

Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery



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List of Acronyms

CCSAS: Clinical care for sexual assault survivors

CMR: Clinical management of rape

GBV: Gender-based violence

GBVIMS: Gender-based Violence Information Management System

EC: Emergency contraception

IASC: Inter-Agency Standing Committee

IEC: Information, education, communication

IDP: Internally displaced person

IPV: Intimate partner violence

IRC: International Rescue Committee

LGBTI: Lesbian, gay, bisexual, transgender, intersex

NFI: Non-food items

NGO: Non-governmental organization

PEP: Post-exposure prophylaxis

PSEA: Protection from sexual exploitation and abuse

PRIMERO: Protection Related Information Management System

SEA: Sexual exploitation and abuse

WGSS: Women and girls safe space(s)

Glossary of Terms

Common terms and definitions used in this document are defined below.

Assessment: An assessment is a process undertaken to collect and analyze information in order to better understand a particular issue. In humanitarian settings, NGOs and UN agencies carry out assessments to identify community needs and gaps, and then use this information to design effective interventions. A security assessment looks at the security situation in an operational context and the requirements to implement service delivery in a safe way. GBV-specific assessments are carried out to improve understanding of the nature or scope of violence against women and girls, to evaluate a program or service, to identify gaps in support, and to identify local attitudes and behaviors related to sexual violence and other forms of GBV.

Caseworker: Caseworkers are professionals who provide case management services to GBV survivors through a service-providing agency. Caseworkers must be trained appropriately on client-centered case management, be 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 or case managers, among other terms.

Case management: GBV case management, which is based on social work case management, is a structured method for providing help to a GBV 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 a survivor and her/his family face are identified and followed up in a coordinated way. Caseworkers provide the survivor with emotional support throughout the process.

Coping skills: The ability to identify resources in life (people, things, activities) that help provide happiness, relaxation and comfort when one feels bad. This includes the ability to develop a plan to participate in positive activities that bring enjoyment, engage people or pursue interests, and cultivate strengths that enable one to feel healthy and supported.

Community focal points: Female members of the community (often women leaders) or who are representatives of local organizations that work with women in mobile sites who are chosen to support mobile teams (on- and off-site), provide further outreach to the community, and link community members to caseworkers.

Community mapping: During a GBV-specific assessment, drawing a community map in focus group discussions can serve as a means to assess the community's knowledge of services available to women and girls (e.g. number, location, and quality of medical and psychosocial care services), challenges women and girls may face in accessing services (e.g. lack of privacy and safety, distance), and the community's perception of areas that present high risks to women and girls (public or remote areas where sexual assaults or harassment are likely to take place, for example), as well as safe spaces for women and girls.

Dignity kits: Dignity kits contain hygiene, sanitary and other items explicitly tailored to the local needs of women and girls of reproductive age in a given community. Generic hygiene kits help people improve cleanliness (with items such as soap, sanitary materials, toothbrushes and toothpaste). While dignity kits are similar to the basic hygiene kits often distributed at the onset of emergencies, they contain a wider range of items and so serve a broader purpose. Dignity kits focus on promoting the mobility and safety of women and girls by providing age, gender, and culturally-appropriate garments and other items (such as headscarves, shawls, whistles, torches, underwear, and small containers for washing personal items), in addition to sanitary supplies and basic hygiene items.

Entry point for case management: An entry point for case management links GBV case management services with other, non-GBV services. This allows survivors to access case management services confidentially, while they appear to be participating in non-stigmatized services, so that they do not need to disclose their survivor status to other community members. There are two main entry points for providing in-person case management services: 1) temporary safe spaces for women and girls; and 2) entry points that are co-located and linked with services provided by other sectors, either within or external to your organization. Further, as hotlines provide a remote means for survivors to access case management services confidentially, they can also be an entry point for case management.

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

GBV guiding principles: Internationally accepted principles that are meant to guide the work of all helpers – no matter what their role is – in taking a survivor-centered approach in all their interactions with people who have experienced GBV. This includes a survivor's right to safety, confidentiality, dignity and self-determination, and non-discrimination.

GBV Sub-cluster: A 'cluster' is essentially a coordination group focused on a specific area of humanitarian response. It may also be referred to (using the more traditional term) as a 'sector'. At the global level, the IASC has designated 11 'global clusters', each with a lead agency or agencies. The global cluster lead works with UN and NGO partners within that cluster to set standards and policies for the cluster, build standby response capacity, and provide operational support to organizations working in the field. Under the Protection Cluster, the GBV Sub-cluster coordinates GBV services.

IEC materials: Information, Education, Communication materials inform communities about the availability of services, how to access them, and the ways in which services will be provided (i.e. confidentially, etc.).

Mobile GBV service delivery: With mobile GBV service delivery, service providers move to where people are displaced, residing, or in transit, in order to provide services to those who cannot be easily reached with traditional (static) services. This model can be used in situations when the population is dispersed and/or displaced among host communities in rural or urban settings.

Mobile site: The catchment area/location to which a mobile team deploys.

Mobile team: A group of staff (caseworkers, community outreach staff or mobilizers, transport operators and others) equipped to deliver contextually-relevant services at a mobile site. They travel to the mobile site to provide services.

Normalizing: A strategy used in GBV mobile response to reduce the stigma of talking to caseworkers in public view. Examples include communication and activities conducted by caseworkers in the community to ensure that they are not associated with GBV, to create the impression that it is normal for them to speak with community members one-to-one about matters other than GBV.

Outreach/community mobilization: Different activities undertaken by GBV mobile teams to raise awareness about services, introduce GBV basic concepts, empower the community, and build community capacity to address problems. Examples include sessions to assess GBV risks and concerns, and engaging community leaders, service providers and the general community about risk mitigation for GBV. It can also include service mapping and strengthening referral pathways, as well as sessions to discuss topics such as women's rights.

Phone-based referral/phone-based referral pathway: Procedures established whereby a service provider, with the consent of survivors, can contact another service provider by phone in order to refer survivors to other services that may meet their needs.

PRIMERO/GBVIMS+: The Protection Related Information Management System/GBVIMS+ is a web application developed to enable GBV humanitarian actors to safely collect, store, manage and share data for incident monitoring and case management. It combines field-proven tools, global best practices, and the latest open-source technology, to bring a user-friendly and scalable solution for data management. The system utilizes technology enhancements with an on/offline data collection platform, and can function through a mobile application.

Remote services: Services that are provided over a technology platform (i.e. hotline, chat or SMS) rather than in person.

Risk-reduction supplies: Supplies that can be used to reduce the risk of violence. This includes dignity kits, as well as items that reduce risk in the environment: locks for latrines, showers and shelters; lights and other supplies. The need for these supplies is identified during safety audits.

ROSA (Remote-offered Skill-building Application): A remote supervision and skill-building application available offline on tablets and smartphones. It facilitates capacity building and GBV skill assessment for frontline workers, creates a community space for peer learning and coaching, and connects workers to tools for GBV rapid assessments and advocacy resources.

Safe house: A safe house provides immediate security, temporary refuge and support to GBV survivors escaping violent or abusive situations. This resource (if available) can be provided to women (and often their children) who are in imminent danger. Admission is usually contingent on specific criteria. Safe houses are usually in undisclosed and/or protected places to protect the safety of survivors.

Safe space for women and girls (mobile context): A women- and girl-identified community space where women and girls can come together to discuss their issues in confidence. Women and girls safe spaces (WGSS) can be standalone structures, such as a house or a tent, either borrowed from the community or rented from an owner. They can be spaces designated only once a week when the mobile team is on-site, or spaces that function 24 hours a day, seven days a week. Most importantly, these spaces are chosen and preserved by the women and girls they are designed to serve.

Safety audits: Safety audits are typically carried out in camps or settlements during displacement, but can be used to assess safety and security concerns for women and girls in any geographic location that has specific boundaries. The safety audit tool uses visual observation to assess GBV risks related to the physical structure and layout of the location, resource availability, and provision of humanitarian services and assistance.

Short-term rapid GBV response: A short-term GBV response during the acute stage of an emergency, when a population is affected by humanitarian crises, in transit or newly displaced but will not remain long in the site. Short-term rapid GBV response involves the deployment of a GBV mobile team to a site once or a few times within a few days to provide immediate, lifesaving interventions to populations, crisis response, risk-reduction supplies and information about available services.

Static services: Services that are stationary, have a set location and do not move.

Static GBV services: The term used for traditional, standard GBV services that are stationary. This is the typical way GBV practitioners set up services in refugee camp locations (with identified boundaries), whereby beneficiaries access services through established centralized locations (most often women and girls safe spaces), under management of GBV providers, with regular access to confidential case management services. These services are established in buildings that are often designed for maximizing confidentiality.

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.

Introduction

Gender-based violence (GBV) is an umbrella term for any harmful act perpetrated against a person's will based on the socially ascribed (i.e. gender) differences between females and males.¹ Women and girls are disproportionately affected by GBV because of their subordinate status in society relative to men and boys. Conflict and disasters exacerbate many forms of GBV that women and girls experience in times of stability. During humanitarian crises, for example, risks of sexual violence, intimate partner violence (IPV), early marriage and other forms of violence increase. Women and girls from marginalized populations face even greater risk, based on intersecting dimensions of inequality such as race, class, disability, sexual orientation and gender identity. Men and boys, particularly from marginalized populations, may also be at risk of sexual violence in humanitarian settings.

GBV is a serious and life-threatening issue and poses significant safety and protection risks. Breakdowns in state, community and family protections, increased militarization, displacement, limited services and access to basic resources, unsafe living conditions and weakened infrastructure all increase risks of GBV. Gaps in humanitarian assistance heighten the likelihood of women and girls being forced to engage in negative coping strategies, like survival sex or early and forced marriage, in order to meet basic needs. Displaced women, especially widows and female-headed households, as well as adolescent girls, are particularly vulnerable to GBV.

Despite the scope and severity of the problem, current responses to GBV by humanitarian actors are insufficient to address the issue. Preventing and responding to GBV is now recognized as an essential lifesaving component of humanitarian action and *“all humanitarian actors must be aware of the risks of GBV and – acting collectively to ensure a comprehensive response – prevent and mitigate these risks as quickly as possible within their areas of operation. Failure to take action against GBV represents a failure by humanitarian actors to meet their most basic responsibilities for promoting and protecting the rights of affected populations.”*² Worldwide, GBV is underreported, and it is imperative that *“all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions regardless of the presence or absence of concrete ‘evidence.’”*³

Responding to GBV in emergencies should be prioritized at the earliest stage of a crisis to minimize risks to women and girls and ensure that GBV-specific services are available and accessible.⁴ While this is increasingly recognized in the humanitarian community, emergency responses consistently face obstacles to establishing lifesaving health, psychosocial and safety services for survivors and to implementing actions to reduce risks of violence. Service delivery for GBV is critical during the acute stage of any crisis. This includes psychosocial support and case management for survivors, and linking them to other available services, including health, safety, protection and legal services. Due to its immediate, time-sensitive and potentially life-threatening health consequences, addressing sexual violence is critical, and ensuring clinical care for sexual assault survivors (CCSAS)/clinical management of rape (CMR) is imperative.

Most models and quality standards for GBV service delivery in humanitarian settings are geared towards large refugee and internally displaced person (IDP) camp populations, in which centralized GBV case management services are attached to static women's centers and/or health facilities. However, the changing nature of displacement, in which affected populations are more likely to be out-of-camp, urban/peri-urban, multiple and dispersed, means that static, centralized services are not always feasible to implement. In 2017, conflict and natural disasters led to more than 65.6 million people displaced globally, and more than 40.3 million are people displaced within their own country. Increasingly, these displaced persons are living in host communities, urban settings or informal settlements, with more than half of the world's displaced people living in urban areas.⁵

1 Inter-Agency Standing Committee (2015), *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery*, p.5

2 Ibid, p. 14

3 Ibid, p. 9

4 IRC (2014) *Emergency Response and Preparedness Toolkit* - <http://gbvresponders.org/emergency-response-preparedness/>

5 Internal Displacement Monitoring Centre (2017) *Global Report on Internal Displacement (GRID)*

In response to the changing nature of displacement, mobile services, in which services are provided to people where they are displaced, residing, or in transit and not easily reached with traditional (static) services, and remote services, in which staff connect with beneficiaries from a distance using technology, have begun to be used. These models have been designed to meet the needs of GBV survivors from vulnerable, displaced, out-of-camp populations, dispersed in urban and rural settings, who are often hidden, difficult to reach, isolated, and at heightened risk of violence. While these innovations are necessary, until now the humanitarian community has been challenged to develop replicable, scalable and quality mobile and remote service delivery models and document best practices. These Mobile and Remote Gender-based Violence Service Delivery Guidelines are designed to address these gaps and provide guidance to support the development of GBV mobile and remote service delivery in acute and protracted crises.

With the support of U.S. Bureau of Population, Refugee and Migration Services (PRM) and the European Civil Protection and Humanitarian Aid Operations (ECHO), the International Rescue Committee (IRC) has developed tools, platforms and program guidance for mobile and remote GBV service delivery, in consultation with GBV expert practitioners. These were piloted in Myanmar, Iraq and Burundi in 2017 and 2018, and evaluated for their feasibility and acceptability by external researchers Leah James and Courtney Welton Mitchell. The learning from the implementation and results of the feasibility and acceptability study have informed these guidelines.⁶

These guidelines also reflect interagency collective knowledge of and experience with mobile and remote services, as well as the IRC's work in other humanitarian contexts where mobile and/or remote service provision models have been developed to provide GBV services. These guidelines are meant to complement and be used in tandem with the *Inter-Agency Gender-Based Violence Case Management Guidelines* (2017), the *IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (2015), the *Clinical Care for Sexual Assault Survivor's Toolkit* (2014), the *IRC's Emergency Response and Preparedness Toolkit* (2014), and the *IRC and UNICEF's Caring for Child Survivors of Sexual Abuse - Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings* (2012).

Scope of the resource

This resource provides guidance on establishing GBV mobile and remote services, in order to provide case management, psychosocial support, and referrals to meet the immediate needs of GBV survivors. Such services should be established in settings where traditional services based in static centers with continuous access to trained caseworkers cannot be set up or consistently accessed due to the nature of displacement and/or ongoing insecurity that hinders both humanitarian access and the displaced population's movement.

Women and girl survivors require different means and supports to access GBV services, compared to male (and male-identified) survivors of sexual violence. Because the majority of GBV survivors in humanitarian settings are women and girls,⁷ a significant portion of this resource will focus on developing mobile services specifically for them - inclusive of other identities and vulnerabilities, such as disability, sexual orientation and gender identity. However, meeting the case management needs of male sexual violence survivors and other vulnerable populations will also be addressed as a subsection of these guidelines.

This resource includes the following:

Part 1: Overview of Mobile and Remote GBV Service Delivery. This part provides an overview of mobile and remote service delivery and outlines the circumstances under which organizations should consider implementing such responses.

6 The research brief and full report of the findings from the feasibility and acceptability study can be found on GBV Responders: <https://gbvresponders.org/response/mobile-and-remote-gbv-service-delivery/>

7 *Inter-Agency Gender-Based Violence Case Management Guidelines* (2017), the *IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action* (2015)

Part 2: Setting up Mobile and Remote Service GBV Service Delivery. This section provides step-by-step guidance for establishing mobile and remote GBV services including pre-deployment preparedness, conducting assessments, and designing the response.

Part 3: Minimum Standards for Mobile and Remote GBV Service Delivery. This section provides guidance on appropriate entry points for GBV case management and outlines the resources required (human, security, financial) to adhere to the guidance. Staff designing and implementing mobile and remote responses will need to be familiar with the minimum standards before beginning the assessment and design process outlined in Part 2.

Part 4: Providing Case Management and Group Psychosocial Support. This section covers the recommended adaptations to the GBV case management process in light of time limitations associated with mobile and remote service provision. It includes guidance on providing group psychosocial support and on data and information management specific to mobile and remote responses.

Part 5: Supervision and Monitoring of Mobile and Remote GBV Service Delivery. This part provides guidance on approaches to supervision, monitoring and capacity building for mobile and remote service delivery, including how to use technology to carry out remote supervision of caseworkers, a function that is often critical in insecure and/or inaccessible contexts.

Intended Audience

This resource is developed for staff and organizations who have technical expertise and are experienced in providing GBV case management and survivor-centered psychosocial support in humanitarian contexts, who need to adjust or expand their services to reach displaced populations in out-of-camp settings, or in unserved, insecure or hard-to-reach locations. All modalities of mobile and remote service delivery require trained, skilled and experienced GBV case management staff to implement.



Part 1: Overview of Mobile and Remote GBV Service Delivery

1.1 Mobile GBV Service Delivery

1.1.1 What is mobile GBV service delivery?

While many of the elements are similar, mobile GBV service delivery is distinct from static service delivery. With static services, women and girls come to established centralized service locations and have daily access to confidential GBV case management, which is often linked to other services, such as age-appropriate psychosocial support and health services. In contrast, mobile GBV services endeavor to meet the needs of survivors who cannot access static services, due to limited mobility, distance, insecurity or other obstacles. For mobile service, providers move to sites where the population is located.

With mobile GBV service delivery, service providers move to where people are displaced, residing, or in transit, in order to provide services to those who cannot be easily reached with traditional (static) services. This model can be used in situations when the population is dispersed and/or displaced among host communities in rural or urban settings.

Types of GBV mobile responses

To date, there has been enormous variance in how the humanitarian community has defined mobile GBV response. While these guidelines intend to set standards for safe and ethical mobile GBV service delivery, it is also important to note that mobile responses will take shape according to the realities of each humanitarian context.

The two main types of mobile GBV responses that will be discussed in these guidelines are:⁸

- 1. Mobile GBV service delivery in protracted crisis and/or displacement settings.** In this type of response, GBV teams deploy to a site (or several sites) of protracted crisis or displacement to provide GBV services on a rotational basis (e.g. once a week in each site, over the course of months), usually after the acute phase of a crisis has passed. If mobile teams provide a response to several sites, each site requires a unique and tailored intervention appropriate to the context.

From the field:

In the Makamba region of Burundi, from April 2017 to August 2018, IRC mobile staff deployed from an office four days a week to support four mobile sites. Each mobile site (under two hours away from the office) was visited once a week, according to an agreed schedule. The IRC mobile teams provided case management and psychosocial support in dedicated women and girls safe spaces, which were rented buildings. Community focal points provided other recreational and skill-building activities – based on needs specified by women and girls – in the spaces on the days the IRC mobile teams were not there. The women and girls were thus empowered to organize their own activities, and the IRC provided case management services once a week.

The following graphic provides an overview of what mobile GBV services in protracted crises or displacement contexts look like. The process for designing a mobile intervention and the minimum standards that should be followed in doing so are explained in Part 2 and Part 3 of this resource.

⁸ These two types mobile GBV service delivery were piloted and evaluated as part of the project and as such form the basis of the guidance.

Mobile and Remote Approaches to Gender-based Violence (GBV) Service Delivery in Contexts with Protracted Displacement

Mobile teams



Once coordination mechanisms are established and security clearance obtained, **mobile teams travel to target communities** on a set interval.

The number and composition of mobile team members and vehicles needed depends on displacement density and population per site, the distance between sites and assessed needs for direct program support.



Establish entry points for case management linked with non-GBV activities in mobile sites

Identify private space and time to link with non-GBV, non-stigmatized group activities for confidential access.



Temporary safe spaces for women and girls

- Encourage community ownership of social networking activities
- Individual support and empowerment
- Community risk assessment, safety planning, advocacy and coping skills
- Case management for survivors of GBV



Entry points co-located and linked with other sector services

- Case management in private rooms linked with non-GBV static services like health clinics
- Case management in private spaces created through the use of tents or assembled infrastructure when deploying with another sector
- Requires strong coordination, training, time on site and ethical referral procedures



Hotlines, training and community outreach

Hotlines and the training of service providers, strong referral pathways and capacity building of community focal points to refer survivors increases access, effectiveness and sustainability when mobile teams are not on site.



2. **Short-term rapid response.** During the acute stages of a humanitarian crisis, a short-term rapid response may be the most appropriate and efficient means of providing immediate, lifesaving interventions to populations, if the population will not remain in one location long enough to set up longer-term mobile or static services. Short-term rapid GBV response involves the deployment of a GBV mobile team to a site once or a few times within a few days to provide crisis response, risk-reduction supplies and information about available services.

From the field:

In Myanmar, IRC GBV mobile teams have been providing short-term rapid GBV response to reach small groups of displaced populations on a cyclical basis, when villagers flee to church grounds due to conflict between the Myanmar Army and other ethnic armed groups. The mobile teams are comprised of IRC and partner GBV staff who speak the appropriate languages, as well as IRC health staff, who can provide medications to prevent pregnancy and HIV, and referrals for rape survivors within 72 hours. The teams meet with women and girls separately, listen, assess, and (if appropriate) address safety and security risks, provide information about services, including a hotline for remote GBV services, and provide dignity kits if required. These displaced villagers usually return to their village of origin within a week. The team then ends support to this particular displaced group, unless an individual follows up through the hotline.

The content in this resource is focused primarily on the first type of mobile response listed above, **mobile responses in protracted crises or displacement settings**, because they are longer term and require a more comprehensive approach to designing and providing GBV services. However, guidance related to designing and implementing short-term rapid responses is also included in Part 2.

1.1.2 When to consider a mobile response

A mobile response should only be considered when a static response CANNOT be implemented, or when mobile support can serve as a stop-gap until static services are established, either directly or through building the capacity of a committed local partner. Mobile GBV services, due to time limitations on-site, may not allow for the provision of comprehensive case management, psychosocial support services, or referral services and thus should not be implemented whenever it is possible to implement static services. Furthermore, the human and financial resources required to carry out safe and quality mobile programming may be more demanding than with static services, making it potentially more challenging to implement.

Nonetheless, many contexts require more flexible and adaptable modes of service delivery, and GBV mobile service delivery can be used to effectively respond to the immediate and longer-term needs of affected populations. While the reasons for selecting a mobile service delivery model may vary across contexts, below are some of the factors that may determine the use of mobile services.

- There are vulnerable displaced populations in the area with limited or no access to GBV services (learned via consultation with other humanitarian actors through coordination mechanisms, interagency assessments or/and with communities).
- The population reports being unable to access static services due to distance, movement restrictions or other reasons.
- The population is widely dispersed across multiple locations in urban and rural settings and host communities.
- The population is newly displaced, highly mobile or in transit.
- Humanitarian assistance cannot be sustained in the locations due to security, access or other restrictions (poor weather, etc.).

- There are no other GBV service providers (including GBV mobile teams) in the area.
- There are too many urgent needs and too few resources among protection actors to set up stable, daily static services at the time.

All actions and decisions to provide GBV mobile services should be based on a careful analysis of the needs, capacities, risks and benefits of any intervention and should be linked to a longer-term plan for service delivery. GBV actors should **consider a mobile response only when the likely benefit of the intervention outweighs the risks**, and the organization's presence will not endanger staff, beneficiaries or others.

1.2 Remote GBV Service Delivery

1.2.1 What is remote GBV service delivery?

Remote GBV service delivery provides GBV services (predominately emotional support and case management) over a technology platform (i.e. hotline, chat, or SMS) rather than in person. Remote GBV services can be provided as follows: 1) as a separate stand-alone intervention in places where the population cannot access services in person or an organization cannot set up in-person services due to insecurity; 2) implemented in tandem with static programming to expand the geographic reach of services, in which case they are often accessible on a regional or national level; and/or 3) implemented as part of a mobile service delivery approach to enhance continuity of GBV services when the mobile team is not on-site, in which case they may have a more limited geographic scope, accessible only to the population at the mobile sites.

1.2.2 When to consider remote service delivery

Many of the reasons listed above for when to consider implementing a mobile approach also apply to remote service delivery. In addition, remote service delivery, whether implemented alone or as a complement to mobile or static programming, offers the following benefits:

- Allows survivors to immediately access help when they experience a crisis.
- Expands access to crisis support and case management in areas that are inaccessible or unserved as well as to populations who cannot reach in-person services due to restricted mobility.
- Offers greater confidentiality for all survivors, but may be particularly useful in reaching survivors who face additional stigma related to help-seeking, such as male or LGBTI survivors.
- Potentially increases service access for adolescent survivors, who are more likely to use such technologies and are at high risk of sexual violence, abuse, and exploitation in humanitarian settings.
- As mentioned above, when used with mobile responses, hotlines can provide continuity in GBV service delivery when a mobile team is not on-site. The functions of a hotline when used as part of a mobile intervention include:
 - » Allows GBV caseworkers to speak directly with survivors and offer crisis intervention, safety planning, information resources and referrals;
 - » Allows GBV caseworkers to speak with community volunteers who support mobile programming (referred to as community focal points in this resource) and other service providers to support their work with survivors.

Because hotlines can be implemented as both a stand-alone intervention and as part of a mobile response, in this resource they will be discussed throughout the sections on mobile service delivery. Further guidance on implementing a telephone hotline can be found in Annex 5.⁹

9 The guidelines do not address remote "chat" functions and other remote service delivery options using new technology.



Part 2: Setting up Mobile and Remote GBV Service Delivery

Before designing mobile response, several activities should be conducted as part of pre-deployment preparedness (Step 1) and on-site assessment (Step 2).

Step 1: Pre-deployment preparedness

For all mobile responses, including short-term rapid responses, the following tasks and activities should be part of pre-deployment preparedness.

- **Gather information.** Upon hearing about a new displacement, GBV mobile teams should coordinate with the GBV sub-cluster and other humanitarian organizations to find out as much as possible about services, including existing mobile services, and locations of static services. Other information that should be gathered includes approximate disaggregated population figures, languages spoken, names and positions of relevant community leaders and their contact information, and relevant government contacts.
- **Assess security.** Before any deployment, trained field security personnel should conduct an initial security assessment for each location the assessment team will potentially visit, including assessing the routes and alternative routes between locations. Security personnel should gather information from several different sources (INGOs, NGOs, local representatives) to verify the information. A sample Security Risk Assessment for Emergency Response can be found in Annex 1. In locations with rapid cyclical displacements, security actors should track regional trends in security information and road conditions. **A strong gender lens is required in determining risks, as the majority of GBV service delivery staff are female.** Once clearance is provided and permission obtained to travel, identify means of transportation to the site(s).

- **Pre-position supplies.** The following supplies should be pre-positioned, stored in an accessible manner, ready for transport and utilization. These include:
 - » Dignity kits, case management materials (i.e. things survivors may need) and other risk-reduction materials
 - » Fuel and supplies for vehicles
 - » Medications (e.g. emergency contraception, etc.)
 - » Culturally appropriate Information Education and Communication (IEC) materials with graphics and images, including hotline number (if applicable)
 - » Staff IDs, agency approvals for operation and any travel authorizations needed
 - » Hibernation kits and first aid kits
 - » Staff emergency grab bags and supplies
 - » Materials for temporary infrastructure: tents, mobile vehicle, awnings, etc.
 - » In contexts where relevant and feasible, mobile phones, tablets, SIM cards
- **Recruit and train staff.** Staff must be chosen to form an initial team that will go to the potential sites to carry out the assessment and to be able to provide basic services.

When starting up mobile responses for protracted settings, organizations with existing GBV services in other parts of the country or region can deploy these staff to carry out the initial scoping and assessment, as they will already have the necessary training and skillset. Where trained staff are not readily available, other staff should be trained appropriately before being deployed. **Short-term rapid responses for GBV can only be implemented if the organization has existing static or mobile services from which staff can be shifted from other duties and temporarily deployed.**

Regardless of the type of mobile response, staff chosen should have the following training and experience prior to being deployed for the assessment:

- Prior GBV case management training and experience, according to the *Interagency GBV Case Management Guidelines*, including CCSAS; experience adapting the case management model for mobile and remote responses (guidance provided in Part 4);
 - GBV response and preparedness training, including on the use of GBV emergency rapid assessments;
 - How to create confidential access to services for survivors at mobile sites;
 - Normalizing one-on-one communication with beneficiaries in order to minimize stigma associated with survivors' disclosing in public view;
 - Distribution of dignity kits;
 - Community outreach strategies to provide information on GBV services;
 - Responding to survivors' immediate health needs.
- **Determine how immediate health services will be provided to survivors of sexual violence.** When carrying out the assessment, it is likely that survivors will disclose incidents of GBV to the assessment team. In cases of sexual violence, the team should be prepared to facilitate access to lifesaving health services within the appropriate time period (72 hours for HIV post-exposure prophylaxis and 120 hours for emergency contraception).¹⁰ If there are health service providers in the mobile site that provide such interventions, survivors can be referred to them. If no such providers exist, consider including a reproductive health staff person on the initial assessment team who is trained in administering such medications, or coordinate joint deployments with a mobile health team that has staff trained in delivering CCSAS, or equip GBV staff (who are trained and allowed by law to do so) with the appropriate medication to disburse directly to survivors.

¹⁰ Note that providing such medication is only one part of clinical care for sexual assault survivors (CCSAS), or as it is sometimes called, the clinical management of rape (CMR). CCSAS is a much more comprehensive intervention that requires specially trained nurses and doctors. During the assessment, analyze what options (if any) exist to provide the full CCSAS intervention. See CCSAS <https://gbvresponders.org/response/clinical-care-sexual-assault-survivors/> for more information on this intervention and the resources required to implement it.

- **Designate a program phone number** through which stakeholders can contact your organization following the assessment. Communicate this to all staff who are part of the assessment team.

The following additional points are important to consider for short-term rapid GBV responses:

Because of their short-term nature, a full GBV assessment to inform the design of services cannot be carried out for short-term rapid responses. The team will not know before deployment if any spaces exist from which to provide case management services, therefore procuring and transporting easily assembled tents and infrastructure will likely be the best option. The response should focus on providing crisis intervention (emotional support and information), risk reduction activities, distribution of dignity kits as well as lifesaving health interventions, to the extent possible.

Step 2: Assessment

The following information will need to be collected as part of the assessment **in each potential mobile site**. Before beginning the assessment, staff should be familiar with the minimum standards described in Part 3.

Emergency GBV assessments.¹¹ This includes conducting focus group discussions, individual interviews, community risk mapping, and safety audits to identify immediate needs, concerns, and safety risks for women and girls in general and those potentially at risk of GBV. Be sure to meet with women and girls separately from men and boys, in the most private spaces you can find or create.

Service and infrastructure mapping. Service and infrastructure mapping is a critical part of the assessment for mobile and remote responses because it will allow organizations to determine: 1) appropriate referrals for survivors as part of the multi-sectoral response to GBV; 2) physical spaces from which services could potentially be provided.

1. Service mapping for case management referrals. This part of the service mapping should focus on identifying existing services in the mobile sites to which survivors can be referred, what services survivors are already accessing, gaps in the quality of services, and overall barriers to access. To carry this out, use the Service Mapping Tool that is part of the *GBV Emergency Response and Preparedness Toolkit*.¹² This tool provides guidance on who to speak to and what information to gather.

In addition, the below questions should be included:

For focus group discussions with community members (gender- and age-disaggregated):

- a. Health services:** Ask where women or girls who are survivors of violence feel safe and comfortable going to receive medical treatment. Ask about informal health providers, who may have regular access to potential survivors, especially in places where formal services are limited. For example, ask where or to whom women would go for prenatal care and delivery, as well as about the existence of any community health workers that visit the community.
- b. Safety options:** What does the community do to protect women and girls? From whom can women and girls seek assistance in case of an immediate safety risk? Are there other services or support (counseling, women's groups, legal aid, etc.) available for women and girl survivors? Are there any safe houses available to women?

11 Recommended emergency GBV assessment tools that are part of the GBV Emergency Responses and Preparedness Initiative can be found at: <https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/>.

12 See GBV Responders for a focus group discussion tool from the *Emergency Response and Preparedness Toolkit* <http://gbvresponders.org/wp-content/uploads/2014/03/Focus-Group-Discussion-Tool-2013-ENG.doc>

For interviews with service providers:

- Are there any restrictions on who could access services? (For example, do they provide services to people who do not have documentation, etc.?). Are there any fees associated with services? Are there any mandatory reporting procedures? Is there a confidential and safe documentation system?
- Can a means be established for the service provider to pay for transportation costs, which your organization can reimburse?
- What other services are in the community that the team may not be aware of and were not mentioned in the focus groups? For example, are there associations or other organizations that engage with and advocate for the rights of specific vulnerable populations?
- Find out whether service providers can be reached by and receive referrals via telephone, and during what hours.
- Do service providers have concerns about their information being publicly available and distributed on a referral pathway? (E.g. there may be safety concerns for organizations working with the LGBTI population, those working with populations without legal status, or those associated with opposition groups).

2. Service and infrastructure mapping to determine physical spaces from which services could potentially be provided.

This mapping will inform decisions about entry points for case management services. As shown in the graphic in Part 1, there are two main entry points for providing **in-person case management services**: 1) temporary safe spaces for women and girls; and 2) entry points that are co-located and linked with services provided by other sectors, either within or external to your organization. These entry points are further described in Part 3.

To identify locations for temporary safe spaces, speak with women and girls to understand what spaces they consider to be safe. **To identify entry points co-located with other sectors/organizations**, find out whether they have space that could function as a private, confidential room from which case management can be provided. Guidance on how to do this is provided in Part 3.

Always ensure that service and infrastructure mapping includes women's organizations because of their access to women, potential space they provide for women to gather, and the role they play in providing psychosocial support.

Meet with community organizations and community leaders. As appropriate, female and male outreach staff should meet with community leaders to assess what support they can provide to reduce and respond to violence. Ask them to identify what marginalized sub-populations exist and whether there are any community associations/organizations or members that could facilitate access to such groups.

Identify potential women leaders who could act as community focal points to support the implementation of the mobile response. Community focal points can be an essential part of mobile service delivery because they can support outreach and other activities while the mobile team is not on-site. This is particularly important if mobile teams will not visit a site more than once per week. Focal points should be women who are considered leaders in the community (from whom women already seek support and help), or who are representatives of local organizations that work with women. The roles and responsibilities of community focal points and how to work with them are described in Part 3.

If considering a remote response, assess access to and use of information communication technology (ICT). Assessing the availability of ICT (e.g. phones, smartphones, tablets, laptops, etc.) is important in deciding whether to establish a hotline (particularly if the intention is to implement it as a stand-alone intervention), the kind of technology it will be possible to use, and the scope of the hotline.

The ICT assessment should include the following:

- **What kind of technology does the population have access to?** It is important to analyze access and usage of mobile devices and the internet, particularly for women and girls, who often have less access than men and boys.¹³ For example, assess whether women have private, individual access to phones, or whether do they share access with family or community members. It will also be important to understand the extent to which sub-populations vulnerable to GBV access and use ICT, in order to understand whether a hotline could facilitate or expand access to services for them.
- **Is there electricity?** How stable is it?
- **Is there internet access?** How stable and strong is it?
- **Is there a mobile network?** How strong is it?
- **To what extent will the government be engaged?** For settings where there is government buy-in and positive engagement, a hotline can potentially have great reach, covering multiple sites, a state or even the nation. If the government is reluctant to approve a hotline, the hotline can be limited in scope, providing services to beneficiaries where GBV mobile services are established.

Step 3: Design the mobile response and develop implementation plans for each site

The information gathered during the assessment will allow the organization to design a mobile response based on the key decision points outlined below. Mobile teams working at several sites on a rotational basis are encouraged to hold a workshop to discuss these elements, make key decisions and develop implementation plans for each site. See Annex 3 for a guide to conducting such a workshop.

Determine entry point(s) for case management in each site. This decision will need to be made before making decisions on any of the other elements below. The components of case management entry points are described in Part 3. If considering a remote response, it is also necessary to determine, based on the ICT assessment, whether a hotline is feasible and what the scope of it will be.

Identify staff needed for each mobile site and the entry points in each site. Outline their roles and responsibilities. Examples of staff needed are caseworkers, community outreach staff or mobilizers, staff to work specifically with adolescents, drivers/transport operators, and other staff according to the type of entry point established. Guidance on these staff positions (the required profile/background, roles and responsibilities, quantity) is provided in Part 3. It will be necessary to determine whether the organization can draw from existing staff or will need to recruit new staff.

Map the potential mobile sites and modes of transportation. Identify the distance between the sites and the means of transportation teams will use to get to and from the sites (e.g., trucks, vans, motorbikes, planes, boats).

Determine the time allocation. Determine how much time will be need in each site to conduct outreach activities and provide services. Based on the means of transportation decided above, determine the time it will take to travel to and from each site.

Hotlines require additional design decisions:

What devices will staff use and how will they be managed (i.e. how will they be charged, where will they be stored at night, what apps are not allowed, what happens if one is lost/stolen, etc.)?

- What telecommunications company(ies) in the area will support the hotline?
- What are the budget allocations for hardware, phone credit, and operating a free line or reimbursing callers?

If implementing a hotline, it is recommended to hold a planning workshop that includes managers, proposed hotline staff, IT staff (if needed), and applicable referral pathway partners. Implementation plans should outline activities and responsibilities, hotline coverage schedule, outreach and information dissemination plans, training plans for staff and partners, and a supervision schedule.

¹³ See the *Safety planning for technology, displaced women and girls' interactions with information and communication technology in Lebanon and harm reduction considerations for humanitarian settings*, Journal of International Humanitarian Action, March 2018.

Determine the rotation schedule. Determine how often the team will be able to schedule visits to the site(s) and what the rotation schedule will be between sites. For example, in contexts where it is only possible to visit one site per day, one team may be able to serve four mobile sites per week. This will vary according to the distance of the sites from the office (where sites are 1.5 hours away or more from the office, only one can be visited per day), and the distance between mobile sites. If deploying from an office on a daily basis, it is recommended to deploy four days a week, using the fifth day in the office for planning and supervision.

Develop a materials management plan. Identify the supplies that will need to be procured in advance versus those that can be sourced locally for day-to-day activities (i.e. tea, coffee, sugar, etc.). Determine what materials will need to be transported to the site(s) and how they will be stored (e.g. is there a safe and lockable place to store materials?).

Determine modes of communication. Consider the following: What will be the mode of communication between staff and supervisors (e.g. will a remote supervision mechanism for GBV caseworkers or community focal points be required)? How will mobile team staff communicate with security to receive updates/checks-ins? How will referrals to other organizations be made when the team is not present in the sites?

Determine scope of group activities. Determine what activities will be implemented directly by the mobile team in the entry points or what support will be needed so community focal points and other service providers can implement such activities.

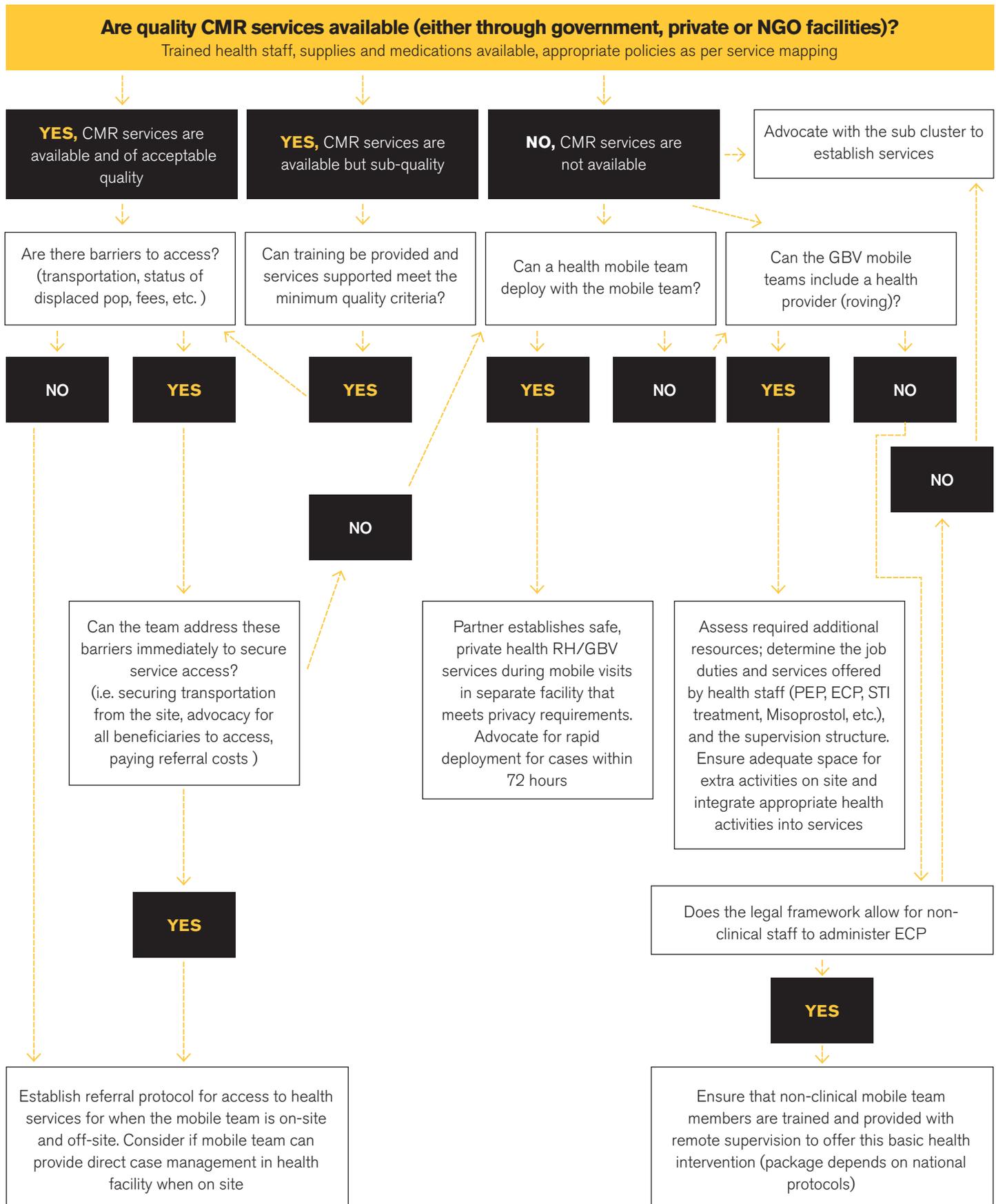
Develop an outreach plan. Decide who is responsible for outreach to the target population to inform them about the services available. Because target populations may be hidden among host communities in mobile sites, seek the help of members of target communities to disseminate information about services to others. Develop key messages for outreach.

Establish referral pathways and determine referrals mechanisms. Service mapping in the area should lead to the development of site-specific referral pathways. The referral pathways should include traditional GBV service needs, such as health services, women's organizations and safe house options, police, traditional leaders, community security authorities and legal services, and child protection. The pathways should also cover non-traditional service providers, such as disability organizations, ethnic and religious groups, community groups and LGBTI organizations. As the mobile team will not be on-site at all times, it is necessary to determine how referrals will happen, including whether coordination with other service providers will happen in-person only or also through phone-based referrals. It is also important to identify safe transportation for survivors to the service provider, establish agreements about payment of fees for services and transportation, and designate a female GBV focal point from the partner agencies who can be called upon to provide services in an emergency.

These issues should be arranged before caseworkers begin making referrals. It is also important to find out whether any of the service providers will need training, and when and how such training can take place prior to making referrals.

Determine how to facilitate access to lifesaving health services. How the mobile team will facilitate access to lifesaving health services for survivors of sexual violence is a critical decision, and can be a significant challenge in mobile interventions since they are often carried out in remote areas. From the assessment, it can be ascertained whether quality CCSAS services are available at the mobile site. If they are not, it must be decided how best to provide such health services for GBV survivors. The decision tree on the next page walks through a process for determining and weighing options and may be helpful in decision-making.

Considerations for Mobile Teams regarding Clinical Care for Sexual Assault Survivors (CCSAS)/Clinical Management of Rape (CMR)



Identify community focal points. If community focal points will be part of the mobile response, it is important to identify who the team will approach to be community focal points in each site and what the next steps are for engaging them as volunteers. Training will be an important first step, either by training community focal points from different mobile sites in a central location, or delivering trainings directly in each site.

Consider an exit strategy/transition plan. Consider the following: how long will the mobile teams provide services, and what are the longer-term options for working with and potentially handing service delivery over to local partners?



Part 3: Minimum Standards for Mobile and Remote GBV Service Delivery

3.1 Entry Points for GBV Case Management

3.1.1 Types of entry points for case management

As explained in Part 2, appropriate entry points for case management are the most critical design decision for establishing GBV mobile or remote service delivery. Just as with static GBV services, the key to an effective entry point for case management in GBV mobile response is that they are provided in a private space that is co-located with other services that are not focused on GBV. This kind of entry point allows survivors to access case management services confidentially without revealing their survivor status to community members, since it will appear they are participating in activities or receiving other services at that entry point.

Potential entry points include:

1. Temporary safe spaces for women and girls

Best practice for providing mobile services to women and girl survivors is to establish temporary safe spaces at sites served by mobile teams. Safe spaces are considered the best entry point for women and girl survivors for the following reasons:

- In most humanitarian contexts, the movement of women and girls is either restricted by gender norms or risk of harassment or other forms of GBV. A safe space is a place where women and girls can gather.
- They allow for the safe provision of services away from perpetrators, who are usually male.
- They also allow for anonymity (and therefore better confidentiality) related to help-seeking, as other activities for women and girls are held in these spaces.

Home visits should not be used as an entry point for providing GBV case management services. The *Interagency GBV Case Management Guidelines* outlines the risks associated with home visits and recommends they not be used for GBV response. More information can be found on pg 37-38: <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementGuidelines>

- Because they are spaces where women and girls can come together, they provide an opportunity for them to develop protective social networks.

2. An entry point co-located with and linked to other services (whether static or mobile) provided at the mobile site.

For example, if there is a health clinic where health services or information are provided that anyone can access, a **private room/space** can be set aside for providing services to GBV survivors. This can also happen through **joint deployments** with other sectors' mobile teams, whereby case management can be provided in a **private room/space connected to other services** (mobile health, mobile child protection, mobile WASH). This may involve bringing in tents, or large vehicles (with awnings), or other infrastructure requiring assembly at the mobile site, out of which services can be provided. These entry points offer options for male sexual violence survivors and other female survivors who may not feel comfortable or be able to access services in a temporary safe space.

3. Hotlines.

As described in Part 1, hotlines provide a remote means for survivors to access services confidentially, and as such they are an important entry point for case management and can be used as part of a mobile response or on their own, particularly for places that remain inaccessible even for a mobile team.

3.1.2 Establishing safe and confidential case management entry points

While establishing a confidential, non-stigmatizing entry point for GBV services is not unique to mobile and remote service delivery, establishing and maintaining them as safe and confidential in mobile contexts can be incredibly challenging. Safeguarding confidentiality requires additional considerations in GBV mobile service delivery due to the physical limitations of operating in borrowed, community spaces or temporary structures. In addition, the limited time staff have at the mobile site means that they will not have consistent control and management over spaces where services are delivered. For each entry point, the minimum standards to ensure the safety and confidentiality of survivors are described below.

1. Temporary safe spaces for women and girls

Temporary safe spaces for women and girls are best established in public community buildings, like schools, halls, and libraries, so they can remain a safe space when the mobile intervention ends - for sustainability. If renting a space is an option, it enables more control over the space in the short term.

The space must:

Have two or more rooms. A room required for group activities and a room required for case management. Additional rooms are better to allow for separate activities, i.e. childcare, work with adolescent girls, etc.

If no adequate infrastructure exists, the organization can try to obtain land permission and arrange to purchase and install a motor home/caravan/tent with two+ rooms permanently on-site, or purchase a structure that can be assembled during mobile deployments.

Be available at a minimum during the mobile team rotation schedule. If using space from the community, it may be in use for other community activities (i.e. school, community meetings) at different times. It will be necessary to ensure that it is be available when the mobile team visits. The more time the space is available for community-led women and girl-only activities (when the mobile team is on- or off-site), the better it is for community engagement and sustainability.

Examples of locations of safe spaces

In some locations, safe spaces have been developed in the homes of female community leaders (who are also program volunteers), when no other spaces were available, and men were not present during the hours of the activities for women and girls. This is acceptable when the focus of the services is on group psychosocial activities, though it may be possible to provide some case management services in another private space in the house.

It is important to keep in mind that having a female community leader's home function as a "safe space" is different than it being a "safe house." Survivors should not stay in staff or volunteers' homes for protection outside of group activities. Having survivors stay at a staff/volunteer's house is a major safety concern, as the host may be targeted by perpetrators or others in the community.

To establish a temporary safe space for women and girls, carry out the following:

Identify the space with women and girls. Start all programming with discussions with women and girls, including a mapping of safe and risky places. Identify potential safe spaces, routes of access, means to address barriers to access, presence of security actors and their effect on perceptions of safety, ownership of spaces and negotiations required to use space, etc. (See Annex 1 for a tool to support this process).

Establish community agreements and public acknowledgment that the space is only for women and girls. In order to not compromise the safety of services that are provided in the safe spaces, it is recommended that organizations develop community agreements that the spaces remain female-only during the hours of operation. These agreements should involve the owners of the community building and land where the safe space operates, community leaders, women and girls, and others who live or operate in the neighborhood. Effective services depend on the women- and girl-only rules, so male perpetrators cannot block access to those seeking services.

2. Entry points co-located with and linked to other sectors'/organizations' services

The space: These types of entry points require one additional room that can function as a private space attached to where other services or activities are being provided by the sector or organization with whom the mobile team is collaborating. For example, this could be a private room connected to a health clinic, nutrition center, a government office, or a child-friendly space.

Coordination with partner organization:

Prior to establishing this type of entry point, it is necessary to plan the following with the partner organization: 1) the schedule for the use of the additional room to provide services, and agreement that this needs to be without interruptions; 2) a means to "normalize" the presence of a caseworker and potential survivors (i.e. other activities are happening or other services are available while GBV case management services are being provided); 3) when and how partner staff can be trained on handling disclosures and making safe and appropriate referrals should they be approached by a survivor; 4) the funding cycle of the partner and any potential disruptions in services. Developing a formal agreement with the partner organization that covers the above is highly recommended.

Establishing a case management entry point through another mobile team

As described above, case management entry point may also be established with other mobile services, whereby GBV mobile teams jointly deploy with mobile teams from other sectors. This can include health (e.g. reproductive health, nutrition, water, hygiene and sanitation (WASH), and protection (e.g. child protection)).

To implement joint deployments, the following is required:

- The deployment of a full GBV team mobile team to ensure that the functions of response and outreach are being met (i.e. joint deployments should not consist of only one GBV staff member who is part of another sector's mobile team).
- A private space from which GBV case management can be provided that is located where the other sectors' mobile team provides services or conducts activities.
- The GBV staff are integrated into the other mobile team's community outreach, services and activities such that they are not known in the community as "GBV staff." This can help survivors access case management in a non-identifying manner.
- The time required to build trust and meet the needs of GBV survivors is understood by all actors and reflected in the deployment schedule (time at site, time between site visits).
- All mobile team staff are trained on GBV guiding principles, how to receive GBV disclosures and make referrals to GBV caseworkers in a safe and confidential manner.
- The GBV staff are trained on the other sector's basic interventions so that they can engage in community outreach with the other sector.
- Other sectors are trained in sector responsibilities outlined in the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action <https://gbvguidelines.org/en/home/> for preventing and responding to GBV in humanitarian settings.

3. Hotlines

Whether establishing a hotline as part of a mobile response or on its own, the following will need to be in place (more detailed guidance on establishing and implementing a telephone hotline can be found in Annex 5).

Space. A private room in a field office from which case management and crisis support can be provided remotely. Space for resource folders, phone lines/mobile service, posters on walls (referral pathways, safety planning questions, key messages, etc.).

Conference calling function. This is required to accommodate translation (if needed) and/or for connecting with referral partners.

Service protocol(s). Protocols need to be established for safe and ethical operation of the hotline. At a minimum, this should include policies and guidance on: ensuring confidentiality; how the calls are answered by the staff (e.g. introductory statements, key messages that should be shared from the beginning of the call on confidentiality, consent and safety; how the calls should be closed (e.g. what information and key messages should be shared when a call is ending); how to respond to survivors in immediate danger; how to respond to callers with suicidal ideation; how to handle prank callers, abuse and harassment on the hotline; and when staff should engage a supervisor for support.

Resources for caseworkers to reference. The following resources are important for hotline staff to have accessible while answering calls so they can easily reference them when needed.

A resource guide. A resource guide that contains information relevant to the context, including the most common types of GBV, information likely to be requested by callers, frequently asked questions and information about other resources. These guides should be translated and customized to the local context, and updated over time according to the calls the hotline receives. Some examples of reference materials to include in a resource guide are:

- safety planning
- types of GBV, common reactions a survivor may have to different types of GBV, the dynamics of IPV
- child survivor reference document
- health factsheets (addressing emergency contraception, PEP, explanation of mandatory reporting requirements)
- basic legal statutes and processes (having a lawyer as a referral pathway partner on a hotline is ideal)
- suicide prevention plan
- how to support a survivor: for friends and families

Many of the topics above are covered in the *Interagency GBV Case Management Guidelines*. It may be helpful to also have some printed copies on hand for quick reference in the local language.

Referral pathways. It is important that hotline staff have a document accessible that outlines existing referral pathways including all service providers identified in locations that are covered by hotline services. Key details include the name of organization and focal point, phone number, email address, physical address, services offered, hours of service, and cost of services. The referral list should be updated regularly, at least every six months. In emergency settings, this should be updated every one to three months as services change more rapidly.

Roster of translators. In locations where several languages are spoken, ensure that a roster of translators is available, including their contact information.

IEC materials and approaches. Develop specific IEC materials for the hotline. Thought should be given about how to brand the hotline such that it is non-stigmatizing and promotes help-seeking. Promote the hotline to all referral pathway partners (include disability associations, LGBTI organizations, and minority service providers) and ensure that they and community focal points are trained on how to speak about the hotline to survivors and the community.

3.1.3 Considerations for other vulnerable populations¹⁴

The following are additional considerations important for establishing entry points for mobile and remote GBV services for sub-populations vulnerable to GBV.

Child Survivors

Child survivors under the age of 12 can receive services in safe spaces for women and girls, since all children should have access to safe spaces. It is important to have caseworkers who are trained in Caring for Child Survivors to provide support. GBV mobile services that are tailored to children can also be established through the child protection sector.

Male survivors of sexual violence

For mobile service delivery, case management for male survivors of sexual violence can be established via:

1. **Health services.** GBV services in health clinics should always be accessible to men, and staff should be trained on the clinical care of sexual assault for working with all survivors;
2. **Identifying a partner from another sector working with men.** Mobile teams can work with a partner who is already implementing services or activities with men, and deploy a caseworker on a rotating basis to the partner organization;
3. **Ad-hoc private spaces identified in the community.** Given that in most humanitarian contexts men and boys' movement is not as restricted as women's and girls', and they have more access to community spaces, identifying a private space to speak in the community is a feasible option. Mobile GBV outreach workers can be trained in GBV case management so that if disclosure happens during outreach, they can meet with male survivors on the spot or at a later point in private spaces identified in the community.
4. **Hotlines.** As mentioned, hotlines have the advantage of being anonymous, and thus can facilitate access to services for men who may be less inclined to seek services in person due to stigma. Furthermore, in most humanitarian contexts, men are more likely to have access to phones and thus able to seek confidential support through a hotline.

Specific information materials about services available for male survivors of sexual violence and how to access them should be created and distributed at mobile sites. They should include messages aimed at destigmatizing sexual violence against men.

Survivors with disabilities

Organizations should work to ensure that all case management entry points, whether they are safe spaces or private rooms co-located within other services/activities, are accessible to survivors with disabilities. This may include providing transportation to and from the entry point. Community focal points and community outreach workers/mobilizers can target outreach to people with disabilities, find and work with disability associations, and ensure hotlines are accessible to people with disabilities.

¹⁴ The approach to providing case management services for each of the populations discussed in this section is outlined in the Interagency GBV Case Management Guidelines. It is important that caseworkers are fully trained to provide case management to these populations, using the resources provided in those guidelines.

Survivors who identify as LGBTI

Other service providers can provide a means to access LGBTI populations through outreach networks that inform them about GBV case management services. Identifying non-traditional service providers for this population and partnering to support their case management needs can lead to greater access to services.

One way to support the LGBTI population is through hotlines. LGBTI women and girls can also access the safe space. Male survivors who identify as LGBTI can access the same case management services as all male survivors of sexual violence.

From the field:

In Myanmar, the IRC's mobile caseworkers held workshops with the local LGBTI organization Lighted Lamp. Lighted Lamp provided information on skills for working with LGBTI populations. The IRC provided an overview of GBV case management. Both programs agreed to cross-refer through the IRC hotline. The IRC supports Lighted Lamp with the costs of providing LGBTI survivors with case management, and provides remote case management support to a Lighted Lamp GBV focal point.

3.2 Staffing Mobile and Remote GBV Service Delivery

Strong GBV technical skills are required for service delivery, supervision and problem-solving within mobile and remote responses, especially in places that are insecure and/or hard-to-reach. Staff need to understand the circumstances of service locations and develop strategies to deliver, maintain and adjust services according to the context of each site and often across multiple sites as part of a rotation schedule. Establishing and preserving locations for services and confidential means to access case management, with appropriate links to other services, requires staff who are highly trained to monitor and troubleshoot challenges in often unstable situations.

When feasible, mobile and remote GBV service delivery staff should have prior experience in providing GBV services in static safe spaces. All caseworkers on mobile and remote teams should have thorough training on case management based on the Interagency GBV Case Management Guidelines, and training on providing care to child survivors as well as on GBV emergency response and preparedness.

The section below outlines the staff positions required to implement and support mobile and remote GBV services. Additional staff that may be needed based on the design of the mobile response is also outlined. In addition to the guidance below, an analysis should always be conducted with existing local staff to determine the profiles of staff needed in order to provide services in the safest manner.

3.2.1 Staffing for GBV Mobile Teams

Staff position	Required profile/ background	Roles and responsibilities of staff members	Guidance on quantity
<i>Staff required to implement mobile response</i>			
<p>Technical Supervisor/s</p>	<p>Skills to troubleshoot complex case management scenarios and visualize the most appropriate service delivery model for each mobile site.</p>	<p>These staff located in office from which the mobile teams deploy.</p> <p>During start-up of response:</p> <ul style="list-style-type: none"> • Deploy initially with mobile team to new sites, then visit mobile sites on a roving basis for on-site support when appropriate. • Choose and monitor the conditions of case management locations (confidentiality of spaces, ensuring links to and co-location with other services). • Develop emergency GBV protocols and referral pathways with other service providers and community institutions. <p>On-going supervision:</p> <ul style="list-style-type: none"> • Oversee deployments to all mobile sites from an office/sub-office. • Monitor the quality of case management. • Oversee psychosocial support activities. • Provide in-person and remote supervision. • Oversee training and capacity building plans for partners and staff. 	<p>For adequate management of mobile and remote service delivery, an adequate number of supervisors according to number of caseworkers and hotline workers (if part of the mobile response) is required.</p>

Staff position	Required profile/ background	Roles and responsibilities of staff members	Guidance on quantity
		<p>On-going coordination:</p> <ul style="list-style-type: none"> Over time, strengthen GBV coordination, referrals and capacity to provide timely care to GBV survivors. Share information regularly with local coordination mechanisms, including GBV sub-cluster/working group. 	
<p>Caseworkers</p> <p>Note: Do not use the term GBV or SGBV in the staff titles.</p>	<p>Previous training and experience providing GBV case management services.</p> <p>Always recruit women to be caseworkers. Often women, female-identifying, and even male survivors prefer to speak to women (since perpetrators are usually male). Unless otherwise requested by a female survivor, female caseworkers should work with female survivors.</p> <p>Assess whether in the context it may be relevant to have a have a male staff person that is trained in case management and community outreach working across mobile sites. However, do not assume that male survivors want to have a male caseworker.</p>	<ul style="list-style-type: none"> Conduct GBV case management. Facilitate safe and confidential referrals to other service providers. Conduct regular service mappings to update referral pathways and coordinate services. Facilitate group-based PSS activities and information sessions for women and girls in safe spaces. Talk to non-survivors on a one-to-one basis to “normalize” individual engagement. Provide training to community focal points or partners 	<p>Determine number based on number of entry points, coverage area and population, time required in sites, and languages required.</p>
<p>Outreach staff/ community mobilizers)</p>	<p>Can demonstrate survivor-centered attitudes.</p> <p>These staff will require training on guiding principles, handling GBV disclosures and making referrals to caseworkers, and on outreach strategies in general, but in particular to reach vulnerable populations.</p>	<p>As part of the initial assessment process:</p> <ul style="list-style-type: none"> Conduct focus group discussions as part of the GBV assessment. Work with other staff to identify locations in communities for use as safe spaces with women and girls. 	<p>Determine number based on number of entry points, coverage area and population, time required in sites, and languages required.</p>

Staff position	Required profile/ background	Roles and responsibilities of staff members	Guidance on quantity
	<p>As mentioned above, assess whether in the context it may be relevant to have a have a male staff person that is trained in case management and community outreach working across mobile sites.</p>	<ul style="list-style-type: none"> • Map local services to inform the development of a referral pathway and service directory. • Facilitate or co-facilitate GBV risk assessments, community safety planning, and advocacy with service providers and community leaders, to get their support to reduce risks in the context. <p>On-going</p> <ul style="list-style-type: none"> • Conduct community outreach to disseminate information on available services in the surrounding community. • Build key relationships with community groups and institutions and other service providers. • Provide trainings for community leaders and other key gatekeepers to increase their involvement and engagement in GBV services. • Identify and train community focal points on GBV basic concepts, referrals and GBV guiding principles. • Provide other training as needed. 	
<p>Drivers/ transport operators</p>	<p>Must be trained on PSEA and confidentiality principles, security policies.</p>	<ul style="list-style-type: none"> • Act as designated drivers for mobile team. • Support with supplies, such as dignity kits. • Support set up of tents or other structures if needed. 	<p>Based on the number of vehicles required for the mobile response, including to transport staff and supplies (often more than one will be needed per mobile site).</p>

Staff position	Required profile/ background	Roles and responsibilities of staff members	Guidance on quantity
<i>Other staff that may be needed based on the design of mobile services</i>			
Sexual and reproductive health staff	Should be female if possible and appropriate in the context.	<ul style="list-style-type: none"> • Immediately deploy to provide services to rape survivors within 72 hours. • Ensure access to or directly provide CCSAS package. • Train health actors on safe identification of survivors and referral procedures. • Conduct reproductive health sessions with women and girls in safe spaces. • Assess existing health facilities and staff capacity to provide clinical care for GBV survivors. • Facilitate information sessions and outreach dissemination plan for access to services. • Work with health community focal points on GBV knowledge, guiding principles and referrals. 	<p>Can be included in a more comprehensive mobile response, if there are no quality health services available in mobile sites. This is not a requirement and may not be feasible based on laws and policies as well as the context.</p> <p>This position could potentially have a roving role between mobile sites.</p>
Hotline staff This applies to using a hotline both as part of a mobile response and on its own.	(See caseworker profile/ background above)	<ul style="list-style-type: none"> • Provide crisis intervention support and case management via the hotline. • Refer cases according to phone-based referral pathways. • Improve referral pathway communication. • If part of a mobile response, provide support to survivors from mobile sites when staff are not on-site. 	<p>The number of hotline workers will depend on the hours of operation deemed appropriate for the program. For example, if a hotline will function 24 hours a day with 8-hour shifts, 3 hotline staff will be required for daily operation.</p> <p>It is recommended to have dedicated hotline staff rather than rely on task-shifting among other caseworkers.</p>

In addition, a percentage of time of the operational staff located in the office from which the team deploys is also required. These staff and their suggested roles and responsibilities for a mobile/remote response are outlined below:

Staff position	Roles and responsibilities for mobile/remote response
Security Manager	<ul style="list-style-type: none"> • Conduct Security Risk Assessment for Emergency Response for each mobile site. • Conduct ongoing security plan monitoring for “go/no-go” security decisions. • Liaise with other organizations for security information. • Document security policies and contingency plans; train staff. • Visit mobile sites for on-site support when appropriate.
Field Manager	<ul style="list-style-type: none"> • Negotiate with authorities to facilitate safe access to mobile sites. • Negotiate service delivery space for mobile teams. • Work on strategy for gaining and maintaining acceptance with local communities, including beneficiaries, parties to conflict, local organizations, and other relevant stakeholders. • Coordinate activities and advocacy with the Technical Supervisor. • Makes security decisions based on reports from security manager. • Visit mobile sites for on-site support when appropriate.
Procurement, Finance, and HR; consider IT	<ul style="list-style-type: none"> • Oversee daily operations required for ongoing support. • Procure program supplies, such as dignity kits. • Contract suppliers. • Support hiring processes and contracts. • Visit mobile sites for on-site support when appropriate.

There may be other staff identified as necessary through the assessment, including:

- Staff to support particularly vulnerable groups in order to enhance meaningful access to services.
- Staff in mobile sites to facilitate activities, for example, teachers if women and girls request literacy activities, or handicraft designers, etc.
- Community health workers.
- Child care workers.
- Guards and cleaners for service locations.
- Transport operators for referrals or to support access to services and safe spaces (e.g. for participants with disabilities or those who live far away).

3.3 Working with Community Focal Points to Implement Mobile and Remote GBV Service Delivery

As previously mentioned, in addition to mobile team staff, community focal points are an essential part of implementing mobile service delivery. The following sections describe the roles and responsibilities of focal points and provides guidance on working with them to help make their work in the community safe and effective.

3.3.1 Roles and responsibilities of community focal points

Community focal points can provide outreach to alert the community to the availability of services and group activities that are part of the mobile response. If the mobile team has established temporary safe spaces as case management entry points, focal points can also support the implementation of group psychosocial activities for women and girls. Community focal points are also key because they can support the mobile team to better understand the cultural context and nuanced needs of survivors and women and girls in general.

Over the course of their engagement with the program, if deemed appropriate and safe in the context, focal points can be trained on how to respond to disclosures of GBV in a safe, nonjudgmental and emphatic manner and to make safe and confidential referrals to the mobile team's case management services. If they receive a disclosure, focal points can provide information to the survivor about when the mobile team will next be on-site and facilitate the survivor's access to a caseworker in person when they are on-site. In addition, if a hotline is being implemented, focal points (who should be provided with mobile phones and phone credit) can facilitate immediate access to a hotline caseworker when the mobile team is not on site.

Below is guidance on the profile of focal points, their roles and responsibilities (including what they should not do), and the number of focal points needed for GBV mobile service delivery.

Required profile/ Background	Roles and responsibilities	Guidance on quantity
<p>To the extent possible members of local women's groups or organizations.</p> <p>Represent all ethnic groups at the site, but speak the operational language of program.</p> <p>Demonstrate appropriate supportive attitudes towards survivors, which can be assessed in writing in the local language, or verbally depending on literacy levels.¹⁵</p> <p>The ability to keep the program phone provided to them safe and confidential.</p> <p>Must sign a code of conduct about GBV guiding principles, after being trained on them.</p>	<ul style="list-style-type: none"> • Conduct outreach in the community about services. • Assist mobile team with psychosocial support activities, including coordinating and implementing group activities in temporary safe spaces that are non-GBV focused when the mobile team is not on-site (such as recreational activities). • Support the mobile team in identifying vulnerable sub-populations (such as ethnic minorities, people who identify as LGBTI, people with disabilities) and facilitating their access to group activities. Communicate to the mobile team any barriers such groups have to services. • Communicate to the community any changes in the mobile team's schedule or to regular group activities. • If deemed safe and appropriate, respond to disclosures of GBV and make referrals to the mobile team's case management services. 	<p>At least two female focal points per mobile site.</p>

¹⁵ Find the survivor-centered attitude scale assessment at <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementGuidelines>

Required profile/ Background	Roles and responsibilities	Guidance on quantity
	<ul style="list-style-type: none"> • Maintain connection with mobile teams via mobile phones for the purposes of ongoing communication, supervision, and if a hotline is part of the mobile response, to facilitate survivors' access to the hotline. • Upon a survivor's request, accompany her to services. <p>Community focal points should not:</p> <ul style="list-style-type: none"> • Carry out case management on their own (unless this is part of an agreed upon handover plan and they have been trained by the mobile team). • Actively identify survivors in the community. • Intervene in or investigate survivors' cases. • Mediate conflicts or speak with perpetrators. • Go to the homes of survivors, unless they are conducting outreach and these homes happen to be part of the outreach catchment area. • Allow survivors to stay in their homes. • Speak with anyone else about a survivor's case, unless requested by the survivor. 	

3.3.2 Ensuring focal point work is safe and effective

When working with community focal points, there are several practices that must be followed in order to ensure that their work is safe and effective.

Provide mobile phones. Focal points should be given phones, battery packs/means to charge the phones, and phone cards for work use. They should not use personal phones or family phones for their work with the program.

Create job descriptions and Memorandum of Understanding (MoU) for the role of the focal point. Job descriptions should outline the roles and responsibilities (outlined above) of the focal point and any other roles deemed safe and appropriate according to the context. After receiving basic training in the GBV guiding principles, each focal point should sign a MoU that covers the following:

- Understanding and agreement of what they should not do as a focal point (outline above).
- Principles and expectations about confidentiality and safety.
- The terms of mobile phone use: that they agree to use the program phone only for program purposes, and that they let anyone who asks to use it to call the hotline do so.
- Safety and communication protocols.
- The training and capacity building in which the focal point will be required to participate to continue in their role.

Provide training and supervision. Before focal points begin in their role, they should be trained on the following (recommended materials to support such training can be found in the accompanying links):

- GBV guiding principles and GBV basic concepts <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementTrainingMaterials>
- Basic responses for responding to a disclosure of GBV (e.g. statements that communicate validation, non-judgment and empathy).
- Does and don'ts and what to say Module 9¹⁶ in https://gbvguidelines.org/wp/wp-content/uploads/2018/03/GBV_PocketGuide021718.pdf
- Making safe and confidential referrals to the mobile team
- Community outreach strategies
- Concepts of power and vulnerability, and how to facilitate meaningful access to services for vulnerable populations (e.g. disability inclusion) <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementTrainingMaterials> and http://www.globalprotectioncluster.org/_assets/files/aors/protection_mainstreaming/IRC_Protection_Mainstreaming_Training%20Facilitators_Guide_March_2013_EN.pdf p30-38
- Carrying out safety audits <https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/>
- General safety planning (i.e. not specific to individual experiences of GBV. See Part 5 for more guidance).

3.3.3 Transitioning activities to focal points

As mentioned in Part 2, organizations should be planning for sustainability from the outset of programming. Gradual transition of the implementation of certain aspects of a mobile response to the focal points, particularly if they are part of local organizations, can contribute to sustainability when the mobile response ends. This can include:

- Providing them with the resources and skills to organize and lead group activities in temporary safe spaces for women and girls, including when the mobile team is not on-site.
- Increasing the capacity of focal points to take on case management services (or shifting particular tasks within the case management process to focal points). If considering this option, it is important to have clear capacity building plans in place and a process for assessing focal points' skill levels. In addition to staffing and skill level, a full transition of service provision would require certain criteria be met with respect to the resources and infrastructure needed to support such services. This would need to be part of a gradual handover process during which on-site or remote supervision and technical support are provided to the focal points and implementing organization.

3.4 Security Requirements for Mobile and Remote GBV Service Delivery

In order to ensure staff and beneficiary safety when providing mobile and remote GBV services, the following security policies, procedures and equipment must be in place before implementing a mobile response.

- Updated and accurate organizational security policies, plans and procedures are in place. Staff and community partners have been trained on them.
- A "Right to Withdraw" policy that provides national, international and partner staff the permission and support to make decisions based on their own safety, without cause for retaliatory practices. This policy should be communicated to all relevant actors.

16 <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementTrainingMaterials>

- Site-specific security management plan/protocol in place, including communication protocols, travel guidelines, assembly points, hibernation plans (e.g. safe places for the team to hibernate on-site, safe places for relocation), evacuation plans (e.g. places where staff can stay mid-route if access is blocked for return) and evacuation routes.
- Daily security assessments, morning briefings and evening debriefs, and a decision-making process for a “go/no-go” decision for deployments.
- Authorization and documentation for travel from authorities in advance of any movement. This should include, to the extent possible, assurances that staff and communities will not be targeted by any armed actors.
- Protocols for driving in a convoy in insecure locations.
- Mechanisms to track the movement of the mobile team.
- Modes of communication and alternatives established with each team (mobile phone, radios, or satellite phone if required). Site-specific emergency cards with emergency security focal point contact information shared with all staff, and a communication tree with clear instructions on how to use it. A security focal point is identified for each vehicle.
- Communication equipment (phones, VHF radio, satellite phones, etc.) provided to all teams and tested regularly. Staff are trained on how to use them.
- Hibernation kits, including food, water/purification tablets, money, sleeping supplies, first aid kits in vehicles, staff grab bags with important items, weather supplies (chains, mud contingencies).

3.5 Financial Resources Required for Mobile and Remote GBV Service Delivery

The following budget categories are needed to implement a mobile response, as well as a remote response if that is part of the intervention. These categories should be considered during the process of designing the mobile/remote response. Budgets can then be adjusted accordingly once implementation begins.

- **Personnel.** This will vary according to the size and reach of the program, but should include the staff listed in Part 3: technical program staff (including caseworkers, supervisors, community outreach staff and potentially hotline staff), drivers, security staff, and operations. If working with community focal points, plan for providing incentives.
- **Service delivery infrastructure/safe spaces.** This requires flexible donor agreements so resources can be utilized according to the options for space available at mobile sites (e.g. programs may need to spend on rent, building supplies, or infrastructure improvements to enhance safety, etc.).
- **Transportation for the mobile team(s).** Mobile teams are required to have their own means of transportation; vehicles should not be cost-shared across sectors. This is to ensure that teams have the independence required to manage their time according to the case management needs of survivors.

Carefully consider the transportation needs in terms of vehicle size, number of vehicles required, and the type of vehicle required given the context. For example, a typical NGO vehicle has only four seats, including the driver's; most likely more than one vehicle would be needed for an adequate number of GBV mobile staff. While a van has more capacity, it is less suited for bad road conditions.

- **Case management supplies.** This includes: funds for referrals (if the service to which survivors are referred has a fee), transportation, accommodation, and other basic needs survivors may have; supplies for working with child survivors and adolescent girls; potential budget to increase accessibility for and inclusion of survivors with specific needs (e.g. survivors with disabilities).
- **Dignity kits and risk-reduction supplies.** This includes sanitary supplies, appropriate clothes, torches, locks, cash, etc.
- **Group activities.** Plan for a weekly activity budget for each mobile site if possible, covering supplies.

- **Technology.** Include costs of procuring and using mobile phones, smart phones, and tablets according to the design of the response as follows:
 - » If working with community focal points, mobile phones and credit for at least two community focal points per site will be necessary.
 - » If mobile applications are used to support the response (such as Primero - described in Part 4), staff will need tablets, and depending on the application, there may be a cost associated with translating the application into the local language.
 - » If a hotline will be used as either part of the mobile response or on its own, a budget for the hardware and ongoing communication costs for the hotline will be needed, including estimated calls/monthly communication fees to ensure there is no interruption in service.
 - » If technology will be used to support remote supervision, a need to budget for the equipment, application and translation of application will be required. (More information on remote supervision and the use of technology can be found in Part 5.)
- **Training.** Venue, accommodation, transportation, and per diem, etc.
- **Supplies for community focal points.** In-kind and cash support (bicycles, t-shirts, bags).
- **Coordination funds.** Meeting supplies and transportation fees should be included for monthly coordination meetings. If service providers can travel to a central location for meeting or training, include their costs/fees.
- **Outreach funds.** Including for information, education and communication materials and translation.
- **Security.** Costs associated with routine assessment of security and maintaining the security of staff and infrastructure (e.g. hibernation kits, IDs, visibility materials where appropriate).



Part 4: Providing Case Management and Psychosocial Support in Mobile and Remote Service Delivery

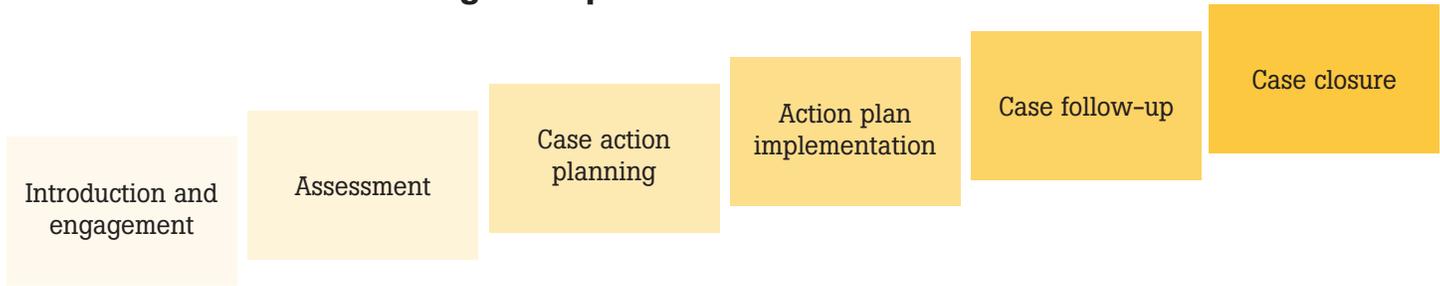
4.1 Crisis Case Management

As previously discussed, in Part 3 care and thought are needed to design safe and effective means of entry for GBV case management in mobile service delivery. While the process for GBV case management has been thoroughly outlined in the Interagency GBV Case Management Guidelines, mobile contexts will likely require an adaptation of the standardized GBV case management process due to the limited time that staff have at mobile sites. Staff must be prepared to provide services in circumstances where they may only see a survivor once, or where they have little time to meet.

Caseworkers that are part of a GBV mobile response should still carry out an assessment of the survivor's situation and needs, be prepared to respond to the primary concerns of the survivor, prioritizing (with the survivor's consent) focus on addressing any immediate safety and health needs.

The following diagram and table highlight the potential difference between the standard case management process and an adapted one for emergencies, including mobile and remote interventions.

The standard GBV case management process



Crisis case management



Standard GBV case management: steps and tasks	Crisis case management adaptation <i>(Times outlined below are approximate.)</i>
<p>Step 1: Introduction and engagement</p> <ul style="list-style-type: none"> <input type="checkbox"/> Greet and comfort. <input type="checkbox"/> Introduce yourself and your role. <input type="checkbox"/> Discuss all aspects of informed consent (confidentiality, mandatory reporting). <input type="checkbox"/> Answer questions. <input type="checkbox"/> Get permission to continue. 	<p>Step 1: Abbreviated introduction and engagement (5 minutes)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Greet and comfort. <input type="checkbox"/> Introduce yourself in one sentence: I am ____ and I work with ____ to support people who have experienced harm/violence. <input type="checkbox"/> We believe strongly in helping you keep your story private. You and I will decide together whether and who to tell about the violence you experienced, for your safety.¹⁵ <input type="checkbox"/> Can you tell me your most important concern today?
<p>Step 2 Assessment</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine whether other responders are involved. <input type="checkbox"/> Understand who the survivor is. <input type="checkbox"/> Invite the survivor to tell you what happened. <input type="checkbox"/> Listen well. <input type="checkbox"/> Respond with validation, compassion & information <input type="checkbox"/> Identify the survivor's concerns and key needs. <input type="checkbox"/> Document relevant information on a form or in case notes with a safe case documentation and storage system. 	<p>Step 2 Assessment (15-20 minutes)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Listen (dedicate time to make ensure the survivor has been heard). <input type="checkbox"/> Assess safety concerns, accessible social networks, state of mind, and needs. Listen as much as possible and do not cut off the survivor's story. <input type="checkbox"/> Respond with validation, compassion & information. <input type="checkbox"/> DO NOT document information on a form or in case notes if there is no possibility of follow-up, and for safety reasons.

17 If there are limitations to confidentiality – placed by the agency or the context – these MUST be explained before proceeding.

Standard GBV case management: steps and tasks	Crisis case management adaptation (Times outlined below are approximate.)
<p>Step 3: Case action planning</p> <ul style="list-style-type: none"> <input type="checkbox"/> Summarize your understanding of the survivors needs. <input type="checkbox"/> Give information about what services and supports are available and what they can expect from them. <input type="checkbox"/> Plan with the survivor how to meet needs, set personal goals and make decisions about what will happen next. <input type="checkbox"/> Develop and document a case action plan. <input type="checkbox"/> Discuss concerns with your supervisor. <input type="checkbox"/> Discuss options for follow-up. 	<p>Step 3: Safety planning and overview of immediate health and security needs and the services available (15-20 minutes)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Safety plan. <input type="checkbox"/> Give information about what services and supports are available.
<p>Step 4 Implement case action plan</p> <ul style="list-style-type: none"> <input type="checkbox"/> Make referrals. <input type="checkbox"/> Advocate for and support survivors to access services. <input type="checkbox"/> Lead case coordination. <input type="checkbox"/> Provide direct services if relevant. 	<p>Implementation (15-20 minutes)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Inform the survivor about referral options for her immediate concerns. <input type="checkbox"/> Make referrals with consent. <input type="checkbox"/> Provide resources (material support, resources, hotline number, contacts of providers in destination location as applicable, encourage her to stay in touch if at all possible). <input type="checkbox"/> Share key messages: the survivor is not alone, not at fault, and affirm/validate survivor's feelings. For the last few minutes, stabilize the survivor so she is not leaving your session in a more traumatized state. (Plan for the rest of the day, encourage the survivor to be in the present.)
<p>Step 5 Follow-up</p> <ul style="list-style-type: none"> <input type="checkbox"/> Meet with and contact the survivor as agreed. <input type="checkbox"/> Reassess safety. <input type="checkbox"/> Review and revise the case action plan. <input type="checkbox"/> Implement the revised plan. 	<p>X</p>
<p>Case closure</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine if/when the case should be closed. <input type="checkbox"/> Document the case closure. <input type="checkbox"/> If possible, administer the client feedback survey. <input type="checkbox"/> Safely store the closed case file (move the closed file to a new cabinet). 	<p>X</p>

4.2 Group Psychosocial Support

4.2.1 Recreational and skill-building activities in temporary safe spaces

If your organization establishes a temporary safe space for women and girls as part of its mobile response, it should be used for ongoing recreational or skill-building activities. These can either be organized and implemented by community focal points, or run by women and girls themselves. Doing so can help empower women and girls in the community, allow the mobile team to focus on the provision of case management while on site, and allow for the continuity of such activities even when the mobile team is not present. These should be tailored for women and girls separately. Some examples of activities that can be implemented are:

- Recreational activities, such as sports, dancing, drama, arts and crafts, or story-telling
- Skill- and knowledge-building activities, including literacy and numeracy, health education, and sewing classes
- Unstructured times, tea times
- Activities (and relevant supplies) for children so that women can bring their children with them when they attend group activities

Women and girls can also be encouraged to create 'group covenants' to support and respect each other, and keep the space only for women and girls.

4.2.2 Group information and psychosocial support sessions

Due to the limited time mobile teams have to provide individualized GBV case management services, organizations may want to think about shifting some of the psychosocial education that usually happens during one-to-one case management with survivors to group sessions. Such group sessions must be carried out by the mobile team caseworkers. For all of the below, it is important that the facilitators of group activities establish ground rules to reduce the likelihood of individual disclosures of GBV to the group. Facilitators should also have a protocol for managing such disclosures in a safe and compassionate manner. Examples include:

- **Safety mapping and risk reduction.** The community mapping tool used during the assessment process can be continually referenced during group activities to discuss safety risks in the community with women and girls. Women and girls can be introduced to safety audit observation lists and learn what can be expected in terms of service provision and service provider responsibilities according to IASC GBV guidelines. Case study examples of safety strategies (e.g. firewood patrols, joint school walks, the importance of participation of women and girls in advocating for the location of water points, the use of lighting for safety, locks on latrines and showers, etc.) can be introduced. Solicit ideas from participants about how to reduce risk in their contexts, what they can do to organize and address those risks, who in their community has the ability to address the circumstances that create these risks, and who the group can tap to do advocacy on safety for women and girls.
- **General crisis safety planning.** Given that mobile responses are implemented with women and girls who have already and may still be experiencing conflict or natural disaster and the crisis of displacement, it can be helpful to carry out safety planning in group sessions to identify people, places and resources that would support their and their families' safety should they be in harm's way. Questions to prompt thinking include: If you needed to leave your home quickly, for example if there was a natural disaster or an intruder in your home, how would you exit the home? Where would you go, what would you need to take with you, how would you get there? Who would you want to be in contact with? Are there others whose safety you would want to ensure as well?
- **Non-personal IPV safety planning.** Using fictional case studies of women experiencing intimate partner violence, the concept of safety planning for those who experience ongoing IPV can be introduced in group sessions. Usually caseworkers do safety planning with survivors to help them anticipate and prepare for potential threats or incidents of violence by identifying patterns in the perpetrator's behavior, circumstances that may escalate the violence, and supporting the survivor to think about people, places and resources that can support their (and potentially their

children's) safety. Working through safety planning with a fictional case study in groups can teach women a skill that they may be able to use on their own should they need to. See the Interagency GBV Case Management Guidelines for further information about safety planning for IPV.

- **Basic principles of emotional support.** In group sessions, basic principles of providing emotional support to each other can be introduced and practiced.
- **Positive coping skills.** Coping skills are the ability to identify resources in life (people, things, activities) that help with happiness, relaxation, and comfort, that one can draw on when one feels bad. Examples include developing a plan to participate in positive activities that bring enjoyment, and engaging people, pursuing interests and cultivating strengths that enable one to feel healthy and supported. More guidance on how to do this in group settings can be found in Annex 6.

4.3 Safe and Confidential Data and Information Management

In order to protect the identity and safety of survivors, all case management data is subject to data protection safeguards as outlined in the *Interagency GBV Case Management Guidelines*.¹⁸

For mobile GBV responses, because the use of paper files with GBV case management data introduces opportunities for theft and loss, which erodes staff ability to ensure confidentiality, mobile teams should not travel with paper GBV case management. No hard copies of GBV consent or intake forms should be transported, and mobile teams should not take notes. In situations of high insecurity, consent should be obtained verbally for case management, referrals and to record data using GBVIMS. GBV caseworkers should complete intake forms upon returning to the office, in a location where data security can be maintained. All hard copies should be stored in a lockable filing cabinet in the office, accessible only to responsible individuals designated by the case manager. Rooms containing paper and electronic information should be locked securely when the staff leave the room. If the office location becomes insecure, paper files should be destroyed. Any soft copies should be password protected.

Primer/ GBVIMS+ Mobile Application

New technologies have emerged to support the safe and confidential collection of data during GBV mobile service delivery, without the burden of transfer or safe storage of paper forms. Primer, the Protection Related Information Management System, and the module within it called GBVIMS+, are the latest database iterations of the GBVIMS. GBVIMS+ is a web application that was developed to enable GBV humanitarian actors to safely collect, store, manage and share data for case management and incident monitoring. It also includes a mobile application to allow frontline staff to safely track GBV incidents and individual survivors' progress as they receive case management services.

More specifically, a mobile application of Primer/ GBVIMS+ has been developed for staff to use on a tablet. With the mobile application, staff can travel to the mobile sites with the tablets so that they can document cases and submit files through a secure server while deployed. This enables staff to quickly enter case management data at the mobile site, so they do not have to rely on their memory. In addition, the

Data management for hotlines

Because of the crisis nature of hotlines, organizations will need to think about whether it is possible to collect information from callers, and furthermore whether it is necessary (i.e. what purpose will it serve).

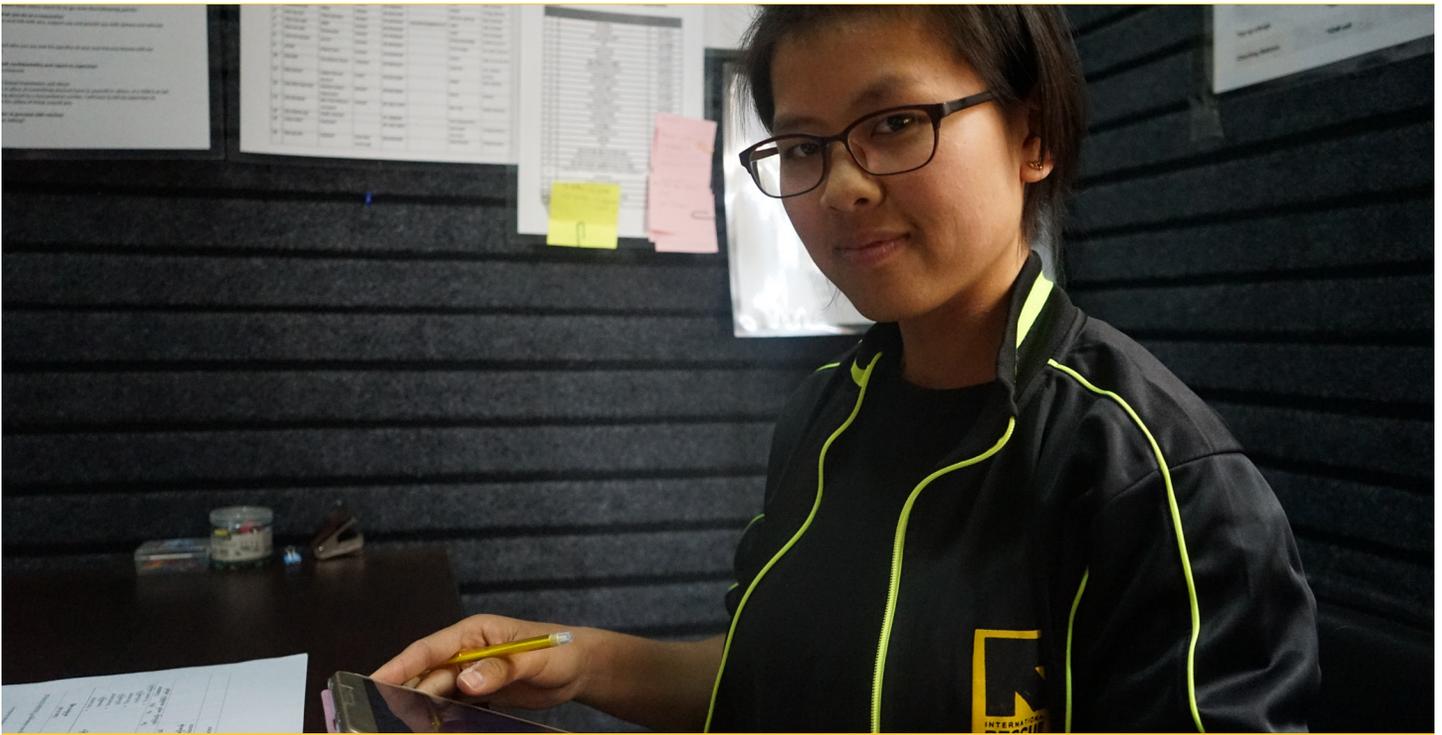
If information is collected from callers, the following should be considered:

- What information will be collected.
- How it will be stored so safety and confidentiality can be guaranteed.
- How the data will be used. Preparing for analysis early encourages good use of data.
- How data collection will be discussed with callers and consent obtained.
- Clear protocols with staff that make clear that the collection of data is not critical and should not be prioritized over supporting the survivor.

18 pg 33-35. <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementGuidelines>

mobile application of Primero/GBVIMS+ has been designed to ensure that case management data cannot be retrieved by third parties if the tablet is stolen. Because beneficiaries may not be used to using tablets, it is recommended that staff document case data in Primero after the case management interaction.

For more information about Primero/GBVIMS+ and what is needed to implement it, visit www.primero.org. For more information on the GBVIMS, visit www.gbvims.com.



Part 5: Supervision of Mobile and Remote Service Delivery

As outlined in the staffing section, supervisors need to be highly skilled to monitor and troubleshoot mobile and remote service delivery.

5.1 Monitoring service locations

Supervisors should visit each site at the start of deployment. Supervisors should monitor locations and conditions of service provision, and ensure there are appropriate confidential means for women, girls and others in need to access case management (e.g. safe spaces for activities with private case management space). When the supervisor is not on-site, staff can send photos of activity and case management rooms, and discuss plans to enhance confidentiality and safety as needed. Through monthly reports, staff should describe in detail any issues with service locations (security challenges, changes in community agreements, other service providers using the space, advocacy required, infrastructure support needs proposed and budget required), ways that caseworkers normalize one-on-one discussions with beneficiaries, as well as activities being provided at each site.

5.2 In-person staff supervision

If mobile teams can come back to the office on a daily basis, at least one day a week should be dedicated to supervision activities between supervisors and mobile team members. Reference the supervision guidance in the *Interagency GBV Case Management Guidelines*.¹⁹

19 Part V, chapter 2 pg. 115-164 <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementGuidelines>

In addition, **in-person supervision of hotlines** requires that supervisors:

- Be available for emergency back-up.
- Conduct debrief calls with hotline staff.
- Establish a regular supervision time every week for staff and supervisors to check in.
- Conduct periodic training, “ghost calls” and/or direct observation of calls (sitting next to staff).
- Provide emotional support to staff, given the potentially upsetting nature of calls. This can take the form of shorter shifts on the hotline, regular supervisory sessions, and temporary task-shifting, and/or individual psychosocial support to prevent burnout.

5.3 Remote staff supervision

Mobile service delivery teams may often be separated from supervisors due to safety and access issues. In places of conflict, only staff who represent the target region’s population may be able to safely access mobile sites. In such cases, remote supervision may be required. It is important to note that service delivery models managed remotely are inherently more difficult to oversee. Services that are highly technical, such as those requiring case management or intensive skills training, usually need greater oversight from senior management, as well as higher capacity of local staff. In cases where low levels of in-person supervision are likely and pre-existing case management capacity does not exist, it may not be immediately appropriate to deploy mobile GBV service delivery.

The strategies below may support remote supervision.

Use technology for communication

Because in-person contact between remote staff and supervisors is limited, interaction is commonly facilitated via mobile phone and technologies such as Skype, Viber, and WhatsApp. All mobile staff should be issued an agency phone to facilitate communication with supervisors. Supervisors should perform weekly check-ins with all remotely-located direct reports to offer at least a minimum level of support and guidance. If discussing cases via phone, staff and supervisors should be clear that survivor identifying information should not be shared.

Use online case management systems to review case management files

Reviewing case files on a regular basis can help determine whether forms are being used and filled out appropriately, and can help assess the quality of services being provided. The use of online information systems such as Primero can facilitate supervisor case review, with appropriate restrictions for confidentiality, allowing supervisors to remotely observe the case management process. Supervisors can set up a schedule for review of a randomly selected number of files from each caseworker, or from a few caseworkers, or review two files per caseworker per week. Supervisors should make note of any particular challenges a caseworker is having with case documentation, or a common challenge that emerges among files across the team. Feedback on trends in case file review should be regularly shared with the caseworkers. Supervisors and casework staff should use software flagging functions, one-on-one discussions, and group calls to discuss such feedback.

Case file reviews are just one part of supervision and should be complemented by other supervision methods.

Use technology to support remote capacity building

Organizations can consider written, visual and audio skill enhancement tools for remote capacity building. Mobile applications for capacity building can be developed for use offline. Mobile teams can thus use the considerable amount of time they spend in transit doing remote capacity building with these offline platforms.



Remote-offered Skill-building Application (ROSA)²⁰ is a new application the IRC developed to facilitate skill assessment and capacity building for frontline workers, and creates a community space for peer learning and coaching. It utilizes knowledge and skills assessments outlined in the *Interagency GBV Case Management Guidelines*.²¹ The application can support caseworker and community focal point knowledge of GBV, and strengthens case management, communication, and survivor-centered attitudes and skills. By downloading the app on a mobile device (tablet, smartphone) in advance, users can access content in settings with low or no connectivity.

Additional examples of remote supervision include:

- Hotlines that allow for immediate support and troubleshooting with caseworkers in the field.
- Supervisors can also schedule calls with mobile staff to discuss key topics, review quality control checklists, provide scenario-based role-play training, and check in on any concerns.

20 ROSA is available on iTunes and the Google Play store. iOS: <https://itunes.apple.com/us/app/rosa/id1303840802?mt=8>
Android: https://play.google.com/store/apps/details?id=org.rescue.rosa&hl=en_US

21 pg193-218 <https://gbvresponders.org/response/gbv-case-management/#InteragencyGender-basedViolenceCaseManagementGuidelines>

Annex 1: Security Risk Assessment for Emergency Response²²

Consider the following elements in the security risk assessment carried out prior to deployment.

- General situation (population dynamics, local attitudes toward humanitarian actors, local police).
- Threats: impact, likelihood, and risk mitigation measures.
 - » History of threats, where they come from, how to obtain information about them.
 - » Should the organization maintain a low, medium or high profile? For example, the branding of vehicles may be protective in some contexts and dangerous in others.
- Movement and access.
 - » History of restrictions/curfews, road and weather conditions.
 - » Approved roads/feasible evacuation routes.
 - » Locations of check points.
- Permissions required from local authorities and conditions imposed on organizations.
- Red lines guided by the principles of humanity, neutrality, operational independence, and impartiality.
- Liaisons required with other organizations to establish an ongoing plan for security monitoring.
 - » If community members are contacted to report on the security context, their identifying information needs to be expunged from security reports to other stakeholders.
- Determine whether staff will face risks, and whether those risks vary according staff characteristics. For example, is the risk different for international, national, or local staff/community, or for men and women, or members of different ethnic groups? What security measures would be required? A strong gender lens is required in determining risks, as the majority of GBV service staff are female.

22 Adapted from IRC Iraq *Security Assessment from for Humanitarian Response*. Unpublished.

Annex 2: Assessment Tool for Identifying Temporary Safe Spaces for Women and Girls

This tool is designed to assess already-existing community spaces (e.g. schools, clinics, community halls) that are being considered for use as a mobile safe space.

The tool collects information on ideal minimum standards for a safe space for women and girls. In recognition that all minimum standards are not always achievable, a final “go/no-go” decision should be made only after consultation with the program manager.

Section 1: Background			
Date of assessment:		Name of assessor:	
Township:		Village tract:	
Village/camp:		Space name:	
Section 2: Minimum standards for case management entry points			
2.1 - Is the location easily accessible to women and girls in the displaced sites and host community?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.2 - How will women and girls get to the space?			
2.3 - Can the space be accessed by women and girls with disabilities?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.4 - Is there a minimum of 1 room for psychosocial activities and 1 room for case management?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.5 - Can the proposed case management room be accessed easily and discretely from the psychosocial room?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.6 - Does the space have a separate, lockable entrance?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.7 - Is there an adequate amount of furniture for planned activities (tables, desks, chairs)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

2.8 - Does the space have safe access to a latrine?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.9 - Is the space private (activities/discussions can take place without being seen or overheard from outside)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.10 - Is the space located near any potential hazards (security checkpoints, social gathering spaces for men, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2.11 - Are there any additional reasons why women and girls might NOT feel comfortable accessing the space?	<input type="checkbox"/> Yes (specify) <input type="checkbox"/> No		
2.12 - Has the team spoken to women and girls separately to get their feedback on the space?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Section 3: Additional information			
3.1 - What is the space currently being used for (e.g. school, clinic, private house, etc.)?			
3.2 - Who is the current owner? Are they aware of the profile of the participants, and are they committed to welcoming all program participants at all times?			
3.3 - Is there a monthly rental fee?	<input type="checkbox"/> Yes (specify) <input type="checkbox"/> No		
Section 4: Go/no-go decision			
4.1 - Can the space be used as a safe space in its current condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.2 - [If no] Can the space be used as a safe space with additional procurement/rehabilitation by the organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
4.3 - [If yes] What additional work on the space is required? Is the likely expense supported in the program budget?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<i>Final Decision</i>	<table border="1"> <tr> <td data-bbox="808 1575 1166 1675" style="text-align: center;">GO</td> <td data-bbox="1166 1575 1521 1675" style="text-align: center;">NO-GO</td> </tr> </table>	GO	NO-GO
GO	NO-GO		
<p>Please include below at least two photographs of the space, if possible:</p>			

Annex 3: Workshop Guide for Designing a Mobile Response

Follow the instructions below to discuss and answer key elements of the design of a mobile response.

Step 1. Draw your offices

Step 2. Draw target communities for mobile services, including existing infrastructure. Make sure to answer the following questions:

- What is the drive time to get to the displacement area?
- What is the situation along the route to the displacement area? Are there unsafe areas, check points, places where movement may be blocked, or presence of military?
- What kind of place is the target area (urban, rural, camp, informal settlement)?
- What kind of structures are people living in (tents, buildings, etc.)?
- What infrastructures/buildings exist that we could potentially use for services? Whose permission is required? Are there priority spaces that women and girls deem safe? How well do these spaces meet ideal space criteria?
- What private, confidential meeting spaces exist where case management can be done? When can these spaces be available? What is the contact information for those with whom coordination is required?

Step 3. Define the mobile population using the following questions:

- Number of estimated displaced people (women, men, girls, boys)? What subgroups exist? What languages do they speak?
- Can we find a means to communicate with persons with disabilities?
- Dynamic of displacement: How long have people been displaced? How long do people expect to be there? Are there any cycles in terms of when people are displaced and return? Are more people expected to come?
- Are there any known local protection issues?
- What is the leadership structure in the area? Are there women's organizations? Women leaders? Disability associations? (Pro-Tip: List contact information!)

Step 4. Draw existing services and define on-going activities using the following questions:

- What are the referral options?
 - » Identify different types of services: health, psychosocial, safety, legal, other. (Use a service mapping tool for more specific information and add GPS points! <https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/>)
 - » Are there GBV focal points for phone-based referrals?
 - » Are there mandatory reporting requirements with these service providers?
 - » Is emergency contraception available at pharmacies?
- What other organizations exist locally?
 - » LGBTI support organizations? Disability organizations? Livelihood organizations?
- What activities exist in the community with which collaboration may be possible?
 - » Are there ongoing women's group activities?
 - » When do they occur (days, times)?
 - » What is the contact information for people with whom coordination is needed?

- What activities should the mobile team be integrated into to “normalize” interactions with the community and individuals?
 - » What resources and skills might the team need to be involved in these activities?
- What are the community-based safe transportation options? How do people get around? Can phone numbers for transportation providers be obtained?

Step 5. Identify technology availability and use. Answer the following questions:

- What kind of technology do women have access to? (examples: phones, smartphones, tablets, laptops, etc.)
- Do women have private access, or do they share access with family or community members?
- Is there a mobile network?
- Is there electricity?
- Is there internet access?

Step 6. Review the map you have created and begin to think about travelling to your mobile sites. Answer the following questions:

- Who is on the team?
 - » How many people? What are their roles?
 - » Is there a health actor on the team?
- Is there a dedicated car for the mobile team?
 - » How many vehicles will be used for the mobile team?
 - » Who is in the car with the mobile team?
- What will you need to bring with you?
- What other resources and skills does the team need to implement the activities?

Step 7. Create an action plan using the following questions:

- How many mobile sites will you visit?
- Will you go to every site every week?
 - » What days and times make sense for your visits, given the available activities and infrastructure?
 - » How long will you spend at each site?
- Who will go to each site?
 - » What activities will each team member be responsible for?
- **Tip: Create a time table for a typical week/month, outlining which days and times each mobile team will go to each site!**

Annex 5: Additional Guidance for the Implementation of a Telephone Hotline

The following is additional guidance to support the implementation of a hotline.

Call answering protocol

To ensure consistency, a call-answering protocol should be developed and written out.

A simple protocol may involve the following steps:

- Answer the call according to a standardized script.
- Ensure confidentiality.
- Collect intake information.
- Provide emotional and psychosocial support.
- Provide accurate, updated, basic information.
- When appropriate, refer callers to resources.

Training for hotline staff

If staff are already knowledgeable in GBV case management (a minimum requirement), hotline staff should receive the following training:

- Reviewing types of GBV, causes and consequences.
- Introduction to hotlines as an entry point for services and how they work.
- Operation of the hotline and service protocols.
- How providing support via hotline is different than in person, and what adaptations need to be made (e.g., for in-person GBV case management we emphasize the importance of establishing rapport and trust with the survivor through the space itself and how body language is used—which cannot be done over a hotline).
- Use and management of resource guides and referral pathways.
- Data management.
- Meeting the needs of diverse survivors, friends and family who may call as co-survivors.

Training can consist of practice role-plays, where a supervisor calls and acts as a survivor, family member, service provider, or an inappropriate caller, in order to monitor the staff person's case management skills. For the role-play exercises, supervisors should role play several different types of callers requesting services for types of GBV common to the context, so that the caseworkers can practice responding to a range of potential survivors. Supervisors should then debrief with caseworkers on their performance.

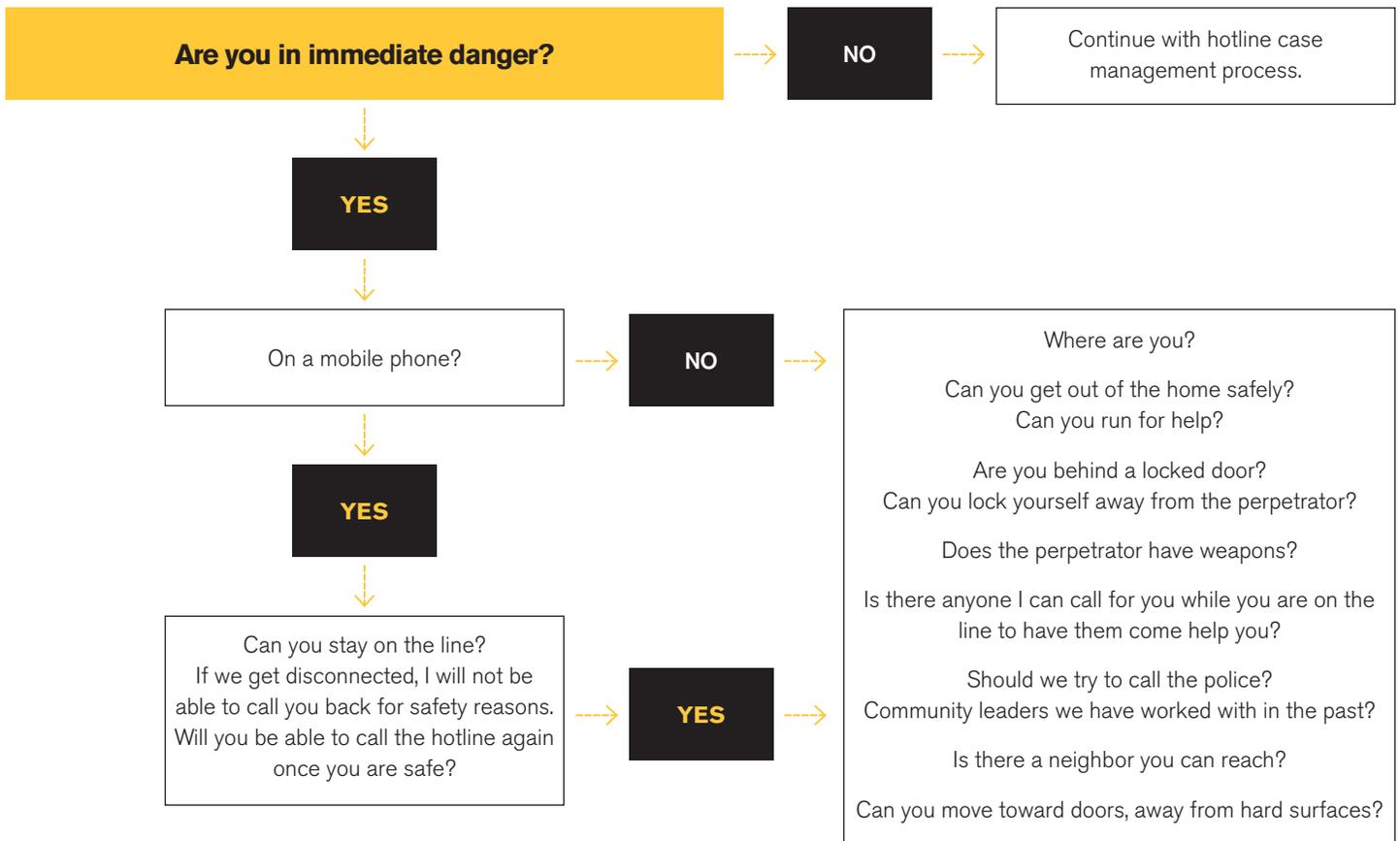
Safety protocols: supporting safe use of the hotline

Because hotlines use technology that can be monitored by perpetrators/abusers, particularly in IPV situations, it is important to establish protocols to promote callers' safe use of the hotline. These protocols should be communicated to the caller from the outset.

- No call back policy. Hotline staff should not call survivors back if there is an immediate risk to their safety, especially in situations of ongoing intimate partner violence. Ask survivors to call you back if you get disconnected.
- Remind survivors to delete the call record from the phone. One of the risks with hotlines is that perpetrators, particularly in situations of IPV, may monitor a survivor's phone use.
- Establish a code/red flag phrase. With survivors that receive ongoing support and case management via the hotline and have safety concerns at home, the survivor and caseworker should agree on a code that the survivor can use to signal to the hotline staff when the survivor thinks the call is being monitored and it is unsafe to talk. IPV perpetrators may not only monitor a survivor's phone use, but also the phone calls. If there are multiple hotline staff, the same code can be used across the program with different survivors to signal that they need to stop talking about violence and assume a different role/narrative, and then promptly end the call. For example, staff could tell all survivors to say, "You are the teacher from the school/clinic. I didn't sign up for the class," if she is in danger and needs to end the call.
- Any requested calls back from the program should be accompanied by a safety plan.

Immediate danger protocol

Because survivors may be calling a hotline for help when they are in immediate danger, it is important to develop a protocol for responding to and supporting a survivor in the safest manner. Below is a sample protocol that can help a caseworker determine how to proceed in such situations (to be adapted to each context). This is not intended to be comprehensive safety planning (which is covered in the *Interagency GBV Case Management Guidelines* (link)).



Annex 6: Instructions for Developing a Coping Plan in Group Sessions²⁴

A coping plan teaches someone to identify resources in their life (like people, things, activities) that make them feel happy, relaxed and comforted, so that they can draw on them when feeling badly (upset, scared, lonely, etc.). Through developing a coping plan, caseworkers encourage participants to participate in positive activities that they enjoy. This will help improve their mood and make them more likely to return to normal functioning (going to the market, talking with others, etc.)

When doing coping plans in a group, encourage individuals to think through these questions themselves. The facilitators may wish to give examples. Do not force sharing, but encourage them to share if they wish.

4-step process for developing individual coping plans in a group

- **Step 1:** Identify the people the participant trusts or feels comfortable with in her life. *“When you are feeling _____ (e.g. scared, sad, lonely), who can you talk to?”* (Have participants list people they feel comfortable talking with.)
- **Step 2:** Identify the activities participants enjoy. Build on interest and strengths. Help the participant identify the positive feelings she has when doing these activities, by asking *“How do you feel when you do those things?”* (happy, relaxed, etc.)
- **Step 3:** Develop a plan with participants to engage people, carry out activities, and pursue interests and other strengths they have identified, to help them when they are feeling badly and need support.
- **Step 4:** Encourage people to share (only if they wish) the activities they identify. Can any of those activities be done jointly in the safe space?

Some useful ways of getting participants to identify their own strengths and interests may include:

- Talk with them to help them identify the people they feel safe with and supported by. Find out how they connect with these people.
- Talk with them to learn about their faith and spiritual beliefs. Help them reconnect to faith if they are feeling isolated.
- Talk with them about what they can do when they feel sad. Find out what kind of activities make them happy and who their friends and “safe people” are.
- Help participants recognize their own strengths. Praise them. All people need to see themselves as capable human beings who deserve love, happiness and protection.

