may make it dangerous for the person's status to be known in the community. In addition to the safety assessment and planning guidance provided in **Part II, Chapter 2**, you will want to consider the following in your safety planning with LGBTI survivors.

- In many contexts, LGBTI persons are unlikely to receive positive support from police or other protection services due to homo/bi/transphobia, and in the case of hate/bias crimes, these actors may be the perpetrators. Be sure you have extensively explored with the person their current and past experiences with the police and other authorities, as well as safety risks, before you and the survivor include them in the safety plan.
- Due to the stigma involved in identifying as LGBTI, the person may not have a support network and already be isolated. This may make it difficult for the person to come up with people whom they can trust and can go to for safety.
- LGBTI survivors may be at high risk of suicide, particularly if they have been ostracized from family and community and are isolated. This does not mean you should assume that an LGBTI survivor is suicidal, but you should carefully look for warning signs, and as with any survivor, take expressions of suicidal thoughts seriously.

CHAPTER 2

GBV CASE MANAGEMENT WITH MALE SURVIVORS OF SEXUAL VIOLENCE

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- **Barriers male survivors may face to accessing care**
- **Providing care and support in a safe and welcoming manner for male survivors of sexual violence**

As discussed in the Introduction, in humanitarian settings, men and boys may also be at risk of sexual violence. Sexual violence against boys and men is often committed by other men in the context of armed conflict or ethnic violence as a means of emasculating men and disempowering their families and communities. Boys may also be at risk of child sexual abuse, usually perpetrated by family members or other men who are known to the child.

As with violence against women and girls, violence against boys and men often goes underreported. Traditional masculine norms may make it difficult for men to disclose and seek help, and may also result in a lack of compassionate responses from family, friends and service providers. Many of the impacts of sexual violence on men and boys are similar to those experienced by women and girls (see **Part III, Chapter 2**). There are, however, some particular experiences that service providers should understand in order to best serve this population.

This chapter will focus on working with adult men who have experienced sexual violence. The *Caring for Child Survivors of Sexual Abuse Guidelines* provide guidance on how to work with boys who have experienced sexual abuse. In the previous chapter, considerations for men who identify as gay or transgender have also been discussed and should be used, as relevant, in conjunction with the information in this chapter. Remember, too, that the *Clinical Care of Sexual Assault Survivors* resources referenced in **Part II, Chapter 3** have specific guidelines for the care of male survivors of sexual violence.

Organizations primarily set up to provide services to women and girls, and/or that do so through women's centres, will need to have clear procedures for how to respond to any disclosures from men. Protocols need to be in place for referring the case to a service provider with appropriate service entry points for men (for example, a health actor who has been trained in clinical care for male survivors, or another protection or mental health actor). If such options are not available, your organization can work with the survivor in an alternative location, such as a nearby health clinic.



TRAINING MATERIALS

→ **Module 17B: GBV Case Management with Male Survivors of Sexual Violence**

2.1 BARRIERS TO CARE⁵³

Many of the barriers to care experienced by men are similar to those previously discussed in relation to other survivors of sexual violence, though may be experienced slightly differently.

Some particular examples of barriers to care for men are described below. Remember that these are generalized and likely to vary from context to context. If and how they are experienced will depend upon specific cultural and social norms and survivor characteristics, such as ethnicity, religion, socio-economic status and sexual orientation.

- **Traditional masculine norms do not promote help-seeking.** Traditional norms of masculinity that pressure men to always be strong, in control, independent and not express emotions make it less likely for them to seek help, even when they have experienced a stressful event.^{54,55}
- **Feelings of shame and fear of stigma.** Related to the masculine norms discussed above, male survivors may experience strong feelings of shame and may fear being stigmatized for what has happened to them. This is particularly the case if the masculine norms in their environment suggest that men must be powerful and sexually dominant.
- **Concerns and fears about sexuality.** A common myth in some settings is that male survivors of sexual violence perpetrated by men are gay or will become gay. There is no evidence to suggest that an experience of sexual violence influences sexual orientation. However, if this myth is commonly believed, and if homophobia is prevalent in a community, male survivors may not seek help because they are grappling with these questions themselves and/or fear the reactions of others. This can be a particularly significant barrier to help-seeking in societies where homosexuality is criminalized.
- **Fear of not being believed.** Due to traditional masculine social norms, male survivors may fear that they will not be believed if they tell someone about what they experienced.
- **Risk of substance abuse.** Using alcohol or other drugs as a way to manage or numb emotions may be even more common among male survivors as a result of norms that discourage men from acknowledging and expressing emotion.

2.2 PROVIDING CARE AND SUPPORT: SPECIAL CONSIDERATIONS

As a caseworker or helper, your job when you are working with a male survivor, just as with any GBV survivor, is to listen, convey warmth, non-judgment and empathy, and provide information and support to the person. However, keeping in mind the above barriers to care and the guidance below can help you tailor your services to make them safe and supportive for male survivors.

- **Do not make assumptions about the person and their experience.**
 - Many male survivors may be in denial about what they experienced and may not be ready to identify as a “victim,” “survivor” or someone who has experienced “trauma.” Respect the language they use to describe themselves and their experience.
 - You should never assume the sexual orientation or gender identity of the survivor or perpetrator. This is particularly important because some male survivors may be asking themselves about their sexual orientation or gender identity as a result of the assault.

53 Rape, Abuse, and Incest National Network (2011). *RAINN Hotline Volunteers Training*.

54 Lindinger-Sternart, S. (2015). *Help-Seeking Behaviors of Men for Mental Health and the Impact of Diverse Cultural Backgrounds*, *International Journal of Social Science Studies*, 3(1).

55 Vogel, D., Heimerdinger-Edwards, S., Hammer, J. H., and Hubbard, A. (2011). *Boys don't cry*. *Journal of Counseling Psychology*, 58, 368-382.

- Do not assume that a male survivor will want to speak with a male caseworker. Given that the perpetrators of violence are often men, they may be more comfortable speaking to a female caseworker. Be sure to ask their preference.
- **Validate and reaffirm their strength.** Just as with other survivors, it is important for male survivors to hear that they were brave and strong to come for help. By emphasizing this, you are helping to reduce their fears and concerns related to the stigma of men reaching out for help.
- **Communicate that they are not alone and that it is not their fault.** Because of the significant stigma, it can be important for male survivors to know that other men experience sexual violence, and that they are not the only ones that this happened to. This can also help to reduce any self-blame.
- **Reassure the person that their reactions are normal.** Let them know that their responses and feelings to what happened are okay and that they are normal to feel. Male survivors may need to hear in particular that feelings such as sadness and fear—which traditional masculine norms often don't allow men to feel or express—are normal. Reassure them that it is safe for them to express their feelings—whatever they are—and that you will be there to listen.
- **Do not be judgmental about substance abuse.** If you are working with a survivor who is using alcohol or other drugs, do not shame them for doing so or try to stop them from using. It is important that you understand that this is one of their ways of coping, even though it may be harmful to them and others in their lives. The best thing you can do is acknowledge that they must be in a lot of pain, discuss other more positive coping strategies they may have, and provide them with information about mental health services or programs that may be helpful. This approach applies to any GBV survivor struggling with substance abuse.

2.3 SAFETY

Male survivors of sexual violence will face many of the same safety risks as other survivors. In addition to the safety assessment and planning guidance provided in **Part II, Chapter 2**, you will want to consider the following in your safety planning with male survivors.

If the incident of sexual assault is known to others in the community or the authorities, the person may be at risk for further violence. Finding formal or community-based sources of protection and security for the person might be very difficult and even the act of seeking such support could put the person in danger.

The significant stigma that male survivors may experience may make it difficult for the person to come up with people whom they can trust and can go to for safety. In cases where the person is at imminent risk, this may mean you have to play a more active role in suggesting options to the person that can help with immediate safety. You should go through each option carefully to understand what the risks could be and help the person choose the option that poses the least risk.

Connecting the person to services and programs that facilitate connection with other may also help the person begin to build sources of support from which they could draw in the future.

CHAPTER 3

GBV CASE MANAGEMENT WITH SURVIVORS WITH DISABILITIES

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Barriers that persons with disabilities may face to accessing case management services
- Dynamics of abuse and violence against survivors with disabilities
- Communication strategies for working with survivors with disabilities
- Providing care and support in a safe and supportive manner for survivors with disabilities
- Working with caregivers of persons with disabilities in a safe and ethical manner

Approximately 15 per cent of any community may be persons with disabilities.⁵⁶ There may be even higher rates of disability in communities that have conflict or natural disasters, as people acquire new impairments from injuries and/or have limited access to health care. The World Health Organization reports that rates of violence are 4-10 times greater among persons with disabilities than non-disabled persons in developed countries.⁵⁷ This has significant implications for their protection in humanitarian settings.

Research from humanitarian contexts has demonstrated that the intersection of gender, disability and displacement increases the risk of violence for women, girls, boys and men with disabilities and their female caregivers. Women with physical disabilities who are isolated in their homes report rape and intimate partner violence. Women, girls, boys and men with intellectual and psychosocial disabilities are also more vulnerable to sexual violence in humanitarian contexts, due to a lack of information and awareness about GBV and gaps in protective peer networks. In addition, women and adolescent girls, who disproportionately assume caregiving roles in households with persons with disabilities, may be exposed to harassment and exploitation when seeking assistance or accessing income.



TRAINING MATERIALS

→ **Module 17C: GBV Case Management with Survivors with Disabilities**

⁵⁶ World Health Organization and The World Bank. (2011). *World report on disability*. Geneva: WHO.

⁵⁷ *Ibid*, p. 59.

Attitudes of families, GBV service providers and community members are the biggest barrier and the biggest facilitator to persons with disabilities accessing safe and effective case management services and assistance.⁵⁸

In this chapter, you will receive information about the barriers faced by persons with disabilities, risk factors for violence, considerations for communication adaptations, key issues related to informed consent and decision-making, and how to work with caregivers in a way that is safe and empowering for the survivor.

3.1 UNDERSTANDING DISABILITY

Disability happens when a health condition interacts with societal barriers that make it difficult to do everyday things and participate in community life in the same way as others. Article 1 of the UN Convention on the Rights of Persons with Disabilities states that:

"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

Persons with disabilities include those who have:

- **Physical impairments:** This includes individuals who have difficulty moving. Some individuals with physical disabilities will use assistive devices, such as a wheelchair or a cane, to conduct daily living activities.
- **Sensory impairments:** This includes individuals who are deaf or have difficulty hearing, as well as individuals who are blind or have low vision (finding it difficult to see even when wearing glasses).
- **Intellectual impairments:** This includes individuals who live with neurodevelopmental disabilities, also known as cognitive or developmental disabilities. Intellectual impairments refer to intellectual functioning (such as learning, reasoning, problem-solving, etc.) and adaptive behavior (the conceptual, social, and practical skills that are learned and performed by people in their everyday lives).
- **Psychosocial disabilities:** This includes individuals who experience mental health difficulties which, in interaction with discrimination and other societal barriers, prevent their participation in the community on an equal basis with others.

Persons with disabilities are not a homogenous group. The risk factors for experiencing GBV, the dynamics of the violence, and how you work with the survivor will depend on an individual's age, gender, access to support networks and type of impairment, among other factors.

3.2 RISK FACTORS FOR VIOLENCE⁵⁹

The causes of GBV against persons with disabilities are rooted in the inequalities and power imbalance between men and women, and the inequalities associated with disability. The following factors have been identified as increasing the vulnerability of persons with disabilities to GBV in humanitarian contexts:

58 International Rescue Committee and Women's Refugee Commission. (2015). "I see that it is possible": Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. <http://gbvresponders.org/wp-content/uploads/2015/06/Building-Capacity-for-Disability-Inclusion-in-Gender-Based-Violence-Programming-in-Humanitarian-Settings-v2.pdf>

59 Ibid.

- **Perceptions about capacity of persons with disabilities.** Perpetrators may perceive that persons with disabilities will be unable to physically defend themselves or effectively communicate and report incidents of violence, which makes them a greater target for violence. People may not listen to persons with disabilities or believe them when they disclose violence, especially if the survivor has intellectual or psychosocial disabilities. Furthermore, persons with intellectual disabilities are often assumed to be incapable of learning the same concepts or participating in the same activities as other people, and are thus excluded from opportunities to learn about violence, sex and healthy relationships, and to develop new skills and strengthen peer networks. As such, they may be more easily manipulated and targeted for rape, abuse and exploitation, or have less capacity to negotiate power in intimate relationships.
- **Social isolation.** Depending on the level of stigma associated with disability in the community, families of persons with disabilities may hide or isolate the individual, which increases their risk and vulnerability to violence, particularly inside the home, and limits their options to report or seek outside assistance.
- **Loss of familial and community support mechanisms.** During displacement, families and communities may become separated and traditional community support structures weakened, which disproportionately affects persons with disabilities and their families. This is particularly relevant in new displacement contexts, where individuals and families have not yet established relationships and trust with others in the community or rebuilt their support systems. Persons with disabilities may rely on assistance from less familiar family or community members, which oftentimes adds to their risk of violence. They may also have fewer people they trust and can turn to for support if they experience violence.
- **Exaggerated issues of power and control.** Issues of power and control may be more complex in relationships in which one person has a disability, particularly if the caregiver is also the intimate partner. In addition to the dynamics of intimate partner violence discussed in **Part III, Chapter 1**, dynamics and tactics of power and control that may be used against persons with disabilities (though not limited to intimate partners) are:⁶⁰
 - Abusers may threaten to not take care of the person or withhold basic care and support from them (food, money, hygiene) or leave the person unattended.
 - Abusers may threaten to or withhold, misuse, or delay specific support that helps the person function (e.g. medication, equipment).
 - Abusers may use the person's money for themselves and/or make financial decisions for them without their consent.
 - Abusers may isolate the person from social networks.
 - Abusers may ridicule and embarrass the person because of their disability.
 - Abusers may blame the person with disabilities for their own stress (e.g. as a result of having to care for them).

60 Wisconsin Coalition Against Domestic Violence. <http://www.springtideresources.org/resource/power-and-control-wheel-people-disabilities-and-their-caregivers>

3.3 BARRIERS TO CARE⁶¹

Survivors with disabilities are likely to face many barriers to accessing care and support. Some of these barriers are described below:

- **Stigma and discrimination:** Social norms discriminate against and stigmatize people with disabilities. They may be ostracized or neglected in their communities and fear seeking support from family and community members. Service providers may also exclude persons with disabilities based on beliefs that GBV prevention and response services are not relevant to or appropriate for persons with disabilities, or out of fear of engaging with persons with disabilities. For example, there is a common myth is that people with disabilities are asexual, and thus they may not receive adequate education about sexuality, healthy relationships and personal safety.
- **Communication barriers.** Information about GBV and response services may not be presented in formats that are accessible for persons with disabilities, including those with visual, hearing and intellectual/ psychosocial disabilities. As a result, persons with disabilities, especially those with intellectual disabilities, may not recognize abuse when it occurs or may not know where to access support. These barriers are exacerbated if an individual has been isolated from the community, making them unable to access informal information networks.
- Furthermore, helpers and service providers may not be trained in accessible forms of communication, preventing them from communicating clearly and respectfully with persons with different types of impairments or communication preferences. This hinders the implementation of a survivor-centred approach, reduces the quality of care provided to the survivor, and discourages individuals from continuing case management support.
- **Relationship with caregivers.** Persons with disabilities may rely on other family or community members to access services and assistance, which makes it difficult for them to access services in a confidential way. If the caregiver is the perpetrator, it will be extremely difficult for the survivor to access help because they are dependent on the caregiver for communication, transportation and daily needs.
- **Fear of not being believed.** As with all GBV survivors, a common barrier to care is the survivor's fear that they will not be believed. This is even more exaggerated for survivors with disabilities, particularly those with intellectual disabilities, whose comprehension and decision-making capacity may be inappropriately questioned. These survivors may fear that if they tell someone, they will not be believed and may put themselves at added risk of further harm.
- **Physical barriers.** GBV prevention and response services may be physically inaccessible due to long distances, lack of accessible transportation or the costs associated with reaching facilities. Furthermore, health clinics and women's centres may not be accessible for wheelchair users or those with other mobility challenges, which may also convey a message that services are not welcoming of persons with disabilities.
- **Challenges to confidentiality.** Persons with disabilities in refugee settings have reported that confidentiality is rarely maintained when a survivor has a disability, as others may have come to their assistance during the incident and the news will often spread quickly throughout the community. Survivors may need to disclose to others in order to access services, and GBV staff may need to involve a wider range of actors in case management processes. This lack of confidentiality and fear of further stigmatization can deter survivors from disclosing and create additional barriers to accessing services and assistance.

61 International Rescue Committee and Women's Refugee Commission. (2015). "I see that it is possible": Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. <http://gbvresponders.org/wp-content/uploads/2015/06/Building-Capacity-for-Disability-Inclusion-in-Gender-Based-Violence-Programming-in-Humanitarian-Settings-v2.pdf>

- **Administrative and policy barriers.** Survivors with disabilities in some contexts have reported being asked to return at a later date or go through lengthy administrative processes when trying to access some services. This is a particular challenge for these survivors as they may face greater difficulties returning to the facility due to more limited resources, less independence and obstacles in accessing transportation.

3.4 PROVIDING CARE AND SUPPORT: SPECIAL CONSIDERATIONS

3.4.1 COMMUNICATION

In most cases, survivors with disabilities can communicate directly with helpers or service providers with no adaptations, or relatively small adaptations, such as identifying someone who can interpret their form of sign language or by using simplified language in discussions. In other cases, it may be less clear what the best way to communicate with a survivor is, and additional steps may be required to determine this. When working with persons with disabilities who find it difficult to communicate you should:

- **Take time, watch and listen.** If you are in a context where you will be able to see a survivor more than once, remember that case management is a process, not a one time event. Each time you meet the person you will learn something new about them and understand better how they communicate and what they mean.
- **Always talk directly to the individual,** even when a caregiver is present. If you are still establishing communication methods with the person and need to ask for advice from the caregiver, make sure that you have these conversations in front of the individual, so they can hear what is being said and participate in any way possible. Remember that people who can't speak or move may still understand what is happening around them and what people are saying about them.
- **Pay attention to any way in which the individual wishes to communicate.** This could be through gestures and sometimes their emotions. Some persons with intellectual and psychosocial disabilities can exhibit a wide range of behaviors. This is sometimes the way they communicate with others. If you observe or sense the person is trying to communicate with you, but you don't understand, it is okay to say "I don't understand."
- **Do not put pressure on the person.** Often times survivors with intellectual and developmental disabilities regress to a lower level of understanding/functioning when under stress. Always respect the individual's readiness to speak about incidents. As with any survivor, beware of unconsciously replicating dynamics of power and control by pressuring the survivor to disclose information they are not yet ready to talk about.

3.4.2 INFORMED CONSENT AND DECISION-MAKING

The Convention on the Rights of Persons with Disabilities highlights that persons with disabilities have the same rights as everyone else to make their own decisions, and that appropriate measures must be taken to support them to exercise their legal capacity. An individual cannot lose their legal capacity to make decisions simply because they have a disability.⁶² **You should initially assume that all adult survivors with a disability have the capacity to provide informed consent independently. Always ask the individual whether they would like to access support to make an informed decision.**

If you are working with a person with whom you are having difficulty communicating, ask yourself the following key questions:

- Did you try more than one method of communicating the information? Have you given them time to process this information and ask questions?

⁶² Convention on the Rights of Persons with Disabilities. <http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

- Are you able to determine whether the survivor understands the information provided and the consequences of decisions they may make? How did you determine this? (e.g. through questions, discussions, gestures or other forms?)
- Have you been able to ensure that the survivor's decisions are voluntary and not forced or coerced by others? How did you determine this?

(Is a caregiver or family member already involved? if so, how? are they answering the questions you ask with consulting the survivor?)

If after reflecting on these questions you are still unsure of a survivor's capacity to consent independently, you should involve a supervisor to help you determine whether there is a need to provide additional support for informed consent. You can discuss taking the following next steps with your supervisor:

- **Consider involving a trusted support person.** Family members, caregivers and peers of persons with disabilities can be a valuable resource in facilitating understanding and communication with the person. If you determine that it is safe to do so, ask the survivor's permission to include someone they trust in your discussion as a way of supporting communication and enhancing the survivor's ability to provide informed consent. Let the survivor identify who they would like to involve, and watch for any signs that they agree or disagree with the suggestions being made by the support person. You will need to carefully check that the support person does not take over the decision making process.⁶³ More information on working with caregivers is provided in Section 3.4.3 below.
- **Evaluate the best-interests of the survivor.** Ultimately, if you are still unsure of the survivor's capacity to consent at any point in the case management process, then you can use the following guiding principles to identify decisions that are in the best interest of the survivor.
 - **Safety:** Does the decision/action protect the survivor from potential abuse (physical, emotional, psychological, sexual, etc.)?
 - **Empowerment:** Is the decision/action in line with the best interpretation of the will and preferences of the survivor?⁶⁴
 - **Cost-benefit analysis:** Do the potential benefits of the decision/action outweigh the potential risks?
 - **Healing:** Does the decision/action promote the survivor's overall healing, growth and recovery?

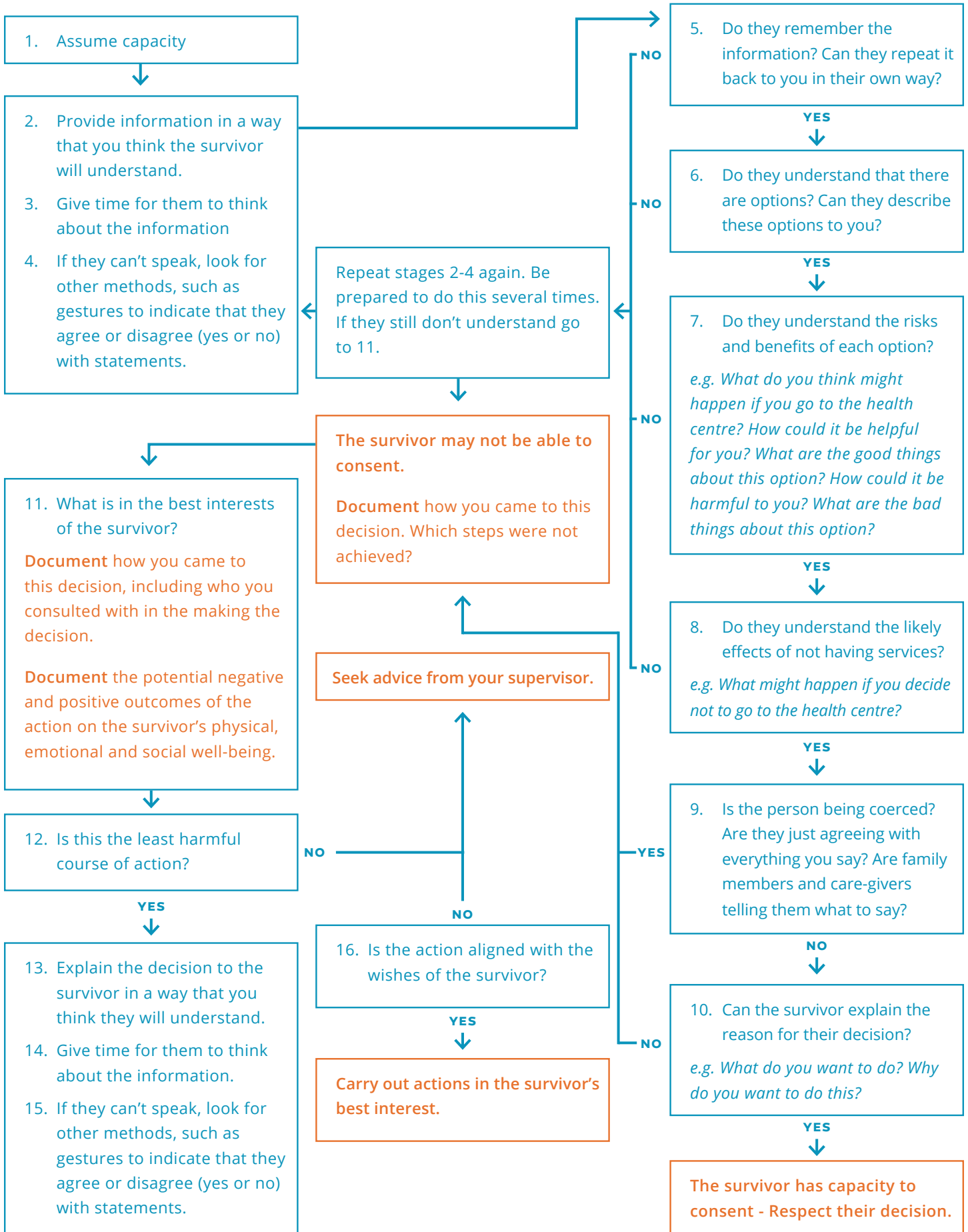
To the extent possible, you should still obtain informed assent from the survivor (i.e. their communicated willingness to participate in proposed decisions, services and/or activities).

The flowchart on the next page is a helpful tool for thinking through the informed consent process and best interest decision-making for survivors with disabilities.

63 Ibid.

64 Ibid.

CAPACITY TO CONSENT AND BEST INTEREST FLOW-CHART FOR PERSONS WITH DISABILITIES



3.5 WORKING WITH CAREGIVERS/FAMILY MEMBERS

As discussed in the previous sections, it can be very useful and in some cases necessary to work with the survivor's caregiver(s) and/or family members. However, doing so can also complicate efforts to promote the safety, confidentiality and interests of the survivor. Persons with disabilities should always be consulted on the involvement of caregivers and family members, as would be the case with all survivors. You will need to routinely assess the risks and benefits of involving a caregiver in a survivor's care and continually ask if it necessary, safe and ultimately empowering for the survivor to do so. Some important things to remember when working with caregivers and family members are:

Assess safety. Routinely carry out a thorough safety assessment to rule out potential abuse from the assisting person, as most often the perpetrator is someone the survivor knows and it may be the person providing them care and assistance on a daily basis.

Focus on the survivor. The survivor is the individual seeking services and all actions should be guided by their will and preferences. The interests of family members and caregivers may or may not be linked to the will and preferences of the survivor. Maintain primary communication and participation with the survivor, and ask for permission from the survivor to communicate with the caregiver or family member.

Maintain confidentiality. If the survivor discloses information they do not wish to be shared with their caregiver/family members, you must respect and maintain the survivor's confidentiality. Do not share any of the survivor's information, even with the caregiver, without explicit permission from the survivor. When sharing information, always think about why the caregiver needs that information and only share what is necessary to facilitate care. For example, you may do a joint session with a survivor and their caregiver to review a case action plan because it requires the caregiver or family member's action. In that case, they only need to know what is relevant for facilitating that part of the survivor's care. Finally, if a caregiver or family member is involved in any aspects of the case management process, they also need to maintain confidentiality. Be sure you have made this clear to the person from the beginning.

Support the caregiver or family member. If you determine that the caregiver or family member involved is safe, you should provide support to the caregiver as well. Providing them with accurate information about the risks and impacts GBV and trauma can help them understand what the survivor may be experiencing and how to best support them. Caregivers may be inclined to blame the survivor, so be sure to communicate that what happened was not the survivor's fault. Caregivers may also blame themselves for not being able to protect the survivor from violence. Providing messages to the caregiver that are supportive, non-blaming and non-judgmental may be important for them to hear. By supporting them, you are also enhancing their ability to support the survivor.

3.6 SAFETY

Safety plans for survivors with disabilities must be highly individualized and should take into account the following:

- The individual's specific disability and living situation and ways in which a perpetrator may try to exploit the survivor's disability to isolate them, prevent them from leaving or further harm them.
- How the survivor's impairment may impact execution of their safety plan, and adjust the plan as necessary.
- What disability-specific items the person may need if they implement their safety plan, such as medication, assistive devices or equipment, or relevant documentation for health or legal support.

PART V

MONITORING QUALITY OF SERVICES, SUPERVISION AND STAFF CARE



CHAPTER 1

MONITORING SERVICE QUALITY

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- How to monitor the quality of case management services
- Tools that can support supervisors in monitoring the quality of case management services

Monitoring the quality of your care and case management services is an ethical obligation and often a requirement for funding. There are three main ways you can monitor the quality of your case management services: client feedback surveys, case file audits, and ongoing supervision of caseworkers. In this chapter, you will be introduced to client feedback surveys and case file audits. In the following chapter, you will receive extensive guidance on supervision structures and approaches.



TRAINING MATERIALS

→ [Module 18: Supervision](#)

1.1 CLIENT FEEDBACK SURVEYS

Client feedback surveys are a key way for you and your organization to know how survivors experienced your service. This can help you understand what is being done well, what needs to be improved and what the challenges are. Depending on the context, client feedback surveys are usually given at the end of a session or at the closing of a case.

At case closure, if you and the person have agreed that their needs/goals have been met, or they have communicated to you that they would no longer like to receive services, you can ask them if they would be willing to complete a survey that asks them questions about their satisfaction with the services they have received.

Asking clients to evaluate your services at case closure may not always be possible, especially in contexts where you may see the majority of survivors only once. If this is the case, your program can decide to use client feedback forms at the end of the first session, if it is feasible to do so.

In contexts where you are seeing clients for longer periods of time, e.g. over a month or three-month period, you can also consider administering client feedback surveys more frequently (e.g. on a monthly or quarterly basis).

Regardless of when you decide to use client feedback surveys, the process for using them with a survivor should be as follows:

- Explain to the person that the purpose is for you and your organization to improve your services, and that their feedback is valued.
- Inform the person that the information will remain anonymous and that it will not impact the services they currently receive or may need in the future. And ultimately, it is their choice as to whether they complete the survey.
- A different caseworker, supervisor or other relevant staff member should be the one who gives the survey to the person and collects it from them at the end. For literate clients, this can be done independently through a paper form or an electronic form (handheld device) in which the person does not have to provide their name, just the name of the caseworker with whom they worked. For those who cannot read or write, another staff member can carry out the survey verbally.

Before choosing to use client feedback surveys and the frequency with which you will administer them, make sure that you have the proper resources to administer the surveys in an anonymous way and to analyse the information from them. This may require a dedicated staff person to help you collect, analyse and learn from the data provided from the surveys. **It is important to only collect feedback if you are able and willing to routinely analyse and use the data.**



TOOLS

A sample *Client Feedback Survey* can be found in Part VI.

1.2 CASE FILE AUDITS

If your organization has a case documentation system, reviewing case files on a regular basis can help your organization track whether forms are being used and filled out appropriately and how services are being provided (as documented in the case file). Case file reviews should never take the place of actual in-person supervision, and the information supervisors get from the reviews should always be complemented by other supervision methods. When reviewing case files, case management supervisors should look for the following:

- **Consent Form**
 - Has the consent form been signed by the survivor, or if a child survivor, by the child's caregiver, trusted adult or the caseworker her/himself (in situations where there is no other adult), or the child herself (if 15 and above)? Has written informed assent been documented when relevant?
- **Assessment Form**
 - Is the caseworker providing a written description of the incident on the assessment form?
 - Are the needs of the survivor documented?
 - Are the initial referrals documented?
- **Case Action Planning Form**
 - Is the caseworker articulating clear goals and outlining actions, timelines and the person responsible for the action?

- Do the goals correspond to the needs identified?
- Is the form or a follow-up form being used for follow-up to document progress and assess new needs?
- **Case Notes**
 - Are notes from follow-up sessions documented?
- **Case Closure Form**
 - Does the case meet the criteria for case closure?
 - Has the case closure form been completed and signed by a supervisor?

Supervisors can set up a schedule in which they randomly select a set number of files to review from each caseworker, or from a few caseworkers, or review two files per caseworker per week, making note of any particular challenges a caseworker is having with paperwork or a common challenge that emerges among files across the team. Findings from case file reviews can be discussed in individual or group supervision sessions.

CHAPTER 2

MENTORING AND SUPERVISION SYSTEMS AND METHODS

IN THIS CHAPTER, YOU WILL FIND INFORMATION AND GUIDANCE ON:

- Different supervision methods
- Guiding principles for supervision
- Using tools to assess, monitor and build staff capacity

Supervision is important for continued staff capacity development and to ensure quality of care. In GBV case management, supervision is important to:

- Ensure that helpers and service providers are able to put knowledge and skills from training into practice
- Provide staff with the opportunity to discuss their work and receive constructive feedback
- Provide staff with a forum to debrief—especially important to prevent secondary traumatization
- Monitor and manage staff stress
- Provide an ongoing opportunity for staff to reflect on their personal values, beliefs and behaviors and how these impact their work with survivors.
- Provide further training opportunities.



TRAINING MATERIALS

→ **Module 18: Supervision**

→ **Module 19: Staff Care**

All organizations providing GBV case management should have at least one case supervisor responsible for ensuring staff are trained and prepared for their case management role, and who regularly monitors caseworkers' practice and provides the support needed for them to provide quality care. Case supervisors should also be on hand for consultation in emergency situations. Ideally, case supervisors are people with several years of direct experience working on GBV cases.

Supervision can be provided through one-on-one support, in groups, through on-the-job observation and coaching and in regular team meetings.

2.1 INDIVIDUAL SUPERVISION⁶⁵

2.1.1 GUIDING PRINCIPLES

Good practice suggests that individual casework supervision is most effective when it is:

- **Regular and consistent.** This means meeting once a week at a set time so the caseworker and supervisor can prepare for the session. Ad hoc support may also be necessary and should be provided, but **should not** take the place of a regular supervision meeting.
- **Collaborative.** Case supervisors should encourage their case management staff to come to supervision meetings with an agenda—identifying the cases they want to discuss, specific questions they have, and/or topical areas for technical support.
- **An opportunity for learning and professional growth.** Case supervisors should use the sessions to support caseworkers' learning and professional development.
- **Safe.** Case supervisors should ensure that supervision meetings feel like a safe space for caseworkers—where they can make mistakes and not be judged, and where they can receive constructive feedback, not criticism.
- **An opportunity to “model” good practice with clients.** Supervisors have the opportunity to model good case management practices during supervision sessions. When communicating with caseworkers during supervision, case supervisors should follow similar communication practices that are promoted for working with survivors. This means that you should:
 - Listen before asking questions.
 - Pay attention to your and the caseworker's verbal and non-verbal communication.
 - Do not begin a question with “why”—instead of saying “Why did you do that?,” try to understand the rationale behind the caseworker's decision or action by saying something like, “Tell me more about your strategy or decision when you did x.”
 - Summarize your understanding of what the caseworker has told you to limit miscommunication. For instance, say: “What I hear you saying is xxx” or “Let me make sure I get this right, you were saying that xxx”.
 - Demonstrate empathy for the caseworker's challenges and concerns about a case.
 - Work from a strengths-based perspective, being sure to highlight what you think the caseworker did well and asking them what they think could have been done differently before you share your feedback.
 - Seek to empower the caseworker by asking her/him to problem-solve instead of immediately providing solutions.

2.1.2 HOW TO STRUCTURE SUPERVISION CONVERSATIONS

DISCUSSING A NEW CASE

When discussing a new case with a caseworker, you should follow the process outlined below.

Understand the background of the case

When discussing a new case, the case supervisor should prompt the caseworker to tell them about the background of the case. Supervisors should listen for the same information a caseworker seeks to collect during their assessment with a survivor, as follows:

⁶⁵ International Rescue Committee (2015). *Women's Protection and Empowerment Case Management Guidelines*.

Listen for:

- *Who is the survivor? (age, level of maturity, family and home environment)*
- *What happened? (Who is the perpetrator, what access do they have to the survivor, how long has the abuse been going on? What type of abuse? When did it happen?)*
- *How was the case reported to your organization? (referral, walk-in, survivor was engaged in other activities/services)*

Once the caseworker has finished explaining the background of the case, you should:

- Summarize your understanding of the case context.
- Ask clarifying questions for the purposes of better understanding the context.

Understand the immediate needs identified

Once you understand the background of the case, seek to understand the immediate needs of the case. You can prompt the caseworker to explain the immediate needs that they identified. You can also ask the caseworker to role-play how they assessed needs (e.g. what strategies and tools they used with the survivor).

Listen for:

- *What are the immediate safety needs?*
 - *Does the perpetrator live/stay in the home of the survivor? Is the perpetrator a relative? Is he a person with authority and power in the community? Does the perpetrator have easy access to the survivor?*
 - *If it is a child survivor, is the primary caregiver engaged?*
 - *Does the child feel safe with the primary caregiver or do they not want them to know what has happened?*
 - *Is the primary caregiver unable to protect the child? (e.g. Are they also being abused/threatened by the perpetrator? Do they not believe the child? Do they blame the child for what happened?)*
- *What are the immediate medical needs?*
 - *Does this require an urgent referral for the clinical management of rape?*
 - *Does it require an immediate referral for treatment of injuries, bleeding, pain?*
- *What are the immediate psychosocial needs?*
 - *What is the caseworker's sense of the survivor's emotional state?*
 - *How did the survivor react when speaking about the abuse? Were there any indications of flashbacks (reliving the abuse), panic attacks (feeling of extreme anxiety which can lead to difficulty breathing), crying uncontrollably?*
 - *Is the survivor expressing suicidal thoughts?*

After allowing the caseworker to discuss the immediate needs:

- Summarize your understanding of the immediate needs the caseworker has identified.
- Ask clarifying questions.
- Determine whether the case is high-risk or complicated.

Understand how the caseworker did case action planning

Next, you should prompt the caseworker to explain the steps they took for case action planning. You can give the caseworker a chance to explain their case action planning before you start asking questions, unless the question is to clarify a point.

→ **Listen for:**

- *How are decisions being made about the case? How is the survivor involved?*
- *Was a safety plan done? What was the safety plan?*
- *Was a medical referral made (if needed)? If so, who will accompany the survivor?*
- *If the survivor declines lifesaving medical care, did the caseworker probe further to understand the survivor's concerns about getting medical care and try to problem-solve?*
- *Is suicidal ideation a concern?*
- *Are there any other immediate risks/concerns to the survivor's physical safety and health?*

→ **If a caregiver is involved in the case:**

- *How are decisions being made about the case? How is the survivor involved?*

After hearing the steps the caseworker took for action planning, the case supervisor should:

- Go back to specific ideas, tasks and concerns related to the case action planning to get a better understanding of the caseworker's decisions and actions regarding the case.
- Identify what the caseworker did well in the case action planning and communicate this.
- Ask the caseworker what specific questions/concerns they have, and work with them to address those questions and concerns, using role-playing whenever possible.
- Ask the caseworker to reflect on what they think could have been done differently/better and provide feedback. Use role-playing to demonstrate how to do something accurately.

Support the caseworker with follow-up

You can support the caseworker with follow-up by helping her/him identify the next steps in the case and help anticipate challenges and identify solutions. You should also ensure that the caseworker has agreed on a follow-up session (day, time, location) with the survivor and that the timing of the next follow-up session is appropriate to the needs of the survivor. For example, if there are immediate safety concerns, the caseworker should plan to have a follow-up session within the next 24-48 hours and should discuss with the survivor how to do that safely. If the

case does not require immediate follow-up, the caseworker should plan to have a follow-up session within the next 1-2 weeks. Once a case stabilizes, the caseworker and the survivor can determine together how frequently follow-up is needed.

Close the supervision session

Close the supervision session by thanking the caseworker for their time and commitment, reassuring them that you are here to support them and scheduling the next supervision meeting.

DISCUSSING ONGOING CASES

The approach for discussing ongoing cases should be similar to that used for discussing new cases. At this point, however, the caseworker should be coming to supervision meetings prepared to provide the supervisor with:

a) updates about case context and needs, particularly regarding changes in safety risks, or new needs that have emerged; b) progress on action plans; and c) specific questions or issues for which they would like support. For each case discussed, case supervisors should be **thinking about**:

- - *What are the new and ongoing risks to the survivor's safety? How are they being handled?*
 - *If a safety plan was developed with the survivor, are they using it? What is working about it? What is not?*
 - *What is the survivor's emotional state? Has it changed since the caseworker saw the survivor? How is she/he coping?*

- **If the survivor is a child or a person with a disability:**
 - *How can we promote the best interests of the survivor?*
 - *How is the survivor involved in decision-making?*
 - *Are appropriate communication techniques being used so that they can understand the questions being asked and the information being provided?*
 - *Is/how is the caregiver involved in decision-making, care and services?*
 - *Who else needs to be involved or consulted so that the best care can be provided (for example, another family member or trusted adult, other organizations, supervisors)?*
 - *Does the caregiver also need psychosocial support?*

Case supervisors should use the following approaches to help them assess the answers to the above questions:

- Give the caseworker the space to talk first before asking questions.
- Ask the caseworker to role-play how she/he approached a conversation with the survivor so that you have a better understanding of their verbal and non-verbal communication. Be sure to emphasize to the caseworker that it is important for them to show you what they said to the survivor, not what the person thinks they should have done or said. Explain that this is the best way for them to learn and for you to provide support.

- Provide concrete feedback on what the caseworker did well.
- Ask the caseworker to reflect on what they think could have been done differently/better and provide your feedback. Provide the caseworker with the opportunity to role-play this “improved” way with you. You can also play the role of the caseworker to demonstrate how to do something accurately.
- Problem-solve with the caseworker—letting them lead the process—before providing solutions.
- Support the caseworker in identifying the next steps for the case, including anticipating challenges so that you can problem-solve/role-play with them.

It will not be possible for caseworkers and supervisors to discuss every ongoing case during an individual supervision session. Priority should always be given to high-risk and complicated cases. For all other cases, the caseworker and supervisor should agree to a rotating schedule unless new/pressing needs emerge or the caseworker identifies a specific issue that requires support from the supervisor. This approach will ensure that most active cases are discussed regularly.

2.2 PEER SUPERVISION SESSIONS⁶⁶

Group or peer supervision provides staff in the same workplace the opportunity to talk with each other about their work, reflect on their work and share information, experiences and problems. It is a forum in which people can listen to each other and give valuable feedback about challenges and strategies they have used to overcome these challenges. Peer supervision should be a supportive learning and sharing experience. they being handled?

Frequency/duration. Depending on the schedule of the case management team, peer supervision meetings can be held for 60–90 minutes once a month, once every two months, or however frequently the case management team decides is useful. Whatever the frequency, the meetings should be held consistently and according to a schedule (e.g. the first Tuesday of every month), so that caseworkers and supervisors know to set that time aside in their schedule.

Preparation. Supervisors should prepare and distribute an agenda and any other supporting materials to the group at least one week prior to the meeting. This will allow caseworkers sufficient time to review materials and come prepared for learning and discussion.

Format. There are many ways to structure group supervision meetings; the structure the supervisor chooses will depend on the goal of the session.

- **Case review.** For a case review, the supervisor assigns a caseworker to discuss an interesting or challenging case from which other staff can learn. Supervisors can also provide hypothetical cases in the event that it is not appropriate for a whole team to discuss a real case. Case presentations should follow principles of confidentiality, i.e. not revealing the survivor’s name or other identifying information. A suggested format can be found on the next page.
- **Topical sessions.** For topical sessions, the supervisor should either choose the topic in advance (based on the technical support he/she identifies to be a priority) or ask the caseworkers to identify topics for which technical support is desired.
- **Teach back.** For teach backs, the case supervisor can identify a caseworker with a particular strength or one who has been successful with a new strategy to lead the group session and “teach” their colleagues. If this strategy is used, it is important that the supervisor review with the caseworker their plan for the group session.

⁶⁶ Ibid.

Structure. Regardless of the format chosen, it is suggested that supervisors use the following structure for the session:

- **Opening and check-in (10–15 min).** Provide participants with the opportunity to do a quick group check-in about how they are feeling, their mood, etc. Be creative in how you do this (e.g. you can ask participants to tell you what color or animal they feel like today and why (i.e. something descriptive other than adjectives). Thank everyone for sharing (make sure that you share also) and make a mental note of anyone who seems like they may need an ad hoc individual check-in.
- **Session content (45–60 min).** This should include presentation, questions and discussion.
- **Closing and care (5–15 min).** Make sure you summarize the key learning points from the session. Finally, give participants the opportunity to do something that revives their energy, spirit and motivation. It could be an energizer, a dance, a song, a joke, a relaxation exercise—anything that will bring some joy or calm (even if little) to their day.



HELPFUL TO KNOW

Format for Presenting a Case in Case Management Supervision

→ Survivor personal information:

- *Gender of the survivor*
- *Approximate age*
- *Nationality*
- *Country of origin (if refugee)*
- *Marital/family status*
- *Living situation*
- *Support people in their life*

→ Type of Abuse

→ Summary of needs

→ Summary of the action plan and any follow-up

→ Key issues/ challenges for discussion

2.3 SUPERVISION TOOLS

In addition to the supervision strategies that have been discussed, case management supervisors may find it useful to have tools that can help them assess staff attitudes, knowledge and skills that are important for providing survivor-centered care and case management services.

Assessing attitudes

Staff members' personal values and beliefs about the causes of GBV, gender roles, and women's rights and roles in society deeply impact their ability to provide quality care to survivors. **The Survivor-Centred Attitude Scale** is a tool for supervisors to evaluate attitudes among staff providing direct support to survivors. It includes 14 statements to assess a staff member's personal values and beliefs. The scale can measure an individual's attitudinal readiness for working directly with survivors, while also highlighting specific areas in which the staff member may require further education and training. **Ideally, this should be administered prior to staff working directly with survivors.**

Assessing foundational knowledge

Most staff are not going to possess all of the knowledge and skills they need for survivor-centred case management before they begin working with survivors. A supervisor's job is to understand the level at which staff are beginning and make sure they receive the appropriate training before they engage in casework. **The Survivor-Centered Case Management Knowledge Assessment** can help you assess the degree to which a staff member has the minimum foundational knowledge for carrying out case management services with survivors. It can also be used as a pre/post assessment for case management training or as a three or six month follow-up assessment to a case management training and on-the-job training to determine how staff progress over time.

Developing skills

Supervisors can continue to shape caseworkers' attitudes and build their technical knowledge, skills and confidence in working with survivors by using the **Survivor-Centered Case Management Skills Building Tool** in supervision sessions. Supervisors must be mindful that the purpose of the tool is to help caseworkers learn and help the supervisor identify the aspects of the case management process for which the caseworker most needs to develop technical skills. It is important that caseworkers do not feel they are being evaluated or that they will be punished if they do not demonstrate accurate knowledge and skills. Instead, you want them to understand that the questions and role-plays included in the tool are to support their skills development.

Assessing the application of skills

Supervisors can also use the **Survivor-Centred Case Management Quality Checklist** with caseworkers as part of their ongoing supervision. The checklist can be used throughout a survivor's case to assess a caseworker's application of skills during each step of the case management process (e.g., assessment, case action planning, etc.) and is best used when directly observing a caseworker working with a survivor.

The checklist can also be used once the caseworker has fully completed the case management services for a particular case, in order to evaluate the overall skill and practice applied in that case. Moreover, the checklist can be used by caseworkers to self-assess their work. This means caseworkers would refer to the checklist after each meeting with a survivor to assess their own application of knowledge and skills during case management. When used in this way, the checklist is meant to be a learning tool and does not take the place of a checklist administered with a supervisor.



TOOLS

These assessment tools and instructions for how to use them can be found in Part VI.



2.4 STAFF CARE

Supervisors and organizations play a critical role in creating an organizational culture that prioritizes the safety and well-being of its staff. This is particularly critical for organizations that are providing GBV services in humanitarian settings given the exposure of staff to highly stressful situations and the risk of vicarious (also known as secondary) trauma. We often talk about “self-care” in our work—or what an individual can do to prevent stress from becoming overwhelming. On a personal level, not practicing good self-care can lead to physical, emotional, mental and spiritual harm. It can disrupt overall well-being, quality of life and personal relationships. While the emphasis of self-care is usually on the individual, self-care is important for individuals and organizations as productivity and work often suffer when good self-care is not promoted and encouraged by supervisors and individuals alike. For these reasons, organizations, particularly those responding to difficult issues such as GBV, also have a responsibility to provide a level of care for their staff.

Caseworkers are often the people working closest with survivors, hearing their experiences of GBV, and responding with care, compassion, and concern. Over time, without appropriate support and supervision, caseworkers may begin to feel overwhelmed and tired, and may even begin to feel hopeless and helpless. In order to prevent caseworker burn-out and to facilitate caseworkers’ capacity to provide the best care and services to survivors, supervisors (and organizations) need to make explicit a commitment to staff well-being and implement specific strategies for promoting it. While every organization will need to develop its own strategies and approaches for staff care based on resources and structure, below are basic tips for how supervisors can promote the care of GBV casework staff.

Facilitating everyday staff care

- Create a supportive climate – regularly check on the well-being of staff, create an environment where staff feel comfortable sharing information and concerns with you.
- Establish routines – including for supervision and team meetings.
- Regularly demonstrate appreciation for staff. This can be as simple as communicating gratitude or praise for something they did or arranging to have refreshments at meetings to something more elaborate such as a “staff of the month” award.
- Manage information – Routinely share information and create an environment of transparency.
- Monitor the health and well-being of staff. For example, be mindful of how staff are taking care of themselves and encourage them to take lunch breaks, etc., and take note of changes in appearance or health.
- Monitor stress levels – support staff to identify and monitor stressors in their lives and to develop self-care plans.
- Provide opportunities for exercise and access to the outdoors.
- Organize “staff care” days that allow staff to come together to do something fun or relaxing.

- Encourage staff to identify a “self-care buddy” – another staff person with whom they connect on a regular basis to discuss how they are and what support they need from each other.
- Accommodate staff – be flexible with the response of different individuals to personal or work crises (e.g. allow flexible schedules if possible, give time off where needed, provide additional supervision, etc.)

Providing support for staff in crisis

When staff are in crisis either because of a professional or personal experience that may be impacting their work, the following may be important:

- Create opportunities for staff to share experiences and stressors (e.g. through supervision)
- Watch for caseworkers who may be suffering in silence and actively reach out to them.
- Connect them to psychological support – if available in the context, connect staff to mental health professionals on a regular basis.

PART VI

ANNEXES AND TOOLS

ANNEXES AND TOOLS

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GBVIMS AND CASE MANAGEMENT

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SERVICE GAP ANALYSIS AND PLANNING TOOL⁶⁷

Use this tool to assess gaps in services that prevent survivors of GBV from receiving a minimum standard of care and to develop and document a plan for addressing these gaps. This tool has three parts:

Part A provides instructions on how to assess capacity gaps and develop an action plan to address them.

Part B is a checklist to identify gaps in meeting minimum standards across sectors. It can be used to measure progress towards addressing gaps once an action plan has been implemented. It can also be used as a quality monitoring tool to ensure that services are implemented according to good practice standards.

Part C is a template to document the action plan, detailing how the gaps will be addressed and by whom.

PART A: STEPS IN ADDRESSING GAPS IN CARE

Step 1. Organize a workshop to develop a plan to address critical capacity gaps.

Invite relevant stakeholders, such as organizations and community groups responding to GBV, to a planning workshop to identify and address critical capacity gaps in services for survivors of GBV in the community.

Step 2. Using the Minimum Standards checklist from Part B, identify whether each standard has been met.

- a. During the workshop, form sector-based working groups for health, psychosocial support, law enforcement, legal and justice services.
- b. Have each group review the list of standards for the sector as set out in Part B: Minimum Standards and discuss whether each standard has been met.
 - If the standard has been met, the working group should tick 'Met'.
 - If the standard has not been met, the working group should tick 'Not Met'.
 - If action is underway towards meeting the standard, the working group should tick 'Working Toward'.
- c. When this exercise has been completed, write the standards marked 'Not Met' and 'Working Toward' in a list, by sector. You now have a list of the critical capacity gaps to be addressed to ensure survivors of GBV receive a minimum standard of care and support.

⁶⁷ UNICEF. (2014). Communities Care Programme: Transforming Lives and Preventing Violence. UNICEF, New York.

Step 3. Develop a plan for addressing each gap.

- a. Have each sector-based working group review and discuss every gap on the list for their sector and identify strategies for addressing each one.
- b. Ask the group to document which gaps and actions are high priority, what the solutions are, who is responsible for them and the timeframe.
- c. You may not be able to identify all the solutions for all the gaps in one workshop. You may need to consult with others before finalizing the action plan.

Step 4. Document, implement and review the action plan for addressing capacity gaps.

- a. Using Part C: Action Plan, document the action plan and distribute it to relevant stakeholders.
- b. Start implementing it!
- c. Organize a review meeting to follow up on progress in implementing the plan and make adjustments as needed. You can use Part B: Minimum Standards again to review and monitor progress towards addressing gaps.

PART B: MINIMUM STANDARDS OF CARE FOR SURVIVORS

HEALTH SERVICES

Minimum Standard	Met	Working Toward	Not Met
Health care can be accessed without police involvement.			
Health care can be accessed without payment or specific documentation that survivors may not have.			
A safe and private environment is available for medical examination and treatment.			
Health workers are trained on confidentiality.			
Doctors or nurses have been trained in the clinical care of sexual assault, including for children.			
Protocols for clinical management are in place and followed.			
Medical examination and treatment is provided by trained staff.			
Appropriate equipment and supplies, including medications/drugs, are available.			
Patients are referred for additional health care as needed.			
Follow-up health care is provided.			
Health workers know how to give information and make referrals for protection, safety and psychosocial support.			
Interpretation is available for survivors who do not speak the same language as health-care workers (where necessary).			
Mental health services are available for survivors.			
Health-care services are accessible to all survivors, regardless of gender, sexual orientation, ethnic/religious background, etc.			
The community is aware of services.			

CASE MANAGEMENT AND PSYCHOSOCIAL CARE AND SUPPORT

Minimum Standard	Met	Working Toward	Not Met
A safe and private environment is available for people to receive compassionate assistance.			
Staff/volunteers are trained on confidentiality.			
Trained staff/volunteers are able to provide relevant information and referrals for health care, police and safety options to people seeking help.			
There are staff/volunteers who are representative of the different ethnic and religious backgrounds relevant to the context.			
Trained staff/volunteers are able to provide basic crisis support to individuals and families.			
Trained staff/volunteers are able to provide case management to survivors.			
Resources are available to meet immediate basic needs, e.g. clothing and food.			
Short-term safety options are available in the community.			
Trained staff/volunteers are available to provide information and education to families of survivors.			
Group activities are available for peer support, community reintegration, and promoting economic empowerment.			
Traditional healing or cleansing practices that survivors perceive as helpful in their recovery and that promote the human rights of survivors are considered, as appropriate.			
Community outreach and education about GBV takes place.			

LAW ENFORCEMENT

Minimum Standard	Met	Working Toward	Not Met
Procedures for reporting complaints to police promote dignity and confidentiality.			
Survivors are not likely to be subject to arrest or detention based on legal status or any other characteristic upon reporting to police.			
Interviews and investigations are conducted by trained police officers.			
Investigative techniques promote dignity of survivors.			
Police have the capacity to respond promptly to criminal allegations of GBV.			
Investigations are documented appropriately.			
Police procedures, including decisions on arrest, detention and the terms under which perpetrators may be released take into account the safety of the survivor and others.			
Training and education on GBV are provided to police, criminal justice officials, practitioners and professionals involved in the criminal justice system.			

LEGAL SERVICES AND JUSTICE

Minimum Standard	Met	Working Toward	Not Met
Legal counseling is available to advise survivors of their legal rights and remedies and on the process for criminal proceedings.			
Legal representation is available and accessible.			
Practical and emotional support is available for victims/witnesses to attend court, e.g. transportation.			
Court mechanisms and procedures are accessible and sensitive to the needs of survivors.			

PART C: ACTION PLAN FOR ADDRESSING CRITICAL GAPS IN SERVICES

Gap identified	Strategy/action for addressing the gap	Responsible	Timeframe	Priority: High, Medium or Low

BARRIERS TO CARE ANALYSIS AND PLANNING TOOL⁶⁸

Use this tool to develop an action plan to address barriers faced by survivors of GBV in accessing care and support services. This tool has two parts:

Part A provides guidance on how to do a barrier assessment and identify solutions.

Part B provides a template to use to document the action plan for addressing barriers faced by survivors.

PART A: STEPS IN ADDRESSING BARRIERS TO CARE AND SUPPORT SERVICES

Step 1. Organize a workshop to develop a plan to address critical capacity gaps.

Do this exercise in a participatory manner, inviting representatives from organizations, community networks and other groups that advocate on behalf of GBV survivors.

Step 2. Identify the service and population to be analysed.

You can choose to look at barriers in different ways. You can look at barriers in accessing a particular service, for example, barriers faced in accessing law enforcement. You can focus on barriers faced by a particular group of survivors, for example, any barriers faced by adolescent girls. Or you could look at barriers faced by a particular group in accessing a particular service, for example, barriers to adolescent girls in accessing health care. You can also do all three as needed, although this will take more time.

- a. To identify barriers survivors face **in accessing a particular service**, write the name of the service in a circle, e.g. health post, police, women's centre, etc., and draw a series of concentric circles around it.
- b. To identify barriers faced by a **particular group of survivors**, write the name of the group in a circle, e.g. adult women, married women, adolescent girls, young children, males, sex workers, etc., and draw a series of concentric circles around it.
- c. To identify barriers faced by a particular group to a **particular service**, write the name of the service and the name of the group in a circle and draw concentric circles around them.

⁶⁸ UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

Step 3. Ask 'why'.

- a. If you put the name of a service in the centre circle, ask participants why survivors don't use the service and write the answers in the second circle.
- b. If you put the name of a particular group of survivors in the centre circle, ask participants why that group doesn't access services and write the answers in the second circle.
- c. If you put the name of a service and particular group in the centre circle, ask why that group doesn't access that service and write the answers in the second circle.

Step 4. Probe and get more information.

- a. For each factor or barrier identified in Step 2, probe further to understand why the barrier exists and write the corresponding answers in the next circle.
- b. Continue this process until all of the barriers and reasons from them have been identified.
- c. Make a list of everything identified.

Step 5. Develop a plan for addressing each gap.

- a. Go through the list of barriers one by one and have participants discuss and explore potential strategies and actions for reducing or eliminating each barrier.
- b. Ask participants to decide which actions are high priority, who is responsible for them and the time-frame for addressing them.
- c. Participants may not be able to identify all the solutions for all the barriers. You may need to consult with others before finalizing the action plan.

Step 6. Document, implement and review the action plan for addressing barriers.

- a. Using Part B: Action Plan for Addressing Barriers, document the action plan and distribute it to relevant stakeholders.
- b. Start implementing it!
- c. Organize a review meeting to follow up on progress in implementing the plan and make adjustments as needed. You can use Part B again to review and monitor progress towards addressing gaps.

CONFIDENTIAL

CONSENT FOR SERVICES

The purpose of this form is to document a conversation between the caseworker and the survivor during the initial meeting about your organization's case management services, confidentiality and exceptions to confidentiality, and the survivor's rights. This form should be stored in a separate file from the case file.

I, _____, hereby give permission to receive case management services according to the following:

My caseworker's primary purpose is to promote my safety, dignity, and well-being according to my wishes. She/he understands that only I fully know my own situation. Therefore, I will guide the process of identifying my needs, goals, and what I would like help with.

I have the right to decide what information I wish to share with my caseworker. She/he will never pressure me to share any information which I do not wish to share.

If I am dissatisfied with the services I am receiving, I have the right to discuss any concerns with my caseworker or their supervisor or to discontinue services at any time.

My caseworker will not refer me to any other service without first explaining the purpose of the referral, the way it would be made, and the expected consequences, and receiving my consent. At my request, my caseworker may accompany me to meet with the referred agency.

My name and information about my case will be kept confidential. My caseworker will not share this information with anyone, with the following exceptions:

1. My caseworker may seek guidance from a supervisor in relation to my case. My caseworker would only share information as needed to support me and it will not include information that could identify me.
2. If I express thoughts or plans of committing physical harm to myself or others, my caseworker will take action to protect my safety and the safety of those around me. This action may include speaking with others in my community about my situation. If there is a risk of immediate danger, my caseworker would not need to seek my consent in such cases, but would do her/his best to inform me of actions taken.

Signature/Thumbprint of client:

(or parent/guardian if client is under 18)

Caseworker Code: _____

Date: _____

CASE ACTION PLAN

Survivor Code:

Caseworker Code:

Date:

Action points/ Goals	Who	By when

Follow up meeting is scheduled for (date/time/location): _____

Caseworker signature and date:

Client/Guardian signature and date:

CASE FOLLOW- UP FORM

Survivor Code:

Caseworker Code:

Date:

PROGRESS TOWARDS GOALS

Evaluate progress made towards action/goals agreed on in the Case Action Plan Form	Not Met	Met	Explain
Safety			
Health Care			
Psychosocial Support			
Access to Justice			
Other (list other goals made here)			

Other Observations/Caseworker notes

RE-ASSESSING SAFETY

	Y	N	Explain	Additional Intervention Planned
Are there new or continued risks of danger at home?				
Are there any new or ongoing safety issues the survivor is facing in the community?				

FINAL ASSESSMENT

	Y	N	Explain	Additional Interventions Planned
A. Safety situation is stable Survivor is physically safe, and/or has a plan to keep physically safe				
B. Health situation is stable Survivor has no medical problems that require treatment				
C. Psychosocial wellbeing has improved Survivor is engaging in regular behavior, has a safe person to talk to				
D. Access to Justice secured (if applicable)				
E. Other Intervention Needed				

Follow up meeting is scheduled for (date/time/location): _____

CASE CLOSURE FORM

Survivor Code:

Case Opening Date:

Caseworker Code:

Case Closure Date:

CASE CLOSURE

Summarize the reasons why the case is being closed. Comment on the progress made toward goals in the action plan. Where necessary, include provisions for continued services, listing agencies and contact persons.

CASE CLOSURE CHECKLIST

Safety plan has been reviewed and is in place. YES_____ NO (explain) _____

Person has been informed she or he can resume services at anytime. YES_____ NO (explain) _____

Case supervisor has reviewed case closure/exit plan. YES_____ NO (explain) _____

Explanation notes here:

Caseworker Signature/Date: _____

Supervisor Signature/Date: _____

CLIENT FEEDBACK SURVEY

Date: _____ Questionnaire Administered By: _____

Instructions for staff:

- Identify who on your team is going to administer the feedback form. Identify whether it will be done in writing (giving the person the questionnaire to complete themselves) or whether a staff member will ask the questions and record the person's answers.
- Inform the person that you will ask them some questions but will not write their name on the form and that the interview will remain anonymous.
- Explain the purpose. Say: "This questionnaire is voluntary and confidential. Its purpose is to collect information about the services that have been provided to you and to help make improvements in the quality of care that GBV survivors receive in this community."
- Remind the person that you will not ask them any questions about their actual case, but are just interested in the services they received throughout the case management process.
- Get consent to proceed or if the person declines, tell the person that it is ok and if they change their minds they can contact you.

ABOUT YOU

If you are the person receiving the service:

- I am 15-19 years old.
- I am 20-24 years old.
- I am 25-49 years old.
- I am 50 years or older.

If you are a caregiver or guardian of a minor:

- The child is 0-5 years old.
- The child is 6-12 years old.
- The child is 13-18 years old.

1. How did you find out about our services? (Tick all that apply.)

- Friend or family member
- Referral from another organization
- Neighbor or community member
- Community discussion
- Flyer or pamphlet you saw or received
- Other (please specify) _____

2. The service was easy to find.

- Yes
- No
- Not applicable

3. The service was affordable.

- Yes
- No
- Not applicable

4. The service was welcoming.

- Yes
- No

5. I received information about what services were available and what my options were.

- Yes
- No

6. Opening hours were at times I could attend (i.e. before and after school, in the evenings and on weekends).

- Yes
- No

Tell us about the options...

7. There was a staff member to interview and help me with whom I felt comfortable.

- Yes
- No

8. I could see the same person at each return visit.

- Yes
- No
- Not applicable

9. I could choose to have a support person with me.

- Yes
- No
- Not applicable

10. I was given full information about what my options were and decided for myself what I wanted to happen next.

- Yes
- No
- Not applicable

11. I was referred to another place if a service could not be provided.

- Yes
- No
- Not applicable

Tell us about confidentiality...

12. I could get help without drawing attention to myself.

- Yes
- No

13. The staff respects confidentiality.

- Yes
- No

14. I met with a caseworker or other staff in private without being overheard.

- Yes
- No

Tell us about the staff...

15. The staff were friendly.

- Yes
- No

16. The staff were open-minded. They didn't judge me.

- Yes
- No

17. The staff were able to answer all my questions to my satisfaction.

- Yes
- No

18. The staff used language I could understand.

- Yes
- No

19. The staff allowed time to let me express my problems in my own words.

- Yes
- No

20. Do you feel like we helped you with your problem?

- Yes
- No

Explain:

21. In general, did you feel better after meeting with us?

- Yes
- No

Explain:

22. Would you recommend a friend who has experienced GBV to come here for help?

- Yes
- No

Explain:

SUICIDE SAFETY AGREEMENT

I, _____, agree that I will not attempt to cause harm to myself.

I promise to not participate in any activity that could result in intentionally causing myself harm or death.

If I ever have thoughts of suicide, feel like I want to kill myself and/or have the urge to cause harm to myself, I will:

1. Remind myself that _____ cares deeply for me and does not want me to harm myself.
2. Remind myself that when I do _____ I feel a little better.
3. I will contact the following safety person if I am feeling suicidal. (List contact names.)

I know that _____ does not want me to hurt myself and cares about me very much.

Signed: _____

Date: _____

SAMPLE REFERRAL PROTOCOL⁶⁹

Purpose

The purpose of this referral protocol is to establish a clear reporting and referral system so that GBV survivors and others know to whom they should report and what sort of assistance survivors can expect to receive from the health, social welfare, law enforcement, legal and justice sectors.

Principles

A GBV survivor has the freedom and the right to disclose an incident to anyone. The person may disclose their experience to a trusted family member or friend, or seek help from a trusted individual or organization in the community. A GBV survivor might choose to seek some form of legal protection and/or redress by making an official “report” to a government agency, such as police or other local authorities.

Anyone the survivor tells about their experience has a responsibility to give honest and complete information about services available and to make sure the survivor has support throughout the process.

Always observe the basic guiding principles:

- Safety
- Confidentiality
- Dignity and self-determination
- Non-discrimination

Keep the number of people informed of the case to an absolute minimum to ensure client confidentiality. The fewer people involved, the easier it is to ensure client confidentiality.

At all times in the referral process, prioritize survivor and staff safety and security.

NO ACTION SHOULD BE TAKEN WITHOUT THE EXPRESS PERMISSION OF THE SURVIVOR, within the bounds of the law.

69 UNICEF. (2014). *Communities Care Programme: Transforming Lives and Preventing Violence*. UNICEF, New York.

Mandatory Reporting Procedures

You need to review and take into account any mandatory reporting laws and/or policies that require certain individuals or professionals to report certain types GBV.

Mandatory reporting requirements can create a dilemma because of the potential for conflict with the guiding principles of respect for confidentiality, dignity and rights of survivors. You will need to understand any mandatory reporting requirements, including reporting mechanisms and investigation procedures.

Document procedures for addressing mandatory reporting here. This includes making sure all service providers are trained to inform survivors about the duty to report certain incidents in accordance with laws or policies, to explain the reporting mechanism to the survivor and what they can expect after the report is made.

Procedures for Children

If relevant, document specific procedures for responding to child survivors based on national laws and policies related to child protection. Include procedures for:

- Obtaining consent
- Action to be taken if there are suspicions that the perpetrator is a family or household member
- Any mandatory reporting laws relevant to acts of sexual violence against children, and procedures that will be taken with regard to those laws
- Referrals to specific organizations skilled in working with child survivors

PATHWAY FOR DISCLOSURE AND REPORTING

Use the following template to fill in details of the referral pathway.

Location:

Date:

TELLING SOMEONE AND SEEKING HELP (REPORTING)

Survivor tells family, friend, community member. That person accompanies survivor to a health and/or psychosocial care provider or other organization.

Survivor self-reports to any service provider.

IMMEDIATE RESPONSE

The service provider provides a safe, caring environment and respects the confidentiality and wishes of the survivor, learns the immediate needs and gives honest and clear information about services available. If agreed and requested by survivor, the provider obtains informed consent and makes referrals. Accompany the survivor to assist them in accessing services as necessary. If, as a service provider, you receive a disclosure and are not a medical/health-care agency or the lead case management agency, you should refer the survivor to the lead case management agency.

Medical/health care entry point

Case management and/or psychosocial support entry point

Enter name of the health centre(s) in this role.

Enter name of the lead case management agency.

IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - OR - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS:

Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police.

Police/Security

Legal Information and Assistance

Enter specific information about the security actor(s) to contact, including where to go and/or how to contact them.

Enter names of services.

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES

Over time and based on survivor's choices, any of the following may be appropriate:

Health care

Social welfare and psychosocial services

Protection and safety actors

Law enforcement, legal and justice actors

Insert names of services.

Insert names of services.

Insert names of services.

Insert names of services.

SURVIVOR-CENTRED ATTITUDE SCALE

INSTRUCTIONS FOR SUPERVISORS

The Survivor-Centred Attitude Scale is a tool for supervisors to evaluate attitudes among staff providing direct support to GBV survivors. It includes 14 statements to assess a staff member's personal values and beliefs. The scale can measure an individual's attitudinal readiness for working directly with survivors, while also highlighting specific areas in which the staff member may require further education and training.

When to Administer: The Survivor-Centred Attitude Scale should be given prior to staff working directly with survivors.

How to Administer:

- **Step 1:** Set up a private, comfortable setting where the staff member has at least 30 minutes to complete the personal assessment. The Survivor-Centred Attitude Scale should not be given as homework or in other ways that would allow the staff person to consult with others. This is a self-administered, personal assessment.
- **Step 2:** Explain the purpose. Supervisors should clearly explain to staff that this is an assessment to better understand their personal beliefs and feelings about GBV and those who experience it. Emphasize to staff that all answers should be honest and self-reflective, and that the Survivor-Centred Attitude Scale is a tool to identify areas where individuals can benefit from further coaching and staff development.
- **Step 3:** Explain to the staff member how to do it. The Survivor-Centred Attitude Scale is divided into 14 questions. Individuals will score themselves according to how much they agree or disagree with a question, based on a scale of 1 through 4.
- **Step 4:** Have the individual complete the Survivor-Centred Attitude Scale in a quiet and comfortable setting.
- **Step 5:** Score the Survivor-Centred Attitude Scale.

The supervisor should ask for 20-25 minutes following the completion of the questionnaire to calculate the score. Use the scoring guide provided.

Each question was devised so that answers can range from a positive high of 4 to a negative low of 1. Guidelines for interpreting the scores are below.

1. **56-46 points:** Scores in this range indicate that the helper has a survivor-friendly attitude – they have positive beliefs and values for working with survivors.
 2. **45-35 points:** Scores in this range indicate some troubling attitudes that may be harmful to survivors. Managers and supervisors should use their discretion in allowing staff to work on cases and may want to consider “coaching” the staff person before they work independently with survivors.
 3. **34 points and below:** Scores in this range indicate that an individual is not ready to work with survivors. Managers and supervisors should work independently with a staff member who scores below 34 to address negative beliefs and attitudes and identify immediate actions to address them.
- **Step 6:** Explain the results. Supervisors should communicate scores to staff as soon as possible to decrease their anxiety about performance.

Review the results with the staff member and discuss any troubling attitudes that were revealed during the self-assessment.

If the staff member does not meet or only partially meets the required attitudes, it may not be appropriate for the individual to work with survivors until she/he undergoes personal reflection on the harmful values and/or beliefs discovered during the attitude assessment. If this is the case, supervisors will need to handle this conversation carefully and sensitively. In some settings, it may be required to discuss these results with a senior manager and get advice on how to approach the conversation.

Following the initial assessment of the staff member's attitudes, the Survivor-Centred Attitude Scale can be administered periodically before individuals are determined to be 'ready' to work with survivors. This provides an opportunity to discover whether caseworkers' attitudes are changing, in either positive or negative ways.

Remember - these are sample statements that can be adjusted according to the context and populations your organization is serving. Be sure that there is agreement within your program of what statements will be used for the assessment.

ATTITUDE STATEMENTS⁷⁰

ATTITUDE STATEMENTS	Strongly Agree	Agree	Disagree	Strongly Disagree
If women or girls who behave inappropriately are raped, it is their fault.	1	2	3	4
Survivors of GBV have the right to get help for what has happened to them.	4	3	2	1
If a survivor can't answer the questions asked during an interview, they are making up the incident.	1	2	3	4
Acts of GBV are always the fault of the perpetrator.	4	3	2	1
Women often say they have been raped or abused so that they can get attention or money.	1	2	3	4
A woman causes her husband's violence because of her own behavior.	1	2	3	4
There are times when a husband is justified in beating his wife.	1	2	3	4
A person who forces another person to have sex is just someone who cannot control their sexual desire.	1	2	3	4
Intimate partner violence is a family matter and should be handled within the family.	1	2	3	4
A survivor should have the right to make a decision about what actions are best for her/him.	4	3	2	1
Most men beat their wives only after they have been drinking or using drugs.	1	2	3	4
A GBV survivor should always report their case to the police or other justice authorities.	1	2	3	4
Women should be allowed to communicate to their sexual partners when they do and do not want to have sex.	4	3	2	1
It is my job as a caseworker to determine whether a survivor is telling the truth.	1	2	3	4
TOTAL SCORE (Supervisor should sum the total score in each column and then add these together for the total score).				

⁷⁰ The attitude statements can be adapted to the specific location and cultural context. Statements can also be added. Remember that if you add or change a statement, it will change the scoring system and you will then need to revise that accordingly.

SURVIVOR-CENTRED CASE MANAGEMENT KNOWLEDGE ASSESSMENT

INSTRUCTIONS FOR SUPERVISORS

The Survivor-Centred Case Management Knowledge Assessment can be used by supervisors to measure individual staff members' knowledge related to survivor-centred case management practice. It is a supervision tool that is simple to implement. It should be used with staff responsible for providing case management services to survivors and, if possible, should be administered following a formal training on case management.

→ **Step 1:** Set up a supervision session with the staff person in a private and quiet space.

→ **Step 2:** Inform the staff member that:

- The knowledge assessment is intended to identify areas where additional training on survivor-centred case management would be beneficial. The purpose of the assessment is to evaluate the caseworkers' level of knowledge in areas critical to providing survivor-centered case management.
- She/he will not be fired if she/he does not fully meet the skill competency assessment. However, he/she will need to demonstrate improved skills over time.

→ **Step 3: Implement the Survivor-Centred Case Management Knowledge Assessment**

- The tool is divided into 20 questions about essential case management knowledge areas described in these guidelines. The supervisor verbally asks the staff member to explain responses to the questions asked.
- The supervisor assesses the accurateness of the answer using the responses provided, providing 2 points if "MET", 1 point if PARTIALLY MET and no points if UNMET.

→ **Step 4: Scoring the Survivor Centered Case Management Knowledge Assessment Tool**

The supervisor administering the tool will need to add up the points in each column and total each column for a final score. Only one score is allowed per question.

31-40 points = MET: Scores in this range indicate that the staff person has met the core case management knowledge requirements and is able to work independently with survivors with ongoing supervision.

20-30 points = PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills in case management. A capacity building plan should be put in place. This may include one-on-one mentoring sessions, training opportunities and shadowing fellow staff members, among other capacity building activities.

0-19 Points = NOT MET: Scores in this range indicate that the staff person does not have sufficient knowledge and skills to provide case management to GBV survivors. A capacity building plan should be put in place. This may include one-on-one mentoring sessions, additional training opportunities and shadowing fellow staff members, among other capacity building activities. Following additional training, the tool should be re-administered. If the staff person does not improve over time with support and training, the supervisor will have to re-evaluate whether they can keep the person on staff as a caseworker.

SURVIVOR-CENTRED CASE MANAGEMENT KNOWLEDGE ASSESSMENT

Staff Name:

Supervisor Name:

Date:

Instructions for Administering the Tool

This assessment represents the minimum knowledge standards of survivor-centred case management required for case management staff working with GBV survivors. This is a staff supervision tool for managers/supervisors to use with staff.

1. This supervision tool should be given through a discussion between the staff member and her/his supervisor in a quiet and confidential location.
2. The supervisor should inform the staff person that this tool is being used to assess areas where further capacity building is needed. It is not a performance evaluation tool. The supervisor should explain that the staff person will receive a score determining whether or not they 'meet' the overall knowledge criteria.
3. The supervisor asks the staff person to explain/describe answers to the questions and scores them accordingly as per the criteria listed for each question—Met (2 points), Partially Met (1 point), or Unmet (0 points) if the individual is unable to answer the question.
4. Once the assessment is complete, the supervisor will score the assessment and discuss with the staff member their scores, what it means, and any further capacity building needed.

KNOWLEDGE ASSESSMENT

Knowledge Area	Criteria for Answering Correctly	Met	Partially Met	Not Met	
1. What are the main types of GBV?	<p>Need to identify all for a Met score. Need to identify 3 types of intimate partner violence and 3 types of sexual violence for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Intimate partner violence – physical abuse 2. Intimate partner violence – emotional or psychological abuse 3. Intimate partner violence – economic abuse 4. Sexual violence – rape 5. Sexual violence – sexual assault/abuse 6. Sexual violence – harassment 7. Sexual violence – sexual exploitation 8. Sexual violence – intra-familial sexual abuse 9. Sexual violence – trafficking for sex 10. Forced or early marriage 			
2. What are the causes of GBV?	<p>Need to identify both answers to receive a Met score.</p> <p>Identify one of the answers for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Abuse of power and control 2. Gender inequality 			
3. What are the possible consequences of intimate partner violence for the survivor?	<p>Need to identify “injury” and at least 2 mental health problems, and “stigma” or “isolation” for a Met score.</p> <p>Partially Met score requires “injury” and at least 1 mental health problem and “stigma” or “isolation”.</p>	<ol style="list-style-type: none"> 1. Injury 2. Death 3. Mental health problems: Low self-esteem 4. Mental health problems: Anxiety 5. Mental health problems: Depression 6. Mental health problems: _____ (other) 7. Stigma, isolation from the community 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>4. Why might it be difficult for a woman to leave her abusive situation?</p>	<p>Need to identify at least 5 of the responses for a Met score.</p> <p>For a Partially Met score, must identify 3 responses.</p>	<ol style="list-style-type: none"> 1. She has nowhere safe to go. 2. She still loves the abuser. 3. She hopes things will change. 4. She is scared of what he would do if he found her. 5. She is worried how she will support herself and her children (economic dependence). 6. She is worried about breaking up the family. 7. She is worried what people in the community will say (stigma). 			
<p>5. What are the possible consequences of sexual violence?</p>	<p>Need to identify: HIV/AIDS or other STIs, pregnancy, 2 mental health problems and stigma, isolation from community for a Met score.</p> <p>For a Partially Met score, must identify HIV/AIDS, pregnancy, and at least 1 mental health problem.</p>	<ol style="list-style-type: none"> 1. Injuries—general 2. HIV/AIDS or other STIs 3. Damage to reproductive organs 4. Pregnancy 5. Mental health problems: Low self-esteem 6. Mental health problems: Anxiety 7. Mental health problems: Depression 8. Mental health problems: _____ (other) 9. Stigma, isolation from the community 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>6. Name and describe the Guiding Principles for working with GBV survivors</p>	<p>Need to list and describe all guiding principles using key words for a Met score. Need to list and describe at least 2 principles for Partially Met score.</p>	<ol style="list-style-type: none"> 1. Right to confidentiality. Survivor's information not shared without their permission 2. Right to safety/ security. Survivor's physical and emotional safety must be ensured throughout helping process 3. Right to dignity and self determination. Survivor's opinions and decisions are respected and followed regardless of our own opinions 4. Non-discrimination. Every survivor is treated and served in the same manner 			
<p>7. What are some of the reasons a survivor may not want to report GBV?</p>	<p>Need to identify at least 5 to receive a Met score. Need to identify 3 for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Fear of retaliation from the perpetrator 2. Fear/worry that no one will believe survivor/how people will react 3. Shame 4. Self-blame 5. Lack of transportation 6. Lack of money to pay service fees 7. Does not trust authorities/ service providers 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>8. What body language can you use to create a welcoming and comfortable environment for the survivor</p>	<p>Need to identify 5 items to receive a Met score, 4 for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Sit face-to-face with survivor, but not at a desk 2. Make eye contact appropriately 3. Keep a friendly facial expression 4. Lean in toward the survivor as they speak 5. Nod your head to show understanding 6. Have a calm, relaxed body posture 			
<p>9. What are some things you can do to create trust and show respect to the survivor during your meetings with them?</p>	<p>Need to identify at least 5 items for a Met score, 4 for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Give full attention (don't take phone calls, etc.) 2. Don't interrupt; give survivor time to talk 3. Use respectful language 4. Don't promise anything you cannot give 5. Give complete and honest information 6. Follow through—do what you say you will do 7. Don't tell survivors what they "should" do, give information to help them make their own choice 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>10. Describe how you should start your first session with a survivor (Introduction and Engagement).</p>	<p>Need to identify all items for a Met score.</p> <p>For Partially Met score, identify 4 items (must include confidentiality, explaining rights, and permission to proceed).</p>	<ol style="list-style-type: none"> 1. Greet the survivor 2. Introduce yourself 3. Make sure you have privacy 4. Explain your role 5. Explain confidentiality 6. Explain their rights (can stop, refuse to answer, ask any questions) 7. Explain how information will be stored 8. Ask permission to proceed 			
<p>11. What are the limits to confidentiality in cases?</p>	<p>Need to explain all points for a Met score.</p> <p>2 for Partially Met score.</p>	<ol style="list-style-type: none"> 1. If the survivor is at risk of self-harm 2. If the survivor is at risk of harming another person (possibly homicidal) 3. If the perpetrator is a humanitarian worker that is part of humanitarian response 			
<p>12. When is informed consent sought during case management?</p>	<p>Need to identify all items to get a Met score, 1 item for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. At the start of case management services 2. For referrals to other services providers 			
<p>13. Explain the main areas of need that you must assess with survivors.</p>	<p>Need to name at least 4 assessment areas for a Met score, 3 for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Safety and protection 2. Medical/health care and treatment 3. Psychosocial needs 4. Legal/justice needs 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>14. What are the steps of case management?</p>	<p>Need to name all 6 steps for a Met and 4 steps for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Introduction and engagement 2. Assessment 3. Case action planning 4. Implementing the case action plan 5. Follow-up 6. Case closure 			
<p>15. What do we want to understand when we assess safety with a survivor?</p>	<p>Need to identify and explain all for a Met score. For Partially Met score, need to identify 2 items.</p>	<ol style="list-style-type: none"> 1. Survivor's sense of personal safety in the home environment 2. Survivor's sense of personal safety in the community environment 3. Survivor's identified safety/support systems 			
<p>16. What are the steps for assessment if a survivor is expressing feelings of suicide?</p>	<p>Need to name all 4 steps for a Met score, 2 for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Step 1: Assess current/past suicidal thoughts. 2. Step 2: Assess risk: lethality and safety needs. 3. Step 3: Address feelings and provide support. 4. Step 4: Formulate a safety action plan. 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
<p>17. What information does a caseworker have to provide to a survivor about health services in cases of sexual assault?</p>	<p>Need to identify emergency contraception and HIV PEP medication and timeframes, as well as 2 additional items for a Met score.</p> <p>Need to identify emergency contraception and HIV PEP medication and timeframes and 1 additional item for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. If within 120-hr. period and concerned about pregnancy: emergency contraception 2. If within 72-hr. period: HIV PEP medication for prevention 3. Forensic examination if survivor wants to pursue justice—best if done within 48-hour period and survivor has not showered or changed clothes. 4. STI treatment medication 5. Pelvic examination 6. Treatment of other injuries 			
<p>18. What are the main healing statements survivors should hear from you in your first interview?</p>	<p>Need to identify all items for a Met score, and at least 3 items for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. I believe you. 2. This is not your fault./ You're not to blame. 3. I'm glad you told me. 4. I'm very sorry this happened to you. 5. You are very brave for telling me and we will try to help you. 			
<p>19. Explain what happens during a follow-up session with a survivor.</p>	<p>Need to identify at least 5 items to receive a Met score, 4 items for a Partially Met score.</p>	<ol style="list-style-type: none"> 1. Update progress on case action plan 2. Reassess safety 3. Reassess psychosocial status 4. Reassess other needs/problems 5. Update the action plan 6. Obtain informed consent for new referrals 			

Knowledge Area	Criteria for Answering Correctly		Met	Partially Met	Not Met
20. What are the main criteria for knowing when to close a case?	Need to name all 3 items for a Met score, 2 items for a Partially Met score.	<ol style="list-style-type: none"> 1. The case plan is complete and satisfactory and follow-up is finished and the survivor and caseworker agree no further support is needed. 2. There has been no client contact for a specified period (e.g. more than 30 days). 3. The survivor no longer want to received services and requests their case be closed. 			
TOTAL POINTS					
TOTAL SCORE					
<p>Case Management Knowledge Assessment - Instructions for Scoring</p> <p>31-40 points = MET: Scores in this range indicate that the staff person has met the core case management requirements and is able to work independently with survivors with ongoing supervision.</p> <p>20-30 points = PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills in case management. A capacity building plan should also be put into place. This may include one-on-one mentoring sessions, additional training opportunities and shadowing fellow staff members, among other capacity building activities.</p> <p>0-19 Points = NOT MET: Scores in this range indicate that the staff person does not have sufficient knowledge and skills to provide case management to GBV survivors. A capacity building plan should be put into place. This may include one-on-one mentoring sessions, additional training opportunities and shadowing fellow staff members, among other capacity building activities. Following additional training, the tool should be re-administered to assess if the person has improve with support.</p>			<p>Final Evaluation:</p> <p>_____ MET</p> <p>_____ PARTIALLY MET</p> <p>_____ UNMET</p>		

OTHER OBSERVATIONS AND COMMENTS

STAFF CAPACITY BUILDING PLAN

Supervisor Signature/Date: _____

Staff Signature/Date: _____

SURVIVOR-CENTRED CASE MANAGEMENT SKILLS BUILDING TOOL

Purpose of the tool: The purpose of this tool is to help case management supervisors support caseworkers to develop important skills and confidence in working with GBV survivors. This tool is intended to guide a process of learning. It is not an evaluation of the caseworker’s performance.

How to use this tool: Supervisors can use this tool in ongoing individual supervision sessions with a caseworker over a period of time, using the questions to guide discussion or role-play. It lists skills associated with good case management practice and describes the correct answers/approach. There is no score involved. The tool is for the supervisor only and is intended to help the supervision process by providing a structured method for identifying in which topics/issues caseworkers need the most support. The column labeled **“Communication and Case Management Skill”** lists the questions or role-plays case management supervisors can use to support the skills development of casework staff. The column labeled **“Listen and Look For”** outlines correct answers/approaches that supervisors should be listening and looking for in their discussion and role-plays with the caseworker.

The column labeled **“Comments and Observations”** provides a space where the supervisor can write the feedback they provided the caseworker—e.g. what was done or answered correctly and what still needs improvement. The column labeled **“Staff Capacity Building Plan”** provides a space for supervisors to identify concrete steps that will be taken to help the caseworker improve in that area. **“Date Reviewed”** and **“Date Completed”** allows supervisors to track their use of the tool with the staff person. Indicate the **“Date Reviewed”** when the first conversation about that topic takes place. Indicate the **“Date Completed”** when the staff person has demonstrated that topic sufficiently.

Supervisors can add or change questions depending on what is most relevant for a particular context, program or staff person.

Supervisor Name: _____

Staff Name: _____

1. Introduction and Engagement Skills

Communication & Case Management Skill	What to listen and look for	Comments and Observations	Staff Capacity Building Plan
<p>What are some things you can do to create trust and show respect to a survivor during your meetings with a survivor?</p>	<ul style="list-style-type: none"> • Give the survivor full attention (don't take phone calls, etc.) • Don't interrupt; give them time to talk • Use respectful language • Don't promise anything you cannot give • Give complete and honest information • Follow through—do what you say you will do • Don't tell the person what they "should" do; give information to help them make their own choice 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Show how to use your body language to help a survivor feel safe and comfortable.</p>	<ul style="list-style-type: none"> • Use appropriate eye contact • Friendly expression on face • Soft, gentle voice • Other culturally appropriate things identified • If it's a child, sit at their level 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

<p>Describe how you should start your first session with a survivor. This should include actions you would take and how.</p>	<ul style="list-style-type: none"> • Greet the survivor • Introduce yourself • Make sure you have privacy • Make sure it is safe for the survivor to be speaking with you at that moment • Explain your role • Explain confidentiality and its limits • Explain survivor rights (can stop, refuse to answer, ask any questions) • Explain how information will be stored • Ask if the person has any questions • Ask the person's permission to proceed 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Show how you explain confidentiality and its limits/exceptions to an adult survivor.</p>	<ul style="list-style-type: none"> • Explain that confidentiality means that “I won’t tell anyone what you tell me” (or similar). • Explain the exceptions to confidentiality (e.g. “There are a few situations in which I may have to tell someone else what you share with me, but it is only for safety reasons: if I think you may hurt yourself or someone else, or if the perpetrator is a humanitarian worker. This doesn’t mean I will tell the police—it just means that I will have to talk to my supervisor and we will let you know if we have to involve others.) 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

<p>Show how you would get informed consent/ assent from an adolescent girl survivor who is 14 years old and does not want her parents to know what has happened because she is afraid they will harm her.</p>	<p>Explain:</p> <ul style="list-style-type: none"> • Your role • Services your organization provides • Confidentiality and its limits • Her rights • Ask her if there is another trusted adult she wants to involve. If she is able to identify another trusted adult, you can get informed consent from that person and informed assent from the girl. If she is unable to identify a trusted adult and you determine it is appropriate, allow her to provide informed consent directly. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Explain what you would do if a survivor walks in to your centre and starts to talk about what happened to her/him immediately (the survivor is not in immediate physical danger or requiring immediate medical attention).</p>	<ul style="list-style-type: none"> • Let the survivor finish what they are saying, but do not ask further questions. • Politely let the survivor know that you understand that they are in distress and that you would like to listen and help. • Explain that before you do that, you to explain a few things that are important for the survivor to know about the help you can provide. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

2. Assessment and Planning

Communication & Case Management Skill	What to listen and look for	Comments and Observations	Staff Capacity Building Plan
<p>Demonstrate how you would start a discussion with a survivor about what happened to them?</p>	<ul style="list-style-type: none"> • “Tell me about what brought you here today” or “I’d like to hear about what brought you here today.” or “Would you like to tell me about what happened?” 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Demonstrate how you would explain to a survivor a medical referral for the clinical management of rape.</p>	<ul style="list-style-type: none"> • What kind of care is available (e.g. testing, medicine, exam). • What will happen during the exam. • That the survivor can stop the exam at any time. • That the survivor can have someone they trust in the room with them if they want. • Costs of services (if any). • Reporting requirements (if any) to receive services and the risks associated with that. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

<p>Demonstrate how you assess safety and do safety planning (With a survivor in general—not specific to intimate partner violence).</p>	<p>Ask the survivor</p> <ul style="list-style-type: none">• How safe they feel at home• How safe they feel in the community <p>Identify strategies and resources in the survivor’s life that can help reduce their risk of harm from the perpetrator.</p>	<p>Date Reviewed:</p>	<p>Date Completed:</p>
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<p>Name and explain the purpose of the healing statements that a caseworker can use to help communicate empathy, validation and reassurance to the a survivor.</p>	<ul style="list-style-type: none"> • I believe you. Purpose: Builds trust • This is not your fault. Purpose: Non-blaming • I am very glad you told me. Purpose: Builds relationship • I am sorry this happened to you. Purpose: Expresses empathy • You are very brave for telling me, and we will try to help you. Purpose: Reassuring and empowering 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Role-play how you would carry out a suicide risk assessment with a survivor.</p>	<ul style="list-style-type: none"> • Assess current and past suicidal ideation. Are they having thoughts about wanting to die? How often? Have they tried in the past? What helped them to keep from trying? • Assess if/what kind of plan the person has—e.g. have they thought about the method and what access they have to that method? Have they thought about the time and/or place? 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

<p>Role-play how you would carry out a suicide risk assessment with a survivor. (cont'd)</p>	<ul style="list-style-type: none"> • Address feelings and provide support. Make sure you do not judge them or tell them that they should not think this way or should not kill themselves. • Instead, say “I can understand why you are feeling this. You went through something really difficult and your feelings are normal. I want you to know that it’s really important to me you don’t hurt yourself. I don’t want anything to happen to you.” • Develop a safety agreement. Say “I would like us to come up with a plan for how to keep you safe—do you think we can do that together?” • Discuss how to remove access to the method they have thought about using. Can they throw it away or give it to someone else and ask that person to throw it away? • Identify positive coping strategies: What can they do to feel better when they start to feel like they want to die or hurt themselves? Who can they talk to that would understand and support them? 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
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<p>Role-play how you would carry out a suicide risk assessment with a survivor. (cont'd)</p>	<ul style="list-style-type: none"> • Identify a safe person who can be with them for the next few days, around the clock and a person that could reach out to in the future for support. • If appropriate give them your organization's phone number and ask if they will agree to contact you if they start to feel this way again. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Describe and show how you would provide information about intimate partner violence (IPV) to a survivor.</p>	<ul style="list-style-type: none"> • Explain that you would like to share some information that can help them understand what happened. • Explain what IPV is, using simple language; be sure to explain the dynamics of power and control. • Explain how survivors may feel as a result of this abuse, what the common and normal reactions are. • Explain why survivors don't often talk to others about what is happening to them. • Ask if they have any questions. • Ask what information was most helpful for them. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

3. Follow-up and Case Closure

Communication & Case Management Skill	What to listen and look for	Comments and Observations	Staff Capacity Building Plan
<p>Role play how you have a discussion with a survivor about setting up a follow-up appointment.</p>	<ul style="list-style-type: none"> • Discuss with the survivor how it will be safest and easiest for you to see the survivor again. • Go through different options and choose one that is best for the person. • Discuss any safety risks associated with this option and plan to mitigate those risks. • Discuss how the survivor can get in touch with you if she needs to change the plan. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Describe and role play the key components of providing follow-up to a survivor.</p>	<ul style="list-style-type: none"> • Assess progress towards actions/ goals since your last meeting • Reassess emerging needs – particularly safety • Make adjustments to the case action plan • Plan for the next follow-up appointment 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

<p>Role play how you would have a conversation about case closure with a survivor whose case action plan is mostly completed.</p>	<ul style="list-style-type: none"> • Review the progress on goals. • Provide positive feedback on how much has been accomplished. • Ask the person to reflect on the progress. And are there any new goals the person has and wants assistance with? • If not, discuss with them that if there is no further work on existing goals or no additional goals to add, that the survivor can decide to close the case. • Explain that this means that while your 1:1 work with the person is done, they can still attend any group activities they are participating in at your organization (if relevant) and that they can always come back if they decide they would like support again in the future. • Review / update safety planning and coping strategies if still relevant for the survivor. 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
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<p>Role play how you would have a conversation about case closure with a survivor who requests that they want their case to be closed despite the fact that you are still working towards goals in the action plan.</p>	<ul style="list-style-type: none"> • Respond without judgment • Review / update safety planning and coping strategies that had been part of the case action plan • Explain to the person that they are welcome to return for services at any point 	<p>Date Reviewed:</p>	<p>Date Completed:</p>
<p>Role play how you would describe a client feedback survey to a survivor.</p>	<ul style="list-style-type: none"> • Explain the purpose of the client feedback survey • Explain how it will be administered and that the information collected remains anonymous • Explain that it is their decision whether to participate in the survey or not 	<p>Date Reviewed:</p>	<p>Date Completed:</p>

SURVIVOR-CENTRED CASE MANAGEMENT QUALITY CHECKLIST

Instructions. The case management supervisor can use this checklist as part of case supervision during regular case reviews. Review the caseworker’s practice on an individual case by asking the caseworker if she or he completed the tasks listed for each step of case management or use the tool following case observations (if such a method is part of your programme’s supervision system). This checklist provides an opportunity to evaluate the caseworker’s direct practice and to receive supervision from his or her case supervisor.

Staff Name:

Supervisor Name:

Date:

CREATE A CLIMATE OF TRUST, SUPPORT, CARE & EMPOWERMENT

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Stay calm and comforting throughout the survivor’s care?				
Communicate with the survivor using simple, clear, non-blaming language?				
Tell the survivor they are strong and brave for telling the caseworker what happened?				
Tell the survivor it is not their fault and that they are not to blame for what happened?				
Respect and follow the survivor’s ideas, views and opinions throughout the case?				

INTRODUCTION/ENGAGEMENT & ASSESSMENT STEPS

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Explain to the survivor in simple, clear terms about case management services and confidentiality?				
Obtain informed consent from the survivor appropriately?				
Conduct a safe and supportive interview (following the best practices for communication/interviewing)?				
Collect only the details of the incident relevant to helping the survivor?				
Assess the survivor's safety, health, psychosocial and legal/justice needs as relevant and appropriately?				
Complete the correct forms and documentation?				

CASE ACTION PLANNING & IMPLEMENTING THE ACTION PLAN STEPS

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Develop an action plan based on the assessment of needs?				
Prioritize safety and health needs if urgent (if applicable)?				

CASE ACTION PLANNING & IMPLEMENTING THE ACTION PLAN STEPS (CONT'D)

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Develop a safety plan with the survivor (if applicable)?				
Allow the survivor to make decisions based on the information provided?				
Explained options for services available to help meet the survivor's needs?				
Ask the survivor how much information they would like to have shared during the referral process and how?				
Obtain informed consent for referrals?				
Coordinate the survivor's needs through safe and appropriate referrals (e.g. accompany the survivor)?				
Implement mandatory reporting procedures (if applicable)?				
Deliver additional psychosocial support (if appropriate and available at your agency)?				
Consult with supervisor on urgent safety concerns raised?				
Make a follow-up plan/appointment?				

CASE ACTION PLANNING & IMPLEMENTING THE ACTION PLAN STEPS (CONT'D)

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Complete the correct forms and documentation?				

CASE FOLLOW-UP

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Meet with the survivor at the requested time and location for follow-up appointment?				
Review the initial case goals and action plan to assess whether/to what extent the survivor's needs have been met?				
Reassess the survivor's needs (especially safety) during the follow-up to see if new issues or needs have emerged?				
Develop a revised action plan to meet new needs the survivor has?				
Obtain informed consent for any additional service providers who will be brought into the survivor's care?				
Make another follow-up appointment with the survivor, ask the survivor what obstacles they may face in keeping the appointment and problem-solve with the survivor?				
Complete the correct forms and documentation?				

CASE CLOSURE

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Assess, with the survivor, whether all needs have been met and no further case management is needed?				
Review safety plan in place?				
Explain to the survivor that they can always come back for further services?				
Complete the appropriate case documentation?				

OVERALL CASE MANAGEMENT PROVIDED

Did the caseworker...	Yes	No	N/A	Supervisor Comment
Follow the GBV Case Management Guiding Principles?				
Complete case management steps and procedures according the survivor-centred approach?				
Listen and receive advice and supervision from the case management supervisor?				

WHAT IS THE GBVIMS?



The Gender-Based Violence Information Management System (GBVIMS) enables humanitarian actors to safely collect, store and analyse reported GBV incident data, and facilitates the safe and ethical sharing of this data with other local actors. The system was created to harmonize GBV data collected during service delivery in humanitarian settings. It is led by an inter-agency partnership with representatives from UNFPA, IRC, UNHCR, UNICEF and IMC.

The GBVIMS includes:

1. A standard intake and consent form (psychosocial and medical) designed to ensure that GBV actors are collecting a common set of data points within the context of service provision, and survivors consent to any information shared;
2. Standard definitions for six types of GBV for data collection purposes;
3. An Excel “Incident Recorder” database designed to facilitate data entry, compilation and analysis; and,
4. An information-sharing protocol template that outlines guiding principles on the safe and ethical sharing of GBV data and best practices for developing an inter-agency information-sharing protocol.

What are safe and ethical standards for GBV data management?

The data generated through the GBVIMS comes from the women, girls, men and boys who are affected by a humanitarian crisis, experience gender-based violence and seek help despite the risks involved. The GBVIMS promotes and protects safety and ethics at every step. The tools and processes of the GMVIMS are based on the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies and other best practices, including:

- ✓ Ensuring services are available to GBV survivors if data is to be gathered from them
- ✓ Making survivor/incident data non-identifiable (no names, contact info, or other identifiers)
- ✓ Only sharing survivor/incident data with the informed consent of the client
- ✓ Sharing client information only within the context of a referral and with the informed consent of the survivor
- ✓ Protecting client data at all times and only sharing with those who are authorized
- ✓ Establishing an agreement with service providers and other local actors to determine how data will be shared, protected and used (for what purpose) – before data is shared

Implementing the GBVIMS

The GBVIMS has been implemented in over 25 countries in Africa, Asia, Europe, South America and the Middle East. The GBVIMS rollout process includes some steps that are standardized across organizations and contexts, and additional steps that require one-the-ground analysis and adaptation by inter-agency coordinators and managers from individual organizations.

Enhanced Programming Resulting from the GBVIMS

In countries where the GBVIMS is implemented, the service-based data generated can be used to inform programming, including design and monitoring. GBVIMS data helps shape programmes by informing staff about acts of violence, survivor and perpetrator profiles, and gaps in service provision. This helps service providers and

coordinating agencies adapt prevention programming and response activities. The GBVIMS data also bolsters advocacy efforts (i.e. policy development and fundraising) and facilitates donor reporting.

Programs can utilize GBVIMS data by looking at trends and trying to understand them in the broader context in which the violence has been reported. The data collected and stored in the GBVIMS is labeled 'service-based' because it is collected at the point of and in connection with the provision of services for GBV survivors.

Visit <http://gbvims.com> for more information.

PROTECTION-RELATED INFORMATION MANAGEMENT SYSTEM



Primero is the Protection Related Information Management System. An application developed to enable humanitarian actors to safely and securely collect, store, manage and share data for protection-related incident monitoring and case management. This platform has individual modules for Gender-Based Violence, Child Protection, and Grave Violations against Children.

Primero combines field-proven tools, global best practice, and the latest open source technology to bring community-level protection workers a user-friendly and scalable solution for their data management challenges.

GBVIMS+

GBVIMS+ is one module of Primero. It is an advancement from the current GBVIMS incident recorder with an added function for GBV case management. The goal of the GBVIMS+ is a survivor-centered system.

System Features

- Online Platform - On/offline data collection platform that manages individual cases and services for survivors as well as incident monitoring.
- Language Compatibility - Accommodates English, French, Arabic, and Spanish. Full internationalization coming soon.
- Heightened Security- Based in a secure framework with role-based access to respond best to the principles of confidentiality, informed consent and need to know.

The screenshot shows the Primero web application interface. At the top, there is a navigation bar with the Primero logo and the text "Protection-related information management". Below the navigation bar, there is a table of incidents. The table has columns for ID#, DATE OF INTERVIEW, DATE OF INCIDENT, VIOLENCE TYPE, and INCIDENT LOCATION. The first row shows an incident with ID# 58A1AF5 and a green flag icon. The second row shows an incident with ID# E96168E, a date of interview of 19-Mar-2013, a date of incident of 17-Mar-2014, and an incident location of Zone 2. There are also buttons for FLAG and ACTIONS.

ID#	DATE OF INTERVIEW	DATE OF INCIDENT	VIOLENCE TYPE	INCIDENT LOCATION
58A1AF5				
E96168E	19-Mar-2013	17-Mar-2014		Zone 2

GBVIMS CONSENT FOR RELEASE OF INFORMATION

CONFIDENTIAL

Incident ID:

Client Code:

This form should be read to the client or guardian in her first language. It should be clearly explained to the client that she / he can choose any or none of the options listed.

I, _____, give my permission for **(Name of Organization)** to share information about the incident I have reported to them as explained below:

1. I understand that in giving my authorization below, I am giving **(Name of Organization)** permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs.

I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.

I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.

I would like information released to the following:

(Tick all that apply, and specify name, facility and agency/organization as applicable)

YES NO

- Security Services (specify): _____
- Psychosocial Services (specify): _____
- Health/Medical Services (specify): _____
- Safe House / Shelter (specify): _____
- Legal Assistance Services (specify): _____
- Livelihoods Services (specify): _____
- Other (specify type of service, name, and agency): _____

1. AUTHORIZATION TO BE MARKED BY CLIENT:

Yes

No

(or parent/guardian if client is under 18)

2. I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

2. AUTHORIZATION TO BE MARKED BY CLIENT:

Yes

No

(or parent/guardian if client is under 18)

Signature/Thumbprint of client: _____

(or parent/guardian if client is under 18)

Caseworker Code:

Date:

INFORMATION FOR CASE MANAGEMENT
(OPTIONAL-DELETE IF NOT NECESSARY)

Client's Name: _____

Name of Caregiver (if client is a minor): _____

Contact Number: _____

Address: _____

(Write questions for Survivor Code Here)

GBVIMS INTAKE AND INITIAL ASSESSMENT FORM

CONFIDENTIAL

INSTRUCTIONS

1. This form must be filled out by a case manager, health practitioner, social worker or other authorized person providing services to the survivor.
2. Note that questions followed by an asterisk* must remain on the intake form and must be answered. These questions are a part of a minimum essential dataset on GBV. Some questions are followed by both an asterisk* and a circle○; these are customizable, and the italicized text of these fields is intended to be adapted to each context and can be modified. Questions that are unmarked may be modified by your agency or removed if they are not necessary for your program and/or case management.
3. Unless otherwise specified, always mark only one response field for each question.
4. Please feel free to add as many questions to this form as needed in your context and/or attach additional pages with continued narrative, if needed.

Before beginning the interview, please be sure to remind your client that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

1-ADMINISTRATIVE INFORMATION

Incident ID*:	Survivor code:	Caseworker code:
Date of interview (day/month/year)*:	Date of incident (day/month/year)*:	
<input type="checkbox"/> Reported by the survivor or reported by survivor's escort and survivor is present at reporting* (These incidents will be entered into the Incident Recorder)		
<input type="checkbox"/> Reported by someone other than the survivor and survivor is not present at reporting (These incidents will not be entered into the Incident Recorder)		

2-SURVIVOR INFORMATION

Date of birth (approximate if necessary)*:	Sex*: <input type="checkbox"/> Female <input type="checkbox"/> Male	Clan or ethnicity:
Country of origin*○: <input type="checkbox"/> Country names here <input type="checkbox"/> Etc. <input type="checkbox"/> Other (specify): <input type="checkbox"/> Etc. <input type="checkbox"/> Etc.		
Nationality (If different than country of origin):	Religion:	
Current civil/marital status*: <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Widowed		
Number and age of children and other dependants:		
Occupation:		
Displacement status at time of report*: <input type="checkbox"/> Resident <input type="checkbox"/> IDP <input type="checkbox"/> Refugee <input type="checkbox"/> Stateless Person <input type="checkbox"/> Returnee <input type="checkbox"/> Foreign National <input type="checkbox"/> Asylum Seeker <input type="checkbox"/> N/A		
Is the client a Person with Disabilities?*		
<input type="checkbox"/> No <input type="checkbox"/> Mental disability <input type="checkbox"/> Physical disability <input type="checkbox"/> Stateless Person		
Is the client an Unaccompanied Minor, Separated Child, or Other Vulnerable Child?*		
<input type="checkbox"/> No <input type="checkbox"/> Unaccompanied Minor <input type="checkbox"/> Separated Child <input type="checkbox"/> Other Vulnerable Child		
Sub-Section for Child Survivors (less than 18 years old)		
If the survivor is a child (less than 18yrs) does he/she live alone?		
<input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", answer the next three questions)		
If the survivor lives with someone, what is the relation between her/him and the caretaker?		
<input type="checkbox"/> Parent / Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Spouse/Cohabiting <input type="checkbox"/> Other:_____		
What is the caretaker's current marital status?		
<input type="checkbox"/> Single <input type="checkbox"/> Married/Cohabiting <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown/Not Applicable		
What is the caretaker's primary occupation:		

3-DETAILS OF THE INCIDENT

Account of the incident/Description of the incident (summarize the details of the incident in client's words)

Stage of displacement at time of incident*:

- Not Displaced/Home Community
 During Flight
 During Return/Transit
 Other: _____
 Pre-displacement
 During Refuge
 Post-displacement

Time of day that incident took place*:

- Morning (sunrise to noon)
 Afternoon (noon to sunset)
 Evening/night (sunset to sunrise)
 Unknown/Not Applicable

Incident location/Where the incident took place*○:

(Customize location options by adding new, or removing tick boxes according to your location)

- Bush / Forest
 Garden / Cultivated Field
 School
 Road
 Client's Home
 Perpetrator's Home
 Other (give details) _____

Area where incident occurred*○:

- Area names here
 Etc.
 Etc.
 Etc.
 Other (specify) :

Sub-Area where incident occurred*○:

- Sub-area names here
 Etc.
 Etc.
 Etc.
 Etc.
 Other (specify) :

Camp/Town/Site:

- Camp/Town/Site names here
 Etc.
 Etc.
 Etc.
 Other (specify) :

3-DETAILS OF THE INCIDENT (CONT'D)

Type of Incident Violence*:

(Please refer to the GBVIMS GBV Classification Tool and select only ONE)

- Rape (includes gang rape, marital rape)
- Sexual Assault (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)
- Physical Assault (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)
- Forced Marriage (includes early marriage)
- Denial of Resources, Opportunities or Services
- Psychological / Emotional Abuse
- Non-GBV (specify)

Note: these incidents will not be entered into the incident recorder

1. **Did the reported incident involve penetration?**
If yes → classify the incident as “Rape”.
If no → proceed to the next incident type on the list.
2. **Did the reported incident involve unwanted sexual contact?**
If yes → classify the incident as “Sexual Assault”.
If no → proceed to the next incident type on the list.
3. **Did the reported incident involve physical assault?**
If yes → classify the incident as “Physical Assault”.
If no → proceed to the next incident type on the list.
4. **Was the incident an act of forced marriage?**
If yes → classify the incident as “Forced Marriage”.
If no → proceed to the next incident type on the list.
5. **Did the reported incident involve the denial of resources, opportunities or services?**
If yes → classify the incident as “Denial of Resources, Opportunities or Services”.
If no → proceed to the next incident type on the list.
6. **Did the reported incident involve psychological/emotional abuse?**
If yes → classify the incident as “Psychological / Emotional Abuse”.
If no → proceed to the next incident type on the list.
7. **Is the reported incident a case of GBV?**
If yes → Start over at number 1 and try again to reclassify the incident (If you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident).
If no → classify the incident as “Non-GBV”

Was this incident a Harmful Traditional Practice*○?

- No Type of practice
- Type of practice Type of practice
- Type of practice Type of practice

Were money, goods, benefits, and/or services exchanged in relation to this incident*?

- Yes No

Type of abduction at time of the incident*:

- None Forced Conscriptio
- Trafficked Other Abduction/Kidnapping

3-DETAILS OF THE INCIDENT (CONT'D)

Has the client reported this incident anywhere else?*

(If yes, select the type of service provider and write the name of the provider where the client reported);
(Select all that apply).

- No
- Health/Medical Services_____
- Psychosocial/Counseling Services_____
- Police/Other Security Actor_____
- Legal Assistance Services_____
- Livelihoods Program_____
- Safe House/Shelter_____
- Other (specify)_____

Has the client had any previous incidents of GBV perpetrated against them?*

- Yes
- No

If yes, include a brief description:

4-ALLEGED PERPETRATOR INFORMATION

Number of alleged perpetrator(s)*:

- 1 2 3 More than 3 Unknown

Sex of alleged perpetrator(s)*:

- Female Male Both female and male perpetrators

Nationality of alleged perpetrator:

Clan or ethnicity of alleged perpetrator:

Age group of alleged perpetrator* (if known or can be estimated):

- 0-11 12-17 18-25 26-40 41-60 60+ Unknown

Alleged perpetrator relationship with survivor *:

(Select the first ONE that applies)

- Intimate partner/Former partner
 Primary caregiver
 Family other than spouse or caregiver
 Supervisor/Employer
 Schoolmate
 Teacher/School official
 Service Provider
 Cotenant/Housemate
 Family Friend/Neighbor
 Other refugee/IDP/Returnee
 Other resident community member
 Other
 No relation
 Unknown

Main occupation of alleged perpetrator (if known)*○:

(Customize occupation options by adding new, or removing tick boxes according to your location)

- | | | |
|---|--|--|
| <input type="checkbox"/> Farmer | <input type="checkbox"/> Trader/Business Owner | <input type="checkbox"/> Religious Leader |
| <input type="checkbox"/> Student | <input type="checkbox"/> Non-State Armed Actor/Rebel/Militia | <input type="checkbox"/> Teacher |
| <input type="checkbox"/> Civil Servant | <input type="checkbox"/> Security Official | <input type="checkbox"/> UN Staff |
| <input type="checkbox"/> Police | <input type="checkbox"/> Camp or Community Leader | <input type="checkbox"/> NGO Staff |
| <input type="checkbox"/> State Military | <input type="checkbox"/> CBO Staff | <input type="checkbox"/> Community Volunteer |
| <input type="checkbox"/> Health Worker | <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

5-PLANNED ACTION / ACTION TAKEN:

Any action / activity regarding this report.

Who referred the client to you?*

- | | |
|---|--|
| <input type="checkbox"/> Health/Medical Services | <input type="checkbox"/> Teacher/School Official |
| <input type="checkbox"/> Psychosocial/Counseling Services | <input type="checkbox"/> Community or Camp Leader |
| <input type="checkbox"/> Police/Other Security Actor | <input type="checkbox"/> Safe House/Shelter |
| <input type="checkbox"/> Legal Assistance Services | <input type="checkbox"/> Other Humanitarian or Development Actor |
| <input type="checkbox"/> Livelihoods Program | <input type="checkbox"/> Other Government Service |
| <input type="checkbox"/> Self Referral/First Point of Contact | <input type="checkbox"/> Other (specify) _____ |

Did you refer the client to a safe house/safe shelter?*

- Yes No

If 'No', why not?*

- Service provided by your agency
 Services already received from another agency
 Service not applicable
 Referral declined by survivor
 Service unavailable

Date reported or future appointment date (day/month/year) and Time:

Name and Location:

Notes (including action taken or recommended action to be taken):

Did you refer the client to health / medical services?*

- Yes No

If 'No', why not?*

- Service provided by your agency
 Services already received from another agency
 Service not applicable
 Referral declined by survivor
 Service unavailable

Date reported or future appointment Date and Time:

Name and Location:

Follow-up Appointment Date and Time:

Notes (including action taken or recommended action to be taken):

5-PLANNED ACTION / ACTION TAKEN (CONT'D):

Any action / activity regarding this report.

<p>Did you refer the client to psychosocial services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/ month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to legal assistance services?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/ month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to the police or other type of security actor?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/ month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>
<p>Did you refer the client to a livelihoods program?*</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If 'No', why not?*</p> <p><input type="checkbox"/> Service provided by your agency</p> <p><input type="checkbox"/> Services already received from another agency</p> <p><input type="checkbox"/> Service not applicable</p> <p><input type="checkbox"/> Referral declined by survivor</p> <p><input type="checkbox"/> Service unavailable</p>	<p>Date reported or future appointment date (day/ month/year) and Time:</p> <p>Name and Location:</p> <p>Notes (including action taken or recommended action to be taken)</p>

6 - ASSESSMENT POINT

Describe the emotional state of the client at the beginning of the interview:

Describe the emotional state of the client at the end of the interview:

Will the client be safe when she or he leaves?

Yes No

If no give reason:

Who will give the client emotional support?

6 - ASSESSMENT POINT (CONT'D)

What actions were taken to ensure client's safety?

Other relevant information:

If raped, have you explained the possible consequences of rape to the client (if over 14 years of age)?

Yes No

Have you explained the possible consequences of rape to the client's caregiver (if the client is under the age of 14)?

Yes No

Did the client give their consent to share their non-identifiable in your reports?

Yes No

PART VII

GLOSSARY OF TERMS

GLOSSARY OF TERMS

Common terms and definitions used in this document are defined below. These terms and definitions are not legal definitions and are not intended as such.⁷¹

Adolescence: defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral and psychosocial spheres.

Adolescent: Any person between the ages of 10-19 years old.

Adult: Any person 18 years and older.

Assessment: The beginning stage of case management or psychosocial services in which information is gathered and evaluated for the purpose of making an appropriate decision about a course of action. Assessment prevents assumptions, creates grounds for developing an appropriate plan of action, and helps identify survivor strengths.

Attitude: Opinion, feeling or position about people, events, and/or things that is formed as a result of one's beliefs. Attitudes influence behavior.

Belief: An idea that is accepted as true. It may or may not be supported by facts. Beliefs may stem from or be influenced by religion, education, culture and personal experience.

Caregiver: This term describes the person who is exercising day-to-day care for another person. He or she is a parent, relative, family friend or other guardian; it does not necessarily imply legal responsibility. Caregiver is a term that is used in this resource to describe a person who provides day-to-day care for a child/children or for a person with a disability (for those who need such support).

Case action plan: The case document that outlines the main needs of the client and goals and strategies for meeting their needs and improving their current condition.

Case conference/meeting: Case conferences are small meetings with appropriate service providers (e.g. already involved in the person's care) scheduled when the person's needs are not being met in a timely or appropriate way. The purpose of the case conference is to gather the appropriate service providers (and concerned support people in the person's life as appropriate) to identify or clarify ongoing issues regarding the person's care. Case conferences provide an opportunity to review activities including progress and barriers towards goals; to map roles and responsibilities; to resolve conflicts or strategize solutions; and to adjust action plans.

Case documentation: Information related to the provision of case management services. Generally, this information includes dates of services; the specific service provider; a brief description of the situation and the person's responses to the subject matter; relevant action plans and follow-up appointment information. Case documentation also includes dates and reason for closing the person's case.⁷²

Case management: GBV case management, which is based on social work case management, is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them

71 In an effort to ensure consistency, to the extent possible, some definitions have been taken directly from the IASC *Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action*. <http://gbvguidelines.org> and from the *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*. <http://gbvresponders.org/response/caring-child-survivors/>

72 In humanitarian settings, it is best practice to collect and store data in case files with non-identifying data only. For more information about the safe and ethical collecting, storing and usage of information, please go to www.gvbims.org.

and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.

Case supervision: The process whereby a caseworker shares case work decisions, challenges and experience with another professional (generally a direct supervisor) who offers guidance, knowledge and support. Supervision helps caseworkers improve their case management skills and allows caseworkers to share the burden of hearing and responding to survivors' problems and experiences regarding violence; it also creates general awareness of the care being provided.

Caseworker: This term describes an individual working within a service providing agency, who has been tasked with the responsibility of providing case management services to clients. This means that caseworkers are trained appropriately on client-centered case management; they are supervised by senior program staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers, case managers, among others.

Child: Any person under the age of 18. Children have evolving capacities depending on their age and developmental stage. In working with children, it is critical to understand these stages, as it will determine the method of communication with individual children. It will also allow the caseworker to establish an individual child's level of understanding and their ability to make decisions about their care. As a result, the caseworker will be able to make an informed decision about which method of intervention is most appropriate for each individual child.

The following definitions clarify the term "child" with regard to age/developmental stages for guiding interventions and treatment:

- Children = 0-18, as per the CRC
- Young children = 0-9
- Early adolescents = 10-14
- Later adolescents = 15-19

Child abuse: Child sexual abuse is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. By this definition, it is possible for a child to be sexually abused by another child. Child sexual abuse often involves body contact. This could include sexual kissing, touching, and oral, anal or vaginal sex. Not all sexual abuse involves body contact, however. Forcing a child to witness rape and/or other acts of sexual violence, forcing children to watch pornography or show their private parts, showing a child private parts ("flashing"), verbally pressuring a child for sex, and exploiting children as prostitutes or for pornography are also acts of sexual abuse.

Child/early marriage: A child or early child marriage is a formal marriage or informal union before age 18. Even though some countries permit marriage before age 18, international human rights standards classify these as child marriages, reasoning that those under age 18 are unable to give informed consent. Therefore, early marriage is also a form of forced marriage as children are not legally competent to agree to such unions.

Confidentiality: Confidentiality is an ethical principle that is associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files. Maintaining confidentiality means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.

Disclosure: The process of revealing information. Disclosure in the context of this resource refers to a survivor voluntarily sharing with someone that she has experienced or is experiencing GBV.

Empathy: Attempting to see things from the survivor's point of view and sharing that understanding with the survivor. Empathy can be communicated through verbal and nonverbal communication.

Economic violence/abuse: An aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency and gaining financial independence. It is one form of intimate partner violence.

Emotional violence/abuse (also referred to as psychological abuse): Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. It is one form of intimate partner violence.

Gender-based violence: Gender-based violence (GBV) is an umbrella term for any harmful act perpetrated against a person based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private spaces. Common forms of GBV include sexual violence (rape, attempted rape, unwanted touching, sexual exploitation and sexual harassment), intimate partner violence (also called domestic violence, including physical, emotional, sexual and economic abuse), forced and early marriage and female genital mutilation.⁷³

Humanitarian worker: An employee or volunteer, whether internationally or nationally recruited, or formally or informally retained from the beneficiary community, engaged by a humanitarian agency to conduct the activities of that agency.

Informed assent: The expressed willingness to participate in services. This applies to younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services.

Informed consent: The voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. To ensure consent is "informed", service providers must provide the following information to the survivor:

- ✓ Provide all the possible information and options available to the person so she/he can make choices.
- ✓ Inform the person that she/he may need to share his/her information with others who can provide additional services.
- ✓ Explain to the person what will happen as you work with her/him.
- ✓ Explain the benefits and risks of services to the person.
- ✓ Explain to the person that she/he has the right to decline or refuse any part of services.
- ✓ Explain limits to confidentiality.

Intimate partner violence: Intimate partner violence applies specifically to violence occurring between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is defined as behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors. This type of violence may also include the denial of resources, opportunities or services.

⁷³ IASC Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action. <http://gbvguidelines.org>

Mandatory reporting: This refers to state laws and policies which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected forms of interpersonal violence (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

Parent: The child's mother or father. Note that in some societies it is common for girls and boys to spend time with other members of their extended family and sometimes with unrelated families. Throughout this resource, the term "parent" generally refers to the biological parent. In some cases, it may refer to the person or persons who assume the child's care on a permanent basis, such as for example, foster or adoptive parents, or extended family members providing long-term care.

Perpetrator: A person who directly inflicts or supports violence or other abuse inflicted on another against his/her will.

Physical assault: An act of physical violence that is not sexual in nature. Example include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. It is one form of intimate partner violence.

Psychosocial: A term used to emphasize the interaction between the psychological aspects of human beings and their environment or social surroundings. Psychological aspects are related to our functioning, such as our thoughts, emotions and behavior. Social surroundings concern a person's relationships, family and community networks, cultural traditions and economic status, including life tasks such as school or work.

Sexual violence: Sexual violence is "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes, at least, rape/attempted rape, sexual abuse and sexual exploitation.

Sexual exploitation: The term 'sexual exploitation' means any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category.

Survivor/Victim: A person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably, although "victim" is generally preferred in the legal and medical sectors, and "survivor" in the psychological and social support sectors.

Trauma: Traumatic experiences usually accompany a serious threat or harm to an individual's life or physical well-being and/or a serious threat or harm to the life or physical well-being of the individual's child, spouse, relative or close friend. When people experience a disturbance to their basic psychological needs (safety, trust, independence, power, intimacy and esteem), they experience psychological trauma.⁷⁴

⁷⁴ Herman, J. *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*, Basic Books, New York, 1992, p. 7.

