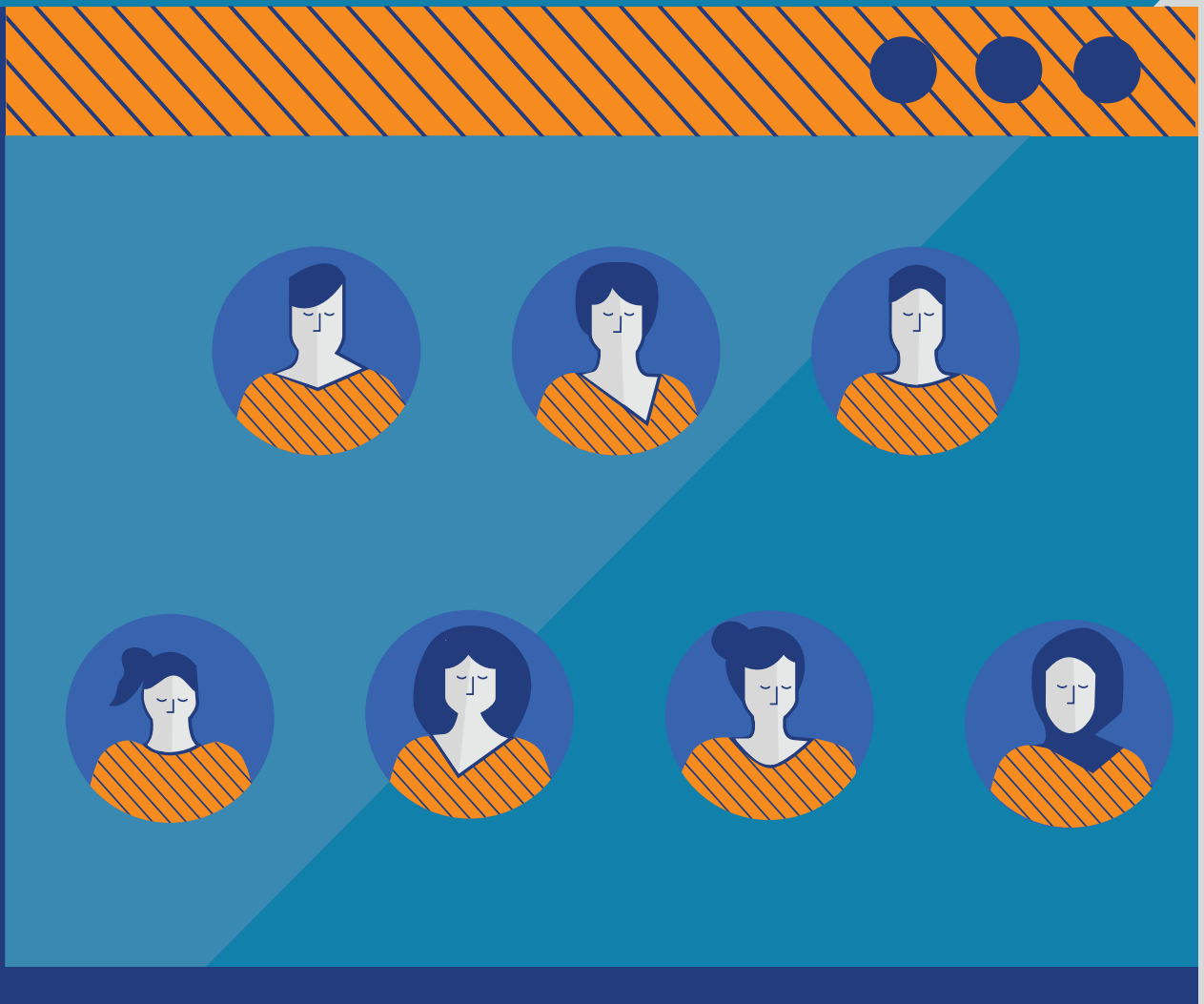

Remote Gender Based Violence (GBV) Case Management during emergencies

Guidelines for GBV Case Workers

By Ghida Anani; Amal Farhat; Zeinab Mortada



Foreword

Due to the COVID-19 pandemic, curfews, quarantines, and similar restrictions (variously described as stay-at-home orders, shutdowns or lockdowns) have been implemented in most countries around the world. Evidence has shown that circumstances under curfews and lockdowns have increased the risk factors for Gender-Based Violence (GBV) at the individual and social levels due to isolation and barriers to survivors and people at risk in seeking help and reporting their situation.

As this foreword is being drafted, it is estimated that millions of women and girls are compelled to stay in their houses with their abusers with limited or no access to resources and/or support. The limited access to assistance during the lockdowns increased the survivors' vulnerability, thus the urgent need for unconventional and innovative modes of GBV service delivery and specifically case management emerged.

The Remote Gender-Based Violence Case Management guide developed by UNFPA Lebanon in partnership with ABAAD is a comprehensive tool that organizations, caseworkers, and their supervisors can benefit from to accommodate for survivors' needs including during emergencies. In addition, this guide can be used by caseworkers during the restricted mobility - due to the pandemic - but can also be considered in regular situations where some survivors and people at risk are unable to seek support in person and therefore can benefit from remote services on a case-by-case basis. Hence, this guide can be useful during humanitarian/emergencies as well as development times.

The survivor-centered approach has been adopted throughout the guide with the aim to provide maximum safety for beneficiaries taking into consideration the challenges that might emerge in remote modalities. Interestingly, this guide doesn't provide a "one-size-fits-all" kind of modality and each case is considered unique. While a lot of survivors and people at risk might benefit from the remote GBV case management services, other survivors prefer to benefit more from face-to-face interaction. The decision around the most suitable and beneficial modality is made jointly by the case worker and the survivor and person at risk while assessing the pros and cons of each modality in their specific case.

Since maintaining the wellbeing of GBV caseworkers has been an area of critical concern, the guide offers tips and recommendations to promote their mental and emotional fitness.

In sum, this guide provides details about a flexible and adaptive approach to ensure that critical and lifesaving GBV services are made available without compromising the safety of caseworkers and/or survivors and people at risk.

Asma Kurdahi
Head of Office, UNFPA
2021

Acknowledgements

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List of Acronyms

GBV: Gender Based Violence
DV: Domestic Violence
SGBV: Sexual Gender Based Violence
CM: Case Management
CW: Case Worker
FtF: Face-to-Face
ISF: Internal Security Forces
MOPH: Ministry of Public Health



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Introduction

This manual intends to support case workers through GBV case management processes during times where face-to-face encounters become complex, and affect the safety of the survivor and the case workers, such as the “COVID-19 General Mobilization”. This can also apply to all remote case management practices despite the reasons that lead to make it an obligation in its application.

During times of crisis, new incidents of sexual and gender-based violence (SGBV), such as intimate partner violence (IPV) and sexual violence can occur and even extremely exacerbate and aggravate. This was observed and reported globally after the breakdown of COVID-19 when all sectors are locked and social distancing is practiced and authorities imposed many restrictions on movement. While forms of GBV are further appearing in households and in healthcare facilities, GBV case management remains one of the entry points to life saving health and mental health support to GBV survivors. While ensuring the safety of case workers and adapting to the different stages of the pandemic, remote GBV case management allows specialists to follow up with victims of gender-based violence throughout their progress and rehabilitation. Thus remote GBV has been developed and broken down into diverse methods and approaches that can be adapted in respect to the different COVID19 contexts.

The newly faced crisis (COVID-19 outbreak) engendered multiple challenges, as survivors might spend more time at home, with abusive partners or family members, even in some cases and on purpose detained by them, with almost no contact with the outside world. Curfews and lockdowns even produced complications in coordinated support, care and slowed responses, which contributed to elevate unintentional hazards on survivors.

GBV case management is a long-term process that may take several months depending on the unique needs of the survivors, their coping mechanisms and support system. In emergencies, there are many elements and components of case management that may not be accomplished during ordinary times, such as face-to-face counseling, timely response in referrals and direct service provision. Therefore, contemplated

alterations should be considered in case of management practice, and only experimentation with time, will permit the evaluation of efficacy and re-arrangement. Henceforth, during this current emergency, remote case management/counseling/referral (via telephone) may be the most feasible and adapted option available for survivors despite its many constraints.

While it ensures a full alignment with GBV Inter-Agency Standing Committee minimum standards along with the GBV survivor centered approach’ guiding principles, this manual provides concrete and practical support for the implementation of remote GBV case management also with respect to the “Do No Harm” principle.

Case management, even remotely, is similar to the face-to-face case management, in terms of steps and essence, but modifications are mainly related to the tools and modality of providing the service.

Survivor Centered Approach (UN Women Definition)

A survivor-centered approach to violence against women seeks to empower the survivor by prioritizing her rights, needs and wishes. It means ensuring that survivors have access to appropriate, accessible and good quality services including Health care Psychological and Social support, Security and Legal service.

By using this approach, professionals can create a supportive environment in which a survivor’s rights are respected and in which she is treated with dignity and respect (UN-FPA, 2015). A survivor-centered approach helps to promote a survivor’s recovery and to reinforce her capacity to make decisions about possible interventions (UNICEF, 2010).

A survivor-centered approach recognizes that every survivor:

- Has equal rights to care and support
- Is different and unique
- 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 the survivor centered approach means:

- Validate the person's experience. A survivor-centered 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-centered approach puts the individual at the center 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-centered 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 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 in helping relationships.
- A survivor-centered 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.
- How to provide Remote Case Management? When providing remote case management over the video or phone, please follow the steps below

GBV Case Management Definition and Purpose of the Manual

Domestic Violence (DV) is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. Behaviours include intermittent acts of physical aggression, ongoing psychological abuse such as intimidation, constant belittling and humiliating, forced intercourse and other forms of sexual coercion and pervasive controlling behaviours such as isolating a person from their family and friends, monitoring their movements, and restricting access to information or assistance. Women represent the majority of victims of domestic assaults and homicides by partners, specifically one out of three women globally report physical or sexual abuse in a relationship (Tarzia, May & Hegarty, 2016). Women who have experienced or women who are experiencing violence in an intimate relationship have feelings such as guilt, shame, fear and low self-esteem. All those feelings that result from violence make impossible for women to cope with it in their everyday lives. Also, a consequence of violence is a series of psychological symptoms such as, anxiety, stress, depression and sleep disorders (Petroulaki, Tsirigoti, Kouveli & Sotiriou, 2015). Abused women use health services more frequently because of increased rates of emotional health issues as mentioned above (depression, anxiety, suicide, somatisation, post-traumatic stress disorder, substance abuse) and physical health issues (chronic somatic complaints, reproductive problems and injuries) (Tarzia et al., 2016). The idea that providing OC services for abused women might be helpful is a relatively new aspect within the counselling field. Abused women state that they value supportive listening, non-judgmental support and compassion, in counselling process. So we can assume that Face-to-Face (FtF) interactions with specialized counsellors or health care professionals may seem a better solution (Feder, Huston, Ramsey, & Taket, 2006). However, according to recent studies there are many barriers for a battered woman in search of FtF help. Sometimes a woman does not get the support that she needs because she is unable or unwilling to seek help in a FtF setting. On the other hand, internet provides an environment characterized by anonymity, in which women can seek help without judgment (Tarzia et al., 2016).

GBV case management is defined as 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 about all the options available to them, and that issues and problems facing a survivor are identified and followed up in a coordinated way.

GBV case management is founded around the survivor-centered approach that aims to create a supportive environment in which survivor's rights are respected and are treated with dignity and respect. The survivor-centered approach is put in place through a set of principles that guide the work of all case workers and their interactions with people who have experienced GBV. This approach should be well preserved and followed all times, regardless of the challenges and obstacles.

The relationship between the caseworker and the survivor is integral to help the survivor achieve her/his goals. Each interaction between the case worker and the GBV survivor should be in line with the survivor-centered approach, regardless of the exceptional circumstances caused by the virus outbreak. While ensuring high safety precautions as listed below, case workers are expected to continue offering non-judgmental and empathetic care to prioritize the wishes and wellbeing of survivors.

GBV guiding principles, should as always, be followed (right to safety, confidentiality, dignity and self-determination, and non-discrimination). Through crisis, and due to stressors encountered by the service providers, these principles may be missed, forgotten or even neglected. Thus, stressing on them is necessary.

This manual's purpose is to guide organizations, service providers and case workers with the needed guidelines to adapt GBV related case management to the current context, overcoming challenges set by the COVID19 outbreak.

Advantage vs Disadvantage of Remote GBV Management



ADVANTAGES

Accessibility: specially for beneficiaries who live in remote areas or those dealing with physical or mental disability

Anonymity: offering beneficiaries a sense of anonymity. More specifically phone\Internet can provide a context in which beneficiaries can interact with someone, without disclosing personal identifying information. This environment can help beneficiaries to be more honest and open about their experiences. Also, the anonymity allows beneficiaries to feel safer, less vulnerable, stigmatized and embarrassed during the process.

Time & cost effectiveness: reducing\limiting time of sessions; reducing waiting lists; less cost of commuting time.

Convenience: the flexibility in scheduling the sessions allows beneficiaries to access the intervention at unexpected times, when an abusive partner is not present, unlike FtF care, where there must be a scheduled appointment



DISADVANTAGES

Lack of Nonverbal and verbal Cues: In many cases, case workers cannot see facial expressions, vocal signals, or body language. These signals can often be quite telling and give the counselor a clearer picture of clients' feelings, thoughts, moods, and behaviors.

Text-based miscommunications: In the context of text-based counselling due to the absence of verbal and nonverbal information, both beneficiary and counsellor rely on their assumption and interpretation of the written word alone. Therefore, this may lead to misunderstandings or misconceptions.

Limited accessibility: Especially for refugees or non-literate beneficiaries due to cost or absence of telecommunication medium.

Remote GBV CM guidelines

1- Case workers' responsibilities during home-based remote case management:

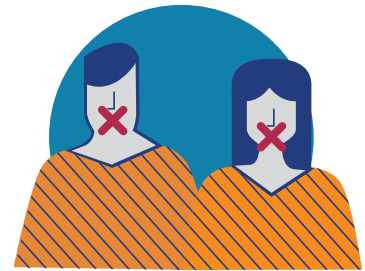
Competency in face to face sessions does not necessarily means that the person is well prepared and competent to provide distant sessions. Case workers need to self-develop certain skills and continuously increase their competence in the provision of remote case management. A personal effort should be established for that aim, and constantly reaching the supervisor for support is a necessity to secure a sustainable quality of service comparing to the face to face sessions.



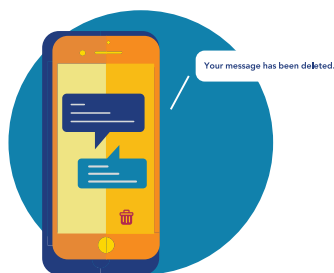
Ensure hotline phones are always available, and fully charge them with credits and password protected



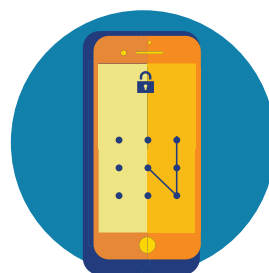
If case workers are working from home, they need to secure a safe confidential room/place to do the counseling



Case workers should inform all family members to not interrupt the sessions under any circumstances



Messages should be deleted if containing sensitive information or as per the request of the survivor



Case workers should be the only ones with access to the phones. This can be achieved through locking the phones and providing the CW's with the passcode

Data safety should be ensured during home-based practices:



It is imperative to ensure the safe storage of any identifiable information about the survivor at home



In case any electronic case management system is in place, please follow the agreed-upon data safety measures whether present in your organization or based on Gender-Based Violence Information Management System guidelines (GBVMS)



It is preferable to have everything digitized (password protected). If possible, avoid the use of Paper work since it might be more difficult to protect the information and ensure confidentiality



Case workers should always stay in contact and have meetings with supervisors and keep them in the loop for everything to stay organized and on the right track.

2- General guidelines for remote case management:

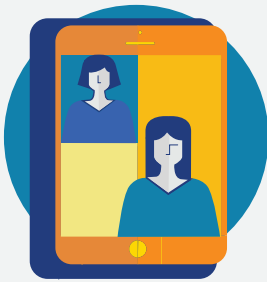
Assessment of suitability of beneficiary for distant case management: There are important determinants to take into consideration in order to assess the suitability of the survivor to benefit from remote-at distance case management". Suitability depends on a multiple of factors (University of Crete, 2018):



Client's preferences



Suggestibility and ability to understand and assimilate information within a particular communication modality and related skills potential risks related to remote case management. In this scenario the face to face case management session should be strictly considered.



The person has to be motivated and capable to experiment with new communication environments and she must feel comfortable describing and expressing herself through the ways distant sessions



Good reading and writing skills, if sessions are conducted via texting or email, the client should have sufficient reading and writing skills in order to communicate efficiently.

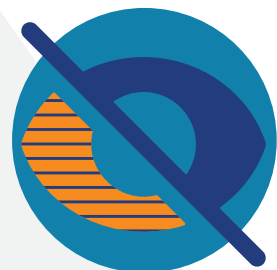
Face to face sessions should be highly recommended for the below situations (University of Crete, 2018):



The client is in a crisis situation; the provision of long-term online counselling services is not the best solution (such suicidal feelings and/or is actively thinking about hurting herself or someone else)



The client is dealing with a serious or complex psychiatric disorder, such as severe major depression, schizophrenia or bipolar disorder



The client has no privacy at home, or others living with her have access to their devices



Inability to contact the case worker in the absence of the perpetrator (University of Crete, 2018)



Follow well known case management steps, and make sure the survivor understands fully each step

Step 1

Introduction & Engagement

Step 2

Assessment

Step 3

Case Action Planning

Step 4

Implement the Case Action Plan

Step 5

Case Follow-up

Step 6

Case Closure

Step1 Introduction and Engagement

- Learn to greet and comfort a survivor to effectively build rapport.
- Explain confidentiality and the exceptions to it.
- Guide survivors through the process of informed consent in a safe and empowering manner.
- Greet and comfort the survivor through being warm, calm and open
- Introduce yourself and explain who you are
- Begin building a relationship with the survivor
- Communicate in a warm and open way
- Get informed consent from the survivor to provide case management services: By obtaining informed consent, we demonstrate our respect for the survivor, show her/him we intend to be collaborative and empowering while showing her/him that we understand the need to be accountable in the case management process.

5 steps of obtaining informed consent:

- ➔ Explain the case management process
- ➔ Explain confidentiality
- ➔ Explain client information
- ➔ Explain the survivor's rights

- Ask the survivor if they have any questions and if they would like to continue
- Explain case management process Caseworker's role
- Listen to the survivor's story and discuss what the person needs to help them recover
- Develop a plan with the person to meet their needs
- Give appropriate referrals that the person approves
- Support the person in accessing services
- Be present throughout the process to help with their emotional recovery
- Explain confidentiality and exceptions
- Explain survivor's rights
- Ask and answer questions
- Use consent form
- Verify that the confidentiality, safety and security conditions are well in place, while asking the survivor's consent to proceed with the case management. If possible, and the survivor is literate, you are sure that the phone belongs to the survivor, and it is safe to text the survivor asking if she/he is available for the interview. Please do not indicate that this is related to case management. In case you call the survivor, please first monitor if she/he sounds uncomfortable or if there is any background sound. If this is the case, please do not continue and ask the survivor to contact you when she/he is available through a missed-call, text message, or any other appropriate means of communication that she/he feels comfortable with. Once you adopt the above measures, please ask the following questions to confirm the safety and security conditions:
 - ✓ Are you comfortable talking right now?
 - ✓ Do you agree to continue this talk now over the phone? Or do you prefer we schedule at a different time? Do you prefer a missed-call or text me when you are ready?
 - ✓ Is this the right number to call on? Do you prefer me to call any other alternative number/s?
 - ✓ Are you taking the call from a room that can ensure privacy and confidentiality of the conversation?
 - ✓ Do you think someone might walk in during our conversation? What do you advise as the best action to do if this happens?
 - ✓ Ask again: Do you feel safe and have enough privacy for our conversation?
 - ✓ Are you fine talking now? (Ask for consent repeatedly)

Step 2 Assessment

- 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.

Step 3 Case Action Planning

- Develop a case plan based on assessment with the survivor.
- Obtain consent for making referrals.
- Document the plan

Ensure safety measures are in place: Say “before we continue, let us go over some of the measures in case we are interrupted or you feel that you are no longer safe”. Decide: with the survivors on the following scenarios:

- Someone asks what the survivor is doing and/or to whom they are talking to over the phone.
- Someone such as any other untrustworthy member in the household answers the phone.
- The survivor starts not feeling safe/confident, as someone may be listening and need to stop the call.
- There is a need to talk to the survivor from an alternative phone number during the interview.
- Agree on a safe word or a code that you can use or decide on a specific subject to change if they feel unsafe or listened to (something simple such as discussing the weather, COVID-19 guidance, or any activities they participate in, etc.).
- Remind the survivor to delete any text messages between you and her/him if it is deemed to further expose the survivor in any danger.
- Remember the principle of **Do No Harm** prevails under such circumstances

Also, REMEMBER, If the survivor does not sound comfortable and/or you hear any sound during the interview, please do not continue and give them an option to contact you when they feel more comfortable speaking, through a missed-call, a text message, or any other means that they feel comfortable. Under such circumstances, never push for information. You are not a journalist but a case worker who is there to empower and enable the person to make decisions, or choose services they may or may not opt for.

Step 4 Implement the Case Action Plan

- Assist and advocate for survivors to obtain quality services.
- Provide direct support (if relevant).
- Lead case coordination.

Once the safety of the survivor is ascertained, the case management process can be introduced. It is important to assure the survivor's confidentiality during all steps of case management. Take the survivor through the case management steps and make sure that the survivor understands each of the steps. Remote case management sessions are expected to last between 20 and 30 minutes, depending on the safety of the survivors and their needs

- ✓ A video call is a good option. Being able to interact through visible body language, create a safe environment that is a healthier and empathetic contact
- ✓ Schedule sessions on fixed dates and days. Creating a routine for survivors is highly advantageous in lockdowns when all routines are disrupted
- ✓ Provide the survivor with full information about the current available and reachable services during the emergency phase. Explain about new modality of reaching services and make necessary referrals when needed
- ✓ Ensure to inform the survivor that there might be a delay in certain services/referrals due to the current situation
- ✓ All case management forms should be used and fully filled, similarly to the day-to-day practice during time of stability, to ensure proper documentation, tracking of work and follow-up
- ✓ Constantly monitor if the person is comfortable and safe during the sessions
- ✓ In case of accumulating challenges during remote case management that is affecting critically the quality of the service and causing harm on survivors, assess in a more interactive way the possibility to shift to a face-to-face session (if possible)
- ✓ Make sure to provide essential basic health information on COVID-19 prevention:
 - * Always rely on updated scientific information shared by reliable sources such WHO (<https://www.who.int/>) and MOPH (<https://www.moph.gov.lb/en>)
 - * COVID19 hotline at 76-592699 / **140** (Lebanese Red Cross) / 01380000 (Rafik El Hariri Hospital)

Step 5 Case Follow-up

Frequent and balanced follow-up is crucial in remote case management, to help the women who are isolated due to the lockdown, to feel connected and not alone. The stress that women encounter may keep them in fight and flight mode that automatically affect the level of concentration. The follow-up will allow to create a space to re-discuss specific issues and make sure the survivor incorporated well the action plan. Since the risk level of miscommunication and misunderstanding is higher in remote case management, comparing to the face to face sessions, the frequent follow-up will ensure a repetitive review to mitigate such risks.

- Follow up on the case and monitor progress
- Schedule times and dates for follow-up
- Re-assess safety or suicidal risk and other key needs.
- Always check on the mental health state of the beneficiary
- Implement a revised action plan (if needed).
- Re-assess safety and other key needs.
- Implement a revised action plan (if needed).

Step 6 Case Closure

- If closure can be delayed and more attentively reassessing in a participatory way the possibility of retarding closure during the major stressors women are facing, is a better option. Uncertainty and unpredictability are factual during the health crisis and lockdown, and the possibility of relapse is higher. The survivor will probably request a second time the renewal of support after achieved closure.
- When the survivor achieved her objectives, it is better to discuss the option of staying in contact slightly until being sure everything is stabilized to an increased extent. The rationale behind such suggestion should be explained to the survivor, to avoid her interpreting such request as a disbelief in her autonomy and ability to end the case management process.
- The choice of survivors should be respected in that matter. Avoiding pressuring her is essential.
- Women who actively ask to end the service, or whom we lost contact for a long period of time, in addition to the women who achieved successfully their objectives and met their needs, are considered fitting the criteria that make them eligible to closure.
- Case transfer in some cases to another agency due to the request of the survivor or her relocation to another area will automatically contribute to the closure of the process.

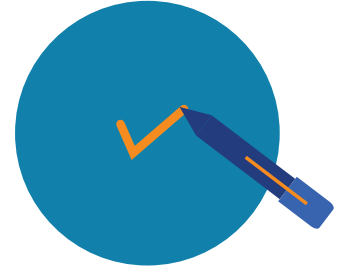
3.1- Remote session with new cases



Introduce yourself, the organization, your role and the process of Case Management.



Make a Rapid Safety Check and Rapid Safety Plan, to ensure the protection of the survivor during current remote session. RSC and RSP constitute of temperature checks, sanitization and in some cases rapid covid-19 testing.



Take appropriate consent to proceed and explain the causes of shifting to remote modality within the organization.



Assess and identify needs



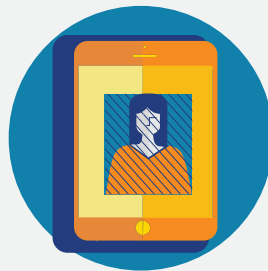
Provide Support to plan for small, achievable and applicable actions that respond to all needs



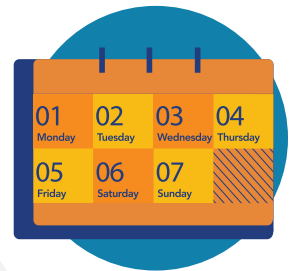
Take into consideration and discuss with the concerned all existing contextual challenges and boundaries that may be encountered and block achievements of specific actions...



Formalize a Specialized Safety Plan to secure a safe and confidential upcoming remote case management sessions



Create a participative safety plan to mitigate/ minimize risks and consequences related to GBV, despite the profile, status and relation to the perpetrator (intimate partner, family member or others, ...) Actions such as: 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.



Close the session and schedule a new one

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.

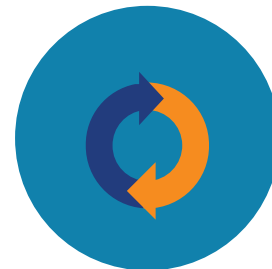
3.2- Remote session with ongoing cases



Make a Rapid Safety Check before starting the Remote CM Session



Emotional check and assessment (due to the stressors related to the curfew and lockdown and overly close to the perpetrators) *.



Collect updates and changes related to the situation, violence, or services she received



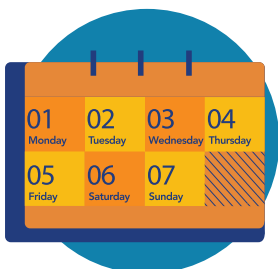
Follow up on agreed upon past actions, and plan for future actions



Update and review the previously set Specialized Safety Plan to secure a safe and confidential upcoming remote case management sessions



Review and apprise the previously set participative safety plan to mitigate/ minimize risks and consequences related to GBV



Close the session and set date for future one

*Guidelines on Emotional Support

Checking in regularly by phone or WhatsApp as a form of emotional support (different from supervision).

Creating chat groups or other relevant fora for staff to connect and support each other.

Sharing resources online that staff can use to continue to build their skills.

e.g. the Rosa App by International Rescue Committee (IRC), GB-VIMS podcasts and videos, etc.

4- Rapid Safety Check during remote sessions



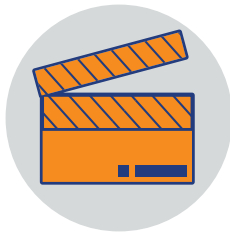
This should always be made at the first of each session, to be sure the person is safe during the current in process remote session

You can follow the below guiding questions:

- Are you comfortable and safe talking right now?
- Are you taking the call from a room that can ensure privacy and confidentiality of the conversation?

5- Specialized Safety Plan to secure a safe and confidential remote session

This plan should be created in a collaborative method with the person of concern at the first encounter, updated and checked on efficiency in each ongoing session

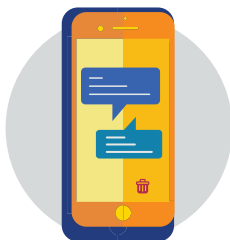


Plan how to act and react on the conceivable below scenarios

- Someone asks what the survivor is doing and/or to whom she is talking to over the phone
- Someone walked in the room where the discussion is held
- Someone such the perpetrator or other untrustworthy member in the household picks up the phone during your conversations
- The survivor starts to feel unsafe during the session as someone may be listening to the call and there is a need to stop
- Someone unknown responded to an agreed upon follow-up call by the case worker

Agree on safe words, signs or codes that you can both use during the below situations

- If she feels unsafe or listened to
- Before starting the session specifically during texting to avoid possible impersonation
- When she needs to inform the case worker about her availability to receive a call



Remind the survivor to delete any text messages between both, if it is deemed to put the survivor in any danger



Demand from the survivor to not save the helpline number on the phone in an identifiable name (case worker or organization name), this can put her at risk if identified by the perpetrator

6- Contextualization and adaptation of the safety plan



The safety plan should take into consideration the new context and circumstances the survivor is facing. Being locked and in daily close contact with the perpetrator may increase the risk of violence and expose her to more harm



Adapted safety plan should focus on the below aspects:

- Discuss the possibilities of decreasing the physical encounter (as much as possible and feasible) with the perpetrator during quarantine and isolation
- Inform the person on the importance of keeping numbers of supportive neighbors, friends and family whom the person can call for help in case of emergencies
- Counsel the person to keep important documents, money and personal things accessible, in case she needed to leave immediately
- Support the person to plan for house exit process in case of emergencies
- Remind the person to save or memorize important numbers and help-lines (midways houses, GBV case workers, ISF hotline for domestic violence or any support services that are accessible)

7- Shift and change in action plan



During crises, needs and priorities of survivors change. Exploring them is essential, and updating the action plan accordingly is vital



Sticking to the same objectives may be unachievable, and this will lead to frustration and affect the self-confidence of the survivor



Objectives such as ensuring and preserving physical safety and well-being can be enough during curfew and lockdown. They have to be the center of the action plan, especially that they are likely to extremely deteriorate



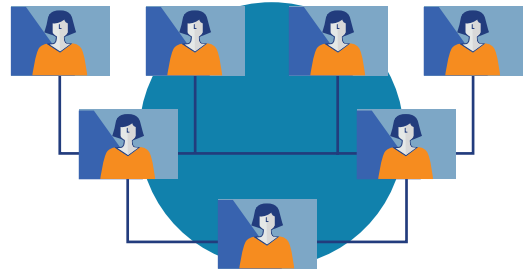
Some objectives previously agreed upon before the health crisis, can be placed on-hold and discussed after return to usual ordinary life before the crisis

Survivors at risk of suicide

Case worker should always probe and assess risk of suicide with all survivors and specifically those who are experiencing and showing the below indicators: (World Health Organization , 2012)



Extreme and acute emotional distress



History of mental health disorders



Chronic pain



Current symptoms of mental health disorder
(mood disorders, anxiety disorder, psychosis,)

It is essential to always evaluate the following aspect: suicidal thoughts, plans and acts/ attempt of self-harm (World Health Organization , 2012). When the risk is confirmed an emergency rapid suicidal safety plan should be designed remotely, and preferably with an active engagement of a supportive adult. In parallel the case worker should consult a mental health agency for support and try to advocate for a fast psychological assessment and MHPSS intervention.

The constant and frequent follow-up with the survivor should be a priority until being stabilized.

Managing male hotline callers



MALE VICTIMS

The hotline should be open for supporting both male and female callers. In case of a male calling in distress, he should receive the same level of support and empathy as any other individual in need of support. The same steps and guidelines apply for both genders, but the hotline should have a list of referral numbers for issues specific to such a situation.

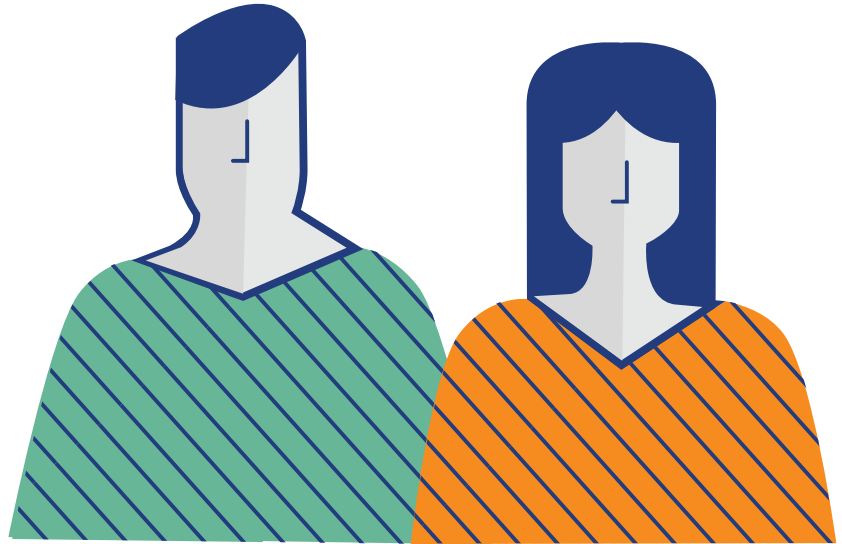


PERPETRATOR CALLS

In the case that the perpetrator of violence ever calls the hotline, it is crucial that the hotline operator doesn't give any information away about victims, no matter how angry the caller might get. Maintaining confidentiality is essential and the operator should only say what is necessary, keeping the conversation to a minimum by stating the purpose of the hotline, and end the call.

General guidelines on emotional support during quarantine and social distancing

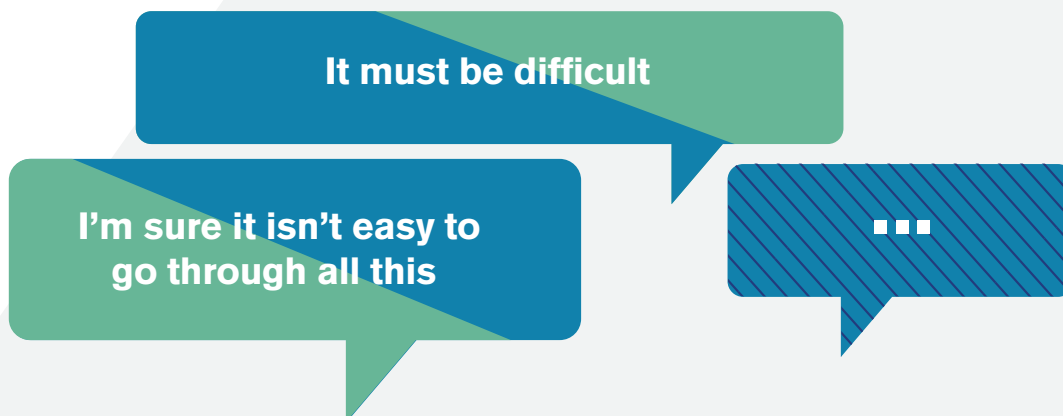
Survivors who are locked up with people using aggressive behaviors against them (physical, emotional, sexual abuse, or any other type) are exposed to additional stressors, added on the already existing stressors related to COVID-19 outbreak. For that reason, it is within the duties of the case workers to provide needed emotional Support, psycho-education and counseling, to make sure the beneficiaries are navigating this phase with less damage/ risks on their mental, social and physical health.



Some steps mentioned below can also be used with any beneficiary expressing symptoms of psychological distress, which can be common due to these circumstances.

1. Normalize emotions of sadness, fear and anxiety because of COVID-19 Outbreak:
 - ➔ Change in mood and behavior is normal during such an outbreak.
 - ➔ Give examples; anxiety about being infected, about the health of people we love, loss of job, disturbance in routines
 - ➔ Sadness, fear, and anxiety are natural responses during crisis and stressors.
2. Validate all feelings
3. Always remind the person that they are not alone and that many organizations are ready to provide support.
4. Discuss the important of Facts Check for information that induce fears and anxieties:
 - ➔ During collective panic, fake news can easily be created and spread
 - ➔ It is important to search for trusted, credible and reliable source of information (WHO, Ministry of Public health)
5. Remind the person about the temporary timeframe of the situation (social distancing/quarantine). The situation may feel interminable and the time may seem as it's going slowly. This feeling is common during difficult times

6. Remind them that during stressful events, symptoms of pre-existing mental health disorders can be exacerbated (for people diagnosed with mental health disorders). Recap about the existing specialized services (psychiatrists and psychotherapist) for MH conditions.
7. Positive coping strategies:
 - Highlight that under stressful circumstances or changes in one's routine and way of life, many people may rely on unhelpful coping strategies, to ease the emotional distress
 - Provide examples of possible unhelpful coping strategies (excessive drinking or smoking, inactivity, excessive usage of social media, eating junk foods filled with unhealthy fat and sugar...)
 - Highlight that some positive tactics/ strategies if committed to, can diminish/ relief the negative consequences of this outbreak on health and mental health
 - Encourage positive coping strategies that can be implemented at the household level (sleep hygiene, physical activity (zero equipment, limited space), healthy eating, finding pleasurable activities or reactivating lost ones, ...)
 - Discuss how they can reestablish and maintain a daily routine
 - Encourage social contact and social network activation and remind the person that physical distancing is not social distancing, and many platforms exist in this era to create virtual contact (WhatsApp, Facebook, etc.....)
8. In case of domestic violence:
 - Share basic information about aggressive strategies of every perpetrator (especially in the context of intimate partner violence, abuse and intimidate the survivor during social distancing/ quarantine:) use to control the survivor
 - Due to the increase of life stressors and the closeness/ proximity, the abuse which already existed before may increase in frequency and intensity.
 - The perpetrator may use fear and guilt induction, and further oppression (FOG Strategies)
 - Always remind the survivor that it is not his/her fault
9. In case the survivor cried over the phone, the focus should be on expressing healing statements and validation of feelings. Replace the non-verbal communication techniques with more healing statements adequately. Such as: "It must be difficult, I'm sure it wasn't/isn't easy to go through all this". However, sometimes silence is needed.



Face to face CM sessions during Covid-19 Outbreak

1- Immediate Key Actions:

Beneficiaries have the right to be safe from the moment they enter the safe space and through all the experiences, navigating all the activities, and moving from place to place within the area. This is the responsibility of each staff member to make sure that survivors are protected to the maximum from any potential infection that may harm their health and the health of their families. Putting in place Infection, Prevention and Control (IPC) measures in accordance with WHO standards, at all service delivery points, from the entrance/ reception area in the safe space, to the counseling/listening room, is mandatory.



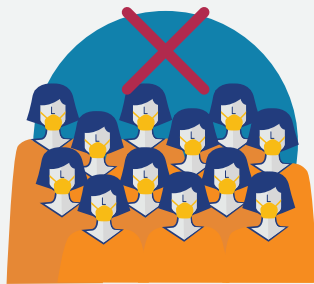
Set up hand-washing stations and/ or make hand sanitizer available immediately upon entrance in places where you meet clients face-to-face



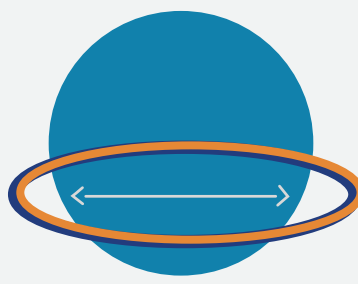
If “thermoflash” thermometers are accessible, it may be appropriate to use them to check temperatures of those accessing services



Mask distribution can also be an option. Reusable masks are the most cost effective and sustainable option, that may be a resource for survivors to be used in daily life having economic challenges and difficulties to buy masks



Ensure adequate distancing in activities and during counseling and be kept 2 meters apart, and avoiding large crowds



In case the counseling room, is too small to ensure physical distance, case workers, can identify other safe, vast and private room to hold session



Ensure that all staff and caseworkers have access to hand-washing stations, masks, hand sanitizer, and tools needed to continue providing support with being safe. Their safety is equally essential as the safety of survivors

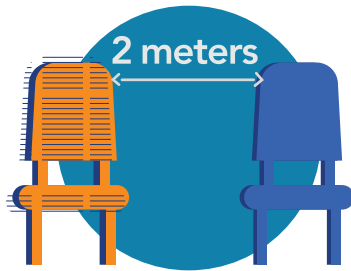
It comes within the responsibility of the case worker to prepare and inform survivors on all potential changes and adaptation regarding the provision methods of service delivery and response. It is crucial to stick to the below:

- Survivors should have a say in accepting one on one sessions, since they can be uncomfortable doing so due to self-health concerns. Consent around these sessions should be granted at all time
- Communicate openly and transparently with women and girls about future changes in activities' variations
- Re-assure clients that support services will always be available, even if the modality changes, and that they will never be alone
- Listen carefully to their fears, questions, suggestions, as well as what will work best for them
- Develop quick discussion guides and communication materials to discuss COVID-19 with your clients in your programs.
- Share any relevant information such as changes in services, hotline numbers, and how to reach relevant service providers in case of a change, as well as their new modality of operations
- Prepare the survivors for possible unpredictable shifts to remote sessions. Agree on possible safe ways to communicate distantly (messages, texting, WhatsApp, times of contact, signs that indicate risks in case of continuation of calls ...)

2- Recommendations before proceeding in the face to face session



Sterilize/sanitize the room before receiving the survivor (chair/desk/door handle/ pen/etc...)



Place the chairs in a way to keep at least 2 m between the Case manager and the survivor



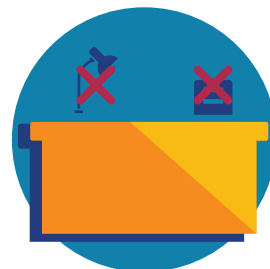
Place the hand gel in an accessible place to both



Make sure to aerate the room before, during, and after the session



Avoid, if possible, having a desk or table that case worker and survivor can lean on or have contact with

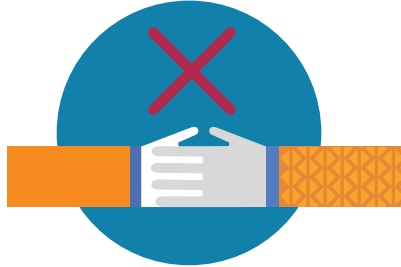


Remove all the unnecessary objects on the surface of the desk

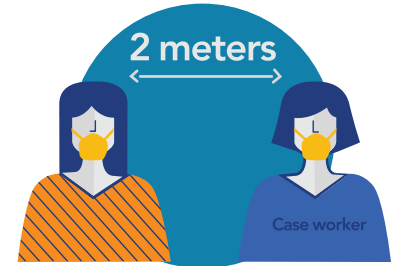
3- Recommendations during the face to face case management session



The Case Worker should be the one opening the door to the survivor



Avoid handshaking or any other form of physical contact (greeting, physical contact to show empathy with a distressed survivor and other circumstances)



Keep 2 meters between the case worker and the survivor



Make sure for the case worker to wash hands with soap and water for at least 20-30 seconds before and after the session



Make sure the survivor uses hand gel before and after the session, out of courtesy the case worker should do the same



Avoid handing documents from Case Worker to survivor (leaflets, brochures, action plan, safety plan etc.)



Avoid receiving documents from the survivor unless it's necessary and ask the survivor to leave the documents on the desk

4- Recommendations after the face to face case management session



Re-sterilize/sanitize the counseling room including the door handles/chairs/desk/ etc.



Make sure to use gloves when handling the documents after the session (do NOT use gloves during the presence of the survivor), and throw it after usage



Arrange the new handled documents/sheets in a plastic file cover and place it in a separated drawer in the iron cabinet (keep this drawer only for new forms)

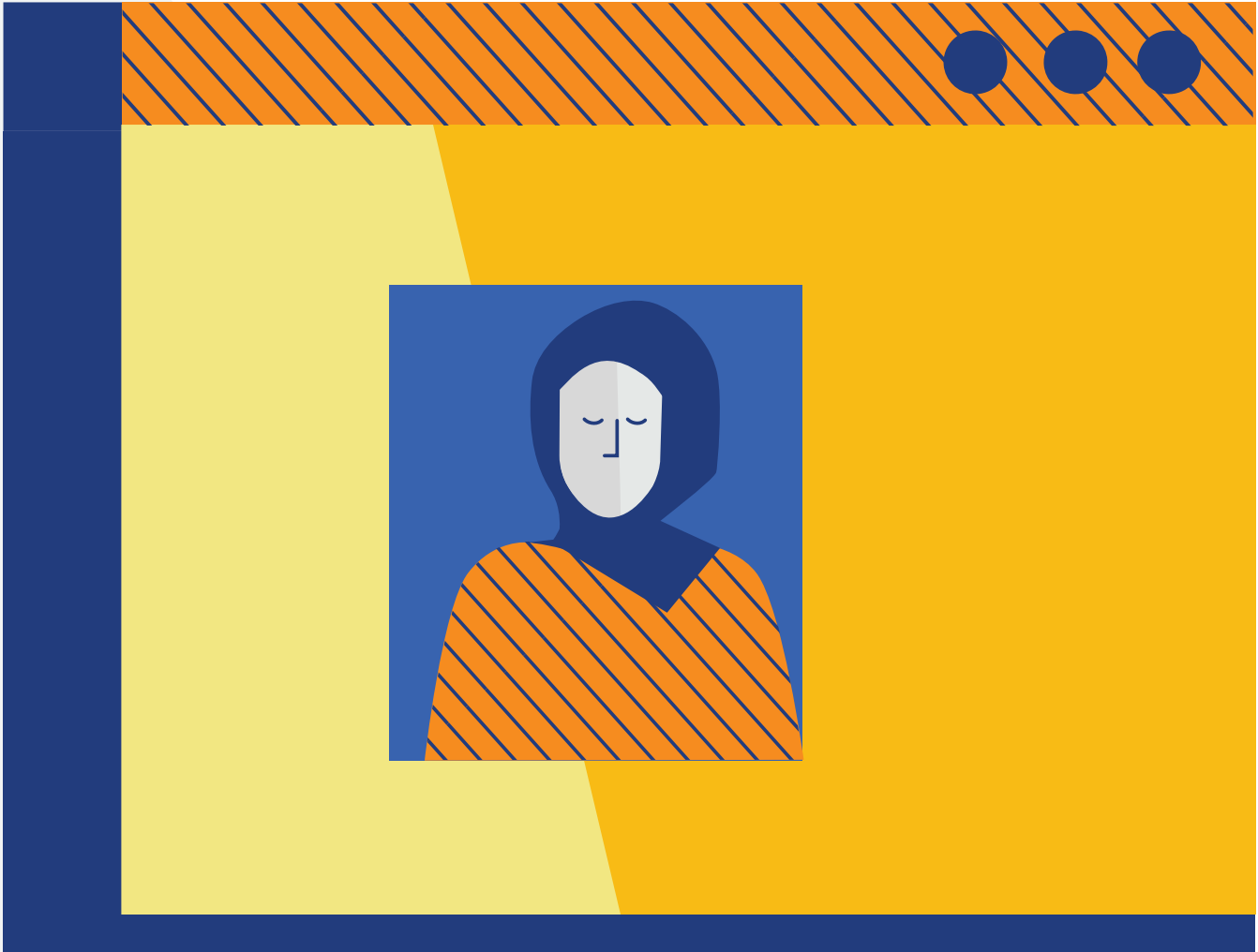
5- Setting boundaries

Boundaries in remote sessions are harder to be set specifically within the context of remote case management (Some clients might send texts or call after working hours without an emergency situation). The distance combined with easy accessibility of communications tools and technology, may lead the person to consider the relationship with the case worker less professional. Efforts should be focused on clarifying and setting clear boundaries and limits that will ensure preventing dependency. Ambiguous boundaries may create an interminable vicious cycle of unfruitful communication that may lead, if accumulated to fatigue and disengagement.

The case worker should dedicate a fair time to discuss with the client the boundaries of their professional relationship and communication:

- The establishment of a time frame for responses could be a helpful way to maintain boundaries.
- The case worker definitely should be available to support during emergencies, and this part should be mentioned and repeated to the survivor to avoid letting the person feel that he is deserted or rejected.
- When emotionally overwhelmed with absence of lack of support, people may find difficult to identify what is considered an emergency. The case worker should help the survivor to specify what an emergency situation mean
- People may find it difficult to adhere to the boundaries during the first phase. Showing understanding, and respecting to the rhythm of the survivor in adapting to the setting is essential.
- When rules are repetitively broken, the case worker should initiate an open discussion to understand the causes of such behaviors. The case worker should be careful in order to never imply any blaming or judgment

Recommendations for supervisors of GBV Case Workers



Some basic recommendations for professionals providing supervision in GBV remote CM are the following (Karcher & Presser, 2018; Mallen et al., 2005)

- Supervisors should educate counselors to accurately assess the client and how to provide a nurturing environment and establish working alliance.
- Interventions like verbal minimal encouragements and non verbal gestures which show support and understanding are missing in text based communication, so online counsellors must be trained on how to replicate those interactions in a text based environment.
- Supervisors should encourage counselors to gain experience in various online interactions, which include asynchronous e-mail, synchronous chat, and video- conferencing.
- Supervisors could model new technologies by using them in supervision, so the counselors will have the opportunity to express any questions or doubts immediately.
- Supervisors in OC should hold to FtF standards regarding supervision.
- Supervisors should be vigilant regarding assessment and direct counselors to continue monitor clients function.
- The supervisor should encourage the counselors to meet online and in FtF sessions, if both parties feel comfortable. Thus direct supervision will help the counselor explore online interactions.

Mitigating GBV Case Workers burnout

Some steps to address potential challenges & staff burnout might be including development of protocols for text-based remote case management and case management during COVID-19, self-care support, and others. Some recommendations for GBV Case Management agencies to consider at exceptional crisis times:



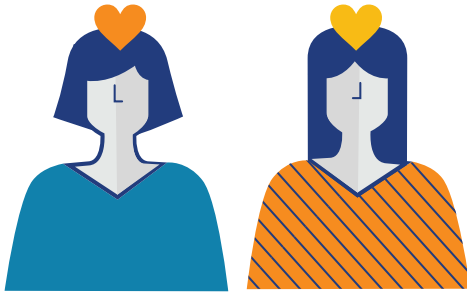
1. Consider structural changes to more dramatically shift workload, working hours, and expectations to help maintain staff wellbeing, including the possibility of hiring additional staff. The sheer quantity and intensity of calls being handled by staff will continue to bear an enormous weight. This requires thinking outside the box to find ways to offer staff more time to rest, regroup, or simply maintain. Changes may be temporary, emergency measures and reviewed as the situation unfolds.

The following are examples of possibilities to inspire new thinking about staff time, roles, and time off, in order to increase staff support and reduce burnout. (Note: these are just an example of the types of thinking that can be done in this regard.). Brainstorm ideas directly with staff to determine what might work best to support their needs and the needs of the organization. Consider the following:

- Changing the way shifts are allocated for the hotline in order for staff to go for longer periods without being on call. Is it possible to use the support of trained volunteers or temporary hires to help alleviate some of the crisis response workload e.g. train a team of

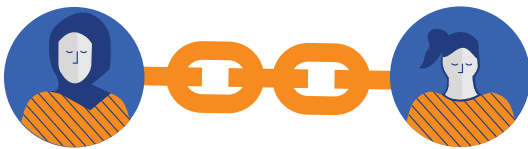
crisis counselors for night shifts so that staff do not have to do overnight shifts. Crisis counselors may not be responsible for full case management but for first-line support only (see section on first-line support below)?

- Instituting rest and recovery (r&r) days for staff, to be used at designated intervals (e.g. 3 days every 6 weeks or some other combination), or rotating emergency days off for staff outside of their annual leave (e.g. provide one week off for all staff, staggered over the coming weeks).
- Temporarily reducing or changing the workday hours. Can staff use more open-ended “flex time” to better manage their schedules amidst the crisis? (e.g. choosing revised hours according to what works best for them, reduced hours over more concentrated periods, etc.). Can staff choose which days to have off rather than all working on the same schedule, to better meet their needs?
- Introducing breaks or pauses throughout the day (e.g. 30-60 min rest period with back up coverage, a recovery space for staff, etc.)_
- Using back-up systems to give staff breaks. When staff are covering the hotline or phonelines, are there back-up people on the same shift in order to give more breaks? How else can back-ups be used to help ensure more time for breaks, pauses and support for staff?
- Hiring additional staff. While hiring additional staff may present challenges, it is worth consideration given the demands of remote case management within the current context. If it is not possible to hire additional staff, then there may be ways of working with trained volunteers, crisis counselors, or temporary hires to help share some of the burden currently being lifted by staff.
- Reducing the hours of the hotline. It may be worth reviewing the hours of availability of the hotline and staff and discuss whether it is sustainable, without severely burning out staff. If it is not possible to sustain it in its current form without severe burn out, then it may be healthier and more effective to create clearer boundaries in hours of operation. The same is true for the hours that staff are available.



2. Offer on-call professional psychological support services for staff.

The significant long and short-term stress and trauma being experienced and witnessed by staff requires multiple levels of support. Some staff may desire or seek professional assistance from a therapist, psycho-therapist, or related psychological support professional. It may be useful for Abaad to maintain a contract with one or more professional psychological support providers, for on-call support to their staff. Share widely with staff how to access support with the contracted provider (phone number, email, website, etc.) and ensure they know that support is free and confidential.



3. Liaise with other actors regarding hotline management for GBV and non-GBV services.

It is critical to continue to liaise with other service providers to ensure adequate response and referrals. At the same time, it may be worth examining how roles can be shared or divided with other service providers in new ways. In particular, Abaad staff have stated that it is important to “de-link” the association of Abaad with financial resources. Consider the following:

- Are there any other hotlines for GBV survivors currently being run? If so, by whom? What kind of support can the organizations offer each other?
- Are there any other GBV service providers who can co-manage or help to staff the hotline?.
- Are there other hotlines which exist for non-GBV-related concerns?
 - ✓ If yes, how much are communities aware of these services? How can you spread awareness about this?
 - ✓ If not, are organizations able to establish one and share the information with communities?
- What steps can you take to help women and girls have more direct access to a range of service providers beyond Abaad?.
- What support can Abaad offer to ensure that other services are women and girl-friendly



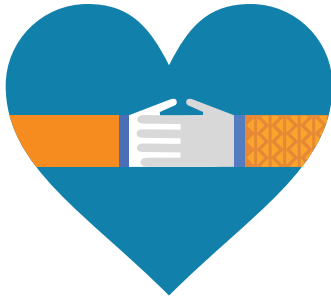
4. Review protocols for hotline and text support, particularly:

- Hours and staffing. (see sections above).
- First-line support vs. case management. Discuss with case management staff whether in practice, the distinctions between providing first-line support, i.e. the immediate support provided to any woman, girl or client who seeks support, and comprehensive case management services, i.e. systematic, documented, and in-depth client case support, are helping them to manage the volume and intensity of calls or whether both are causing severe stress. Are there other protocols necessary to manage the varying types of requests safely and ethically?
- Would it be possible to train teams of advocates to offer first-line support, before transferring to a case manager? Or are there other divisions that might help to avoid burn out?
- Platforms used. Discuss the platforms currently being used with staff for remote support and the pros and cons, including women’s accessibility. Consider whether an app such as Primero/GBVIMS+ might help remote case management or whether any changes to platforms are needed.



5. Hire consultant to review digital safety in the organization case management and develop/adapt protocols.

Develop protocols for texting with survivors, and there are fairly extensive resources available online (See the National Network to End Domestic Violence’s Best Practice Principles for Digital Services and related resources on technological safety in the context of intimate partner violence, sexual assault, and violence against women at <https://www.techsafety.org/best-practice-principles>). However, if this type of support is anticipated to continue, then it would be worthwhile to consider investing in targeted, specialized support around this issue to ensure digital safety across programs and support services.



6. Continue and amplify self and collective-care practices. Continuing to prioritize self-care and collective care is critical. When managing burnout, it is important to try to pay attention to each of the following areas of wellbeing for yourselves and your staff each day: ¹

- Body care: what can we do to help each other take care of our bodies through exercise, nutrition, sleep?
- Achievement: how can we help staff to reframe what it means to “achieve” at work within the current context? Can we reframe our expectations? Can we think about other ways that we can get a sense of achievement beyond work (e.g. achievement for safely getting ourselves and our families through another day). How else can we help staff to feel that they are achieving even during these challenging times?
- Connection: How can we create and protect time to meaningfully connect with family, friends, coworkers, partners and others?
- Enjoyment: How can we support each other to identify things that we enjoy, even in times of crisis, no matter how small, and engage in them. Can we create opportunities or build time for fun into our work?
- It is critical during this time to check-in more with staff and ensure that they feel supported.
- For supervisors, make it clear that you value humanity first and foremost over ‘productivity.’ Reframe expectations in this time, recognizing the immense stress and trauma that people are experiencing and not expecting business as usual. Check in more regularly with staff. Send positive messages of affirmation (consider weekly inspiration messages to staff), support, and humor (as appropriate). Increase supervision meetings as helpful and appropriate (without overburdening staff).
- Consider creating “care circles” amongst staff to help them look out for each other and offer their own ways of support.
- Consider ways to help women support each other in their communities, e.g. creating care circles.

For more in-depth ideas and activities to support self and collective care, there are many feminist resources available, for example:

the GBV Prevention Network and Just Associate’s Zine: Self and Collective Care; Black Lives Matter’s Healing in Action Toolkit; CAPACITAR’s Emergency Response Tool Kit; CREA’s Self-Care and Self-Defense Manual for Feminist Activists; FRIDA’s Self Care Plan; Raising Voices Guidance Note on Amplifying Self and Collective Care during COVID-19); among others.



7. Incorporate GBV-related activities into existing WhatsApp activities for child protection. Abaad staff mentioned that the family response to child protection programming via What’s App during the COVID-19 lockdown was extremely positive and that they are receiving many requests to continue this programming. As a team, consider ways in which you may incorporate GBV prevention activities into this same framework without putting women and girls at greater risk and keeping in mind their safety and security when raising such issues in the home. Raising Voices, an organization based in Uganda, offers some guidance on adapting GBV prevention programs to remote contexts, which can be accessed here: https://raisingvoices.org/wp-content/uploads/COVID19_Note4.RaisingVoices.pdf

The Konterra Group (2020). Managing Burnout During COVID-19. <https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19.pdf>; in Arabic at: https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19_ARABIC.pdf; and French at: https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19_FRENCH.pdf

Useful Resources

- Interagency Gender Based Violence Case Management Guidelines: alnap.org/system/files/content/resource/files/main/interagency-gbv-case-management-guidelines-final-2017-low-res.pdf
- Managing Gender-Based Violence Programs in Emergencies: [https://www.unfpa.org/sites/default/files/pub-pdf/GBV%20E Learning%20Companion%20Guide_ENGLISH.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/GBV%20E%20Learning%20Companion%20Guide_ENGLISH.pdf)
- INTER-AGENCY STANDARD OPERATING PROCEDURES (SOPS) FOR SGBV PREVENTION AND RESPONSE IN LEBANON: <https://www.abaadmena.org/documents/ebook.1491983561.pdf>
- GBV AoR Guidance on GBV Case Management and the COVID-19 Pandemic <https://www.sddirect.org.uk/media/1968/gbv-case-management-and-covid-19-pandemic-updated-version-19052020.pdf>
- GBVIMS Case Management Guidelines http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf
- GBV Pocket Guide: How to support survivors of GBV when a GBV actor is not available in your area https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_PocketGuide021718.pdf
- Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_final.pdf
- The Konterra Group. COVID-19 Resources for Organizations and Employers: Recovery and Wellness. <https://konterragroup.net/covid-19/>
- The Konterra Group (2020). Managing Burnout During COVID-19. Arabic: https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19_ARABIC.pdf; French: https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19_FRENCH.pdf; English: <https://konterragroup.net/wp-content/uploads/2020/04/Managing-Burnout-During-COVID-19.pdf>;
- National Network to End Domestic Violence (NNEDV). Best Practice Principles for Digital Services. <https://www.techsafety.org/best-practice-principles>.
- National Network to End Domestic Violence (NNEDV). (2019). Digital Services Toolkit. <https://www.techsafety.org/digital-services-toolkit>
- National Network to End Domestic Violence (NNEDV). (2020). Response to the COVID-19 Pandemic. <https://www.techsafety.org/covid19>
- Raising Voices (2020) Guidance Note 2: How can activist organizations adapt? Series on Preventing Violence against Women during the COVID-19 Pandemic. Kampala, Uganda. https://raisingvoices.org/wp-content/uploads/COVID19_Note2.RaisingVoices.pdf
- Raising Voices (2020) Guidance Note 3: How can we amplify self and collective care? Series on Preventing Violence against Women during the COVID-19 Pandemic. Kampala, Uganda. https://raisingvoices.org/wp-content/uploads/COVID19_Note3.RaisingVoices.pdf
- Raising Voices (2020) Guidance Note 4: How can VAW prevention programs adapt? Series on Preventing Violence against Women during the COVID-19 Pandemic. Kampala, Uganda https://raisingvoices.org/wp-content/uploads/COVID19_Note4.RaisingVoices.pdf
- Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines <https://www.gbvims.com/covid-19-guidance-on-remote-gbv-services-focusing-on-phone-based-case-management-and-hotlines-out-now/>

ANNEX - Case Management Forms

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:

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.			

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			

Caseworker Signature/Date:

Supervisor Signature/Date:

RE-ASSESSING SAFETY

	Yes	No	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

	Yes	No	Explain	Additional Intervention 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:

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: _____

HELPLINES FOR GBV SURVIVORS



ABAAD safeline (24/7)
+961 81 78 81 78



Embrace hotline
1564



**Internal Security Forces
Hotline for Domestic Violence**
1745