Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines During Pandemics & Epidemics

Updated Edition 2026 - Draft version

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Preface

Updated edition 2026

This guidance was originally developed in response to the COVID-19 pandemic with support from multiple agencies[1], during which GBV case management rapidly transitioned to remote modalities to reduce social contact and limit transmission of infection. While the World Health Organization (WHO) regulations associated with the emergency phase of the COVID-19 pandemic largely concluded in 2023, this guidance remains relevant to pandemics, epidemics and other similar types of emergency and humanitarian contexts where adaptation to remote service delivery is required – updates have been made to reflect this broader level of application.

This updated edition has also been revised to include guidance on supporting child survivors of sexual abuse through remote modalities, aligning with the second edition of the Caring for Child Survivors of Sexual Abuse Guidelines (CCS).[2] Therefore, throughout this guidance, references to survivors include adult and child survivors (including adolescent girl survivors). Structurally, these updates are contained within dedicated and specific sub-sections in the phone-based case management section whereas key considerations for child survivors are embedded and woven into the hotlines section at relevant junctures. This is because first and foremost hotlines need to make an initial suitability determination as to whether or not they are ready and able to take calls from or regarding child survivors. And secondly, hotline operators have the relevant prompts in one place rather than having to switch back and forth. Sections for common application across both types of services and for child and adult survivors are the updating referral pathways and supervision and staff care considerations sections.

Note: The current publication is a draft version published in response to the current Ebola Virus Disease outbreak. It is shared to support immediate access to technical guidance and will be replaced with a forthcoming final version.

[1] The agencies involved in the development of the first edition of this guidance were UNICEF, The GBA AoR Helpdesk (now known as the GBViE Technical Support Hub), the GBV AoR, the GBViMS Steering Committee, Plan International, UNFPA, UNHCR, IRC, Trocaire, IMC and NCA.

[2] UNICEF and IRC, 2023, Caring for Child Survivors of Sexual Abuse Guidelines, Second Edition. UNICEF, New York, 2023.

1. Introduction

Crises such as pandemics and epidemics affect women and girls differently to men and boys, and in ways that place women and girls at greater risk of gender-based violence (GBV),[3] particularly in contexts where gender inequality is already pronounced. This can include, for example, increased exposure to intimate partner violence due to tensions in the home under confinement conditions. Economic issues can also place women and girls at higher risk of sexual violence and exploitation.[4]

In 'normal' times, GBV incidents often go unreported due to lack of safe, ethical and quality response services as well as survivors' fears of stigmatization, reprisal, and lack of information on how to seek help. In settings affected by outbreaks, these limitations may be compounded by a number of factors, including restrictions on movement, increased isolation, caregiving responsibilities, financial stressors and/or fears of being exposed to disease when seeking services.[5]

Why remote services?

For many women and girls, accessing in-person GBV services is not straightforward. Even in stable contexts, significant barriers can prevent survivors from reaching the support they need. These barriers are frequently compounded for women and girls, who may face additional layers of dependence, restricted autonomy, and heightened risk of disclosure-related harm.

In many humanitarian and low-resource settings, GBV services are concentrated in urban areas or camp settings, leaving survivors in remote or dispersed communities with limited access to support. Long distances, lack of transportation, and the physical and financial cost of travel can make in-person service attendance challenging — particularly for survivors who are injured, have caring responsibilities, or cannot safely explain an absence from home.

Active conflict, generalized violence, and unsafe routes to service locations can make travelling to access support dangerous. For women and girls, the risk of harassment, attack, or further violence along the way may outweigh the perceived benefit of reaching a service. In some contexts, the act of being seen entering a GBV service can itself expose a survivor to stigma or retaliation.

Ensuring that women and girls can access GBV support services remains a critical and lifesaving activity. However, maintaining the health and wellbeing of GBV caseworkers — and also

[3] The IASC Guidelines for Integrating GBV Interventions in Humanitarian Action define GBV as an umbrella term for "any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females." GBV includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. Sexual violence is understood as one form of GBV. The IASC GBV Guidelines emphasize that the term 'GBV' is most commonly used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls.

[4] https://asiapacific.unfpa.org/sites/default/files/pub-pdf/COVID-19_A_Gender_Lens_Guidance_Note_3.pdf

[5] See Impact of COVID-19 Pandemic on Violence against Women and Girls, VAWG Helpdesk Research Report: https://gbvguidelines.org/wp/wp-content/uploads/2020/03/vawg-helpdesk-284-COVID-19-and-vawg.pdf

abiding by regulations aimed at stopping the spread of pandemics and epidemics— presents challenges for face-to-face GBV response services. **A flexible and adaptive approach is needed to ensure that life-saving services continue without compromising the safety of GBV caseworkers or survivors**.[6]

Decisions about whether to continue static, face-to-face case management services, or to scale down, or to entirely change the service modality in order to continue to provide services will depend on a number of factors including:

- **Government response to pandemic/ epidemic.** Different government responses will result in different levels of risks and restrictions to GBV service delivery that make some modes of service delivery more possible than others.
- **Resources (including donor flexibility)** for the service provider to maintain stringent Infection, Prevention and Control (IPC) standards at all stages of the pandemic/ epidemic, and in preparation for more advanced stages.
- **Government guidance and policies** that affect freedom of movement, and/or ease of obtaining official permissions, including formal exceptions, which are required to operate static services in the event of mandated lockdown.
- **Risks and perceived risks for staff and others.** It is critical to weigh actual risks not only to the health of staff, but to the health of others who may be exposed by the delivery of services, including in relation to movement to and from service delivery points. In addition, perceived risks also affect staff and survivors' willingness and ability to continue with face-to-face services.
- **Location of static services.** While health clinics are likely to remain open during a pandemic or epidemic, survivors may face challenges accessing case management services through health facilities due to fear of infection, stigma, or because clinics are overburdened. Where possible, separate service points for women and girls should be maintained that follow IPC protocols.
- **Organizational policies.** Each service provider interprets government guidance and policies in a more or less flexible manner, which can influence service provision.

Adapting GBV Case Management to Remote Modalities

This resource presents options for adapting in-person GBV case management to remote modalities so GBV survivors can continue to access and receive safe and confidential services in situations where in person service delivery is considered unsafe or largely inaccessible. It includes guidance on setting up, operationalizing and implementing phone-based case management and phone-based crisis hotlines.

GBV case management is a collaborative, multidisciplinary process which assesses, plans, implements, coordinates, monitors and evaluates options and services to meet an individual's needs through communication and available resources to promote quality, effective outcomes. It

[6] GBV AoR Helpdesk (2020) note "GBV Case Management and the COVID-19 pandemic". Updated 2026

involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.[7] A case management approach is particularly useful for survivors with multiple needs that require them to access services from a range of service providers, organizations and groups.[8]

In humanitarian contexts, GBV case management is an essential and life-saving protection service,and is typically offered through static service delivery points, such as women and girls' safe spaces (WGSS), or through mobile services.[9] It is critical that these services continue even during the physical distancing and isolation measures put in place to stop the spread of disease — not only to ensure ongoing care and support to existing clients, but also to respond to *new* GBV incidents generated by the pandemic and related public health measures.

> **Phone-based case management** is defined as case management that caseworkers provide over the phone to existing clients[10] (or, in some cases when resources, safety and referral processes allow, new clients through direct referrals). It may be accessed through appointments agreed upon by the survivor and caseworker or through survivor-initiated calls when the caseworker is available (i.e., not open to the general public, or operating all hours).
>
> **A hotline**[11] is an established phone service that provides crisis support and information to any survivor who calls. Hotlines aim to meet urgent support and referral needs of survivors and those at risk.[12] A hotline is open to the general public and sometimes, but not always, for extended hours. In many settings hotlines operate with toll-free numbers so that callers can avoid incurring fees.

This guidance clearly differentiates these two types of services, while also recognizing potential issues of overlap, such as referral pathways, supervision and staff care considerations etc. It draws

[7] See the Interagency Gender-Based Violence Case Management Guidelines (2017), pp. 225-256. https://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017_HighResEn.pdf

[8] See IRC's Emergency Preparedness and Response Handbook, pp. 46-49 : https://gbvresponders.org/wp-content/uploads/2018/04/GBV-Emergency-Preparedness-Response-Participant-Handbook.pdf

[9] See IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery; International Rescue Committee; accessed on June 2020 through: https://gbvresponders.org/wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

[10] This resource uses client and survivor interchangeably to refer to women, girls and child survivors who utilize GBV case management or hotline services. The term survivor is also used to refer to any woman or girl who has been exposed to violence, regardless of whether she has accessed services.

[11] Hotlines can also be referred to as 'helplines.' For consistency, this document uses hotlines.

[12] There are other adaptations to GBV service delivery that can be made that are not technology-based. Discussion of these can be accessed here.

from and attempts to synthesize good practices that have emerged in relation to meeting the needs of survivors through these methods.[13] It covers:

- Updating referral pathways in a pandemic/ epidemic
- Supervision and staff care considerations
- Setting up and operationalizing crisis counseling for adult and child survivors via hotlines during a pandemic/ epidemic
- Setting up and operationalizing phone-based case management for adult and child survivors during a pandemic/ epidemic
- Addendum note regarding video-based GBV related case management for adult and child survivors
- Further reading and resources

Data management and safety planning considerations are also addressed within the guidance.

Key Considerations *Prior* to Setting-Up or Adapting Existing Case Management or Hotline Services

Prior to shifting to phone-based services, whether for remote case management *or* for hotlines, there are several key considerations which *must* be taken into account *before* moving forward: access to technology and a phone network, ensuring safety and privacy, determining if service delivery staff have the skills and capacity to support survivors (including adolescent girls and child survivors) and determining if adequate supervision and staff care measures can be put in place. After it is determined that technology can support the service, that safety can be well-managed, that service delivery have the requisite skills and capacity, and that there will be adequate supervision and staff care measures in place, then it is possible to move on to other considerations related to designing and implementing the service.

Technology and Network Access. Having reliable technology is foundational to undertaking phone-based services. Telephone and mobile phone technology vary from country to country. The telecommunications infrastructure in a specific country or region will determine the feasibility of establishing phone-based services. This includes not only ensuring mobile network coverage is available in the settings where the service is being delivered, but that this coverage reaches all the women and girls who may be accessing the services. It also means being able to provide phones, SIM cards, and chargers (including solar chargers in settings where electricity outages are a regular concern), to staff so that they are not expected to use their own devices or their own telephone numbers.

Technology is not just an important consideration for staff; it also must be accessible to the women and girls who are accessing the services — and not only phones, but also phone charging capacity,

[13] For more information about GBV as a lifesaving intervention in emergencies, see the GBV AoR Handbook for Coordinating Gender-based Violence Interventions in Emergencies (revised, 2019), https://gbvaor.net/sites/default/files/2019-07/Handbook%20for%20Coordinating%20GBV%20in%20Emergencies_fin.pdf

call credit, etc. If phones are not common among women and girls in the setting, other options should be considered to allow women or girls to access a phone, such as through trusted community members, or setting up 'phone booths' in existing safe spaces in settings where access to safe spaces is still feasible (i.e. movement restrictions allow and protocols can be assured for sanitizing phones after every use).

In humanitarian settings, women, adolescent girls and children are usually accessing a phone that belongs to another family member, so the safety implications related to a third party knowing that they have accessed a GBV hotline or GBV case management service *must* be considered particularly in relation to survivor safety and confidentiality which are GBV guiding principles. For example, for women and adolescent girls who experience intimate partner violence (IPV) accessing a support service via their partners' device may increase their risk. It is vital that in such circumstances service providers are able to give clear instructions to women and adolescent girls on how to rapidly cover their digital tracks in such situations (e.g. delete traces from the recent calls record) and that access to independent phone devices is discussed as part of safety planning. For children, their access to phone devices will usually be regulated and monitored via adult(s) service providers who will need to understand whose phone the child is using, whether they are a non-offending caregiver/adult in the child's life or, whether they pose a safety risk to them. This will necessitate a set of call probe questions at the start of each call with service providers needing to proceed with caution and, ideally, transitioning child survivors to in-person support as rapidly as possible to mitigate against concerns of phone-based safety breaches.

Basic points to consider regarding technology include:

- What kind of technology does the population have access to, particularly women and girls? What about the most marginalized women and girls?
- Is there a phone network and electricity? How stable are they? What geographic area do they cover?
- Is there the option of a toll-free number, or other strategies for the provider (rather than the survivor) to carry the cost of the call?
- Is it possible to access a conference call function (to support translation, connectingwith supervisors, referral partners, etc.)?
- Do due diligence on the phone network you are using to assess how reliable the network is as it is important to try and minimize outages for survivors in crisis.
- Do due diligence on the phone network you are using to determine if it has sufficient levels of safety/security measures to protect the safety and confidentiality of the survivors who will use it? E.g. is the network open, is it commonly under surveillance? Is it possible to encrypt calls? How does the phone network manage and store data about its users?

Basic points to consider regarding safety and privacy include:

Safety of staff

- Safe delivery of GBV services requires, at minimum, privacy. This means ensuring that phone-based service providers have a separate facility or room where they can receive calls. In some settings, staff may still be able to work in private rooms in an existing GBV

case management service facility (e.g. a safe space), or in some other facility (e.g. a health facility) that is able to put in place adequate protective protocols and equipment.

- If taking calls from home, staff must ensure a private space where no one else can listen in on the calls. This does not mean stepping outside or going into the bathroom when a call is scheduled with a client; it means having an allocated private space, where there will be no interruptions and where confidentiality can be maintained during designated working hours.
- Where they are implemented, it is important that the suitability of home-based work environments are assessed by supervisors in the early stages of planning to explore the feasibility of providing remote based support whether phone-based case management or a hotline. (See Sections 3, 4 and 5 for further guidance).

Safety of users

- Privacy is not just an issue for caseworkers; it is also an issue for callers. Consideration should be given to identifying several easily accessible, yet confidential and safe spaces clients can use to make a call, such as a private room in a survivor's home (if safety allows); a women and girls' safe space that has been converted to a phone-access center when face-to-face services are no longer safe or feasible; the home of a trusted community member; mosques/churches; etc. In the context of a disease outbreak, all of these potential options will have to be assessed for compliance with government restrictions on movement as well as ability to ensure basic transmission precautions.
- Where only essential services are open to the public, it is important to consider whether phones — and private places to use them — can be made available in health facilities, grocery stores, etc., or whether phones will need to be distributed directly to clients.
- If clients access a facility where there is a shared phone, stringent protocols must be established and maintained to ensure every phone is thoroughly sanitized between each call and the facility itself follows health and safety standards.

In summary:

- Will staff be able to provide services safely and privately in their homes? If not, are there other places that services can be provided that are compliant with pandemic/ epidemic restrictions?
- Are there places women and girls can make calls safely and privately, if not from home, that also abide by protocols to limit transmission risk not only in the setting itself, but also when using the phone? How will clients be supported to privately and safely access these places?
- Do clients accessing remote case management support need to be provided with their own phones? Or in the case of child survivors, their non-offending caregiver? Is this safe and feasible?

Basic points to consider regarding staff skills and capacity include:

- Before introducing or adapting service delivery modalities to hotlines or phone-based case management, managers should first confirm how many staff have a safe, suitable space to deliver remote services. A training needs analysis should then be conducted for these staff to

ensure they can provide high-quality, confident, and appropriate support to survivors through remote modalities. This is essential in order to enable delivery of quality services and to ensure that staff are able to engage with survivors confidently and appropriately through these remote modalities.

- It is important to ensure that staff have a good grounding in relevant technical trainings for the specific client/ caller groups they will be working with. For example, if your hotline is open to calls from child survivors, staff should have received caring for child survivors training.
- In addition to technical knowledge, ensuring staff have the requisite communication skills and techniques and positive survivor-centered and child-friendly attitudes is also crucial. Therefore, trainings which focus on skills-building and development and assessing staff should be provided. In relation to survivor-centered and child-friendly attitudes these should be appraised through attitude surveys and supervisor observations ahead of service adjustments being made. Staff who do not hold relevant knowledge, skills and attitudes should not be assigned to work with child and adult survivors.
- If staff have received trainings prior but some time has elapsed, consider providing refresher in-person trainings, providing online e-learning refresher trainings, or additional reading or coaching on the specific aspects that need refreshing ahead of assigning staff to hotlines or providing phone-based case management.
- Further information on training is embedded within the hotlines and the phone-based case management sections of this guidance.

Basic points to consider regarding adequate staff supervision and staff care measures include:

- Before transitioning or adapting service delivery modalities to provide hotlines or phone-based case management staff supervision capacity must be appraised. The recommended ratio of supervisors to caseworkers is 1:5 and the minimum standard is 1:8 as per the Interagency GBV Case Management Guidelines (2017)[14] and the Interagency Minimum Standards for GBV in Emergencies Programming (2019).[15] Once the headcount of staff able to provide safe and suitable remote services safely has been completed, it is also necessary to ensure there are sufficient supervisors—aligned with recommended standards—who likewise have safe and confidential spaces to work from during the pandemic/ epidemic
  - If an adaptation to hotlines and/or phone-based case management is deemed feasible and necessary, then it is important for supervisors to recognize that their style and pattern of delivering supervision for caseworkers may also need to shift and adapt to the remote modality if they are no longer able to deliver supervision in-person. For example, they may no longer be able to rely on non-verbal cues from caseworkers that may indicate they are stressed or struggling and will need to be pro-active in asking open questions in relation to wellbeing and actively listening for responses if conducting supervision sessions via phone.

[14] GBVIMS (2017). Interagency Gender-Based Violence Case Management Guidelines, First Edition.
[15] GBV AoR. (2019). Interagency Minimum Standards for Gender-Based Violence in Emergencies Programming.

The frequency of supervision sessions may also need to increase to support staff through a transition and to account for the specificities of delivering remote services.

- Individual and group supervision remain important to ensure supervisory as well as peer support both technically and to support collective care and wellbeing.
- All supervisors and caseworkers shifting to remote work should be issued with an agency phone and communication allowances (top up/ phone cards/ airtime) to facilitate regular communication between caseworkers and supervisors at agreed times and as needed during hours of work designated for the caseworker.
- Specific technology should be identified to facilitate ease of communication between staff and supervisors, as well as among staff, including WhatsApp, MS Teams and Zoom and staff should be trained in using this technology.

2. Updating Referral Pathways in a Pandemic/ Epidemic

A referral pathway is a flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security, and justice and legal aid. A functional referral system of survivor centered, multi-sectoral service providers supports survivors' health, healing and empowerment. Referral systems must prioritize survivor safety and confidentiality, and respect survivors' choices. Referral systems are the foundation for:

- Coordinating service delivery;
- Improving safe and timely access to quality services for survivors of GBV;
- Prioritizing survivor safety and confidentiality, and respect survivors' choices;
- Ensuring that survivors are active participants in defining their needs and deciding what response and support options best meet those needs.

As such, referral pathways are an indispensable tool for caseworkers and hotline operators to support survivors' access to multi-sectoral care and support. Based on service and infrastructure mapping, referral pathways typically capture information about relevant multi-sectoral organizations, including the names of key focal points, phone numbers, email addresses, physical addresses, services offered, hours of services, and cost of services.

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Establishing a referral system is the task of coordination mechanisms such as a GBV working group, or a child protection (CP) working group. Where both exist, GBV and CP coordination bodies should actively collaborate to ensure referral pathways reflect the needs of all survivors, including

children.[16] In the absence of a coordination body, GBV program actors should conduct their own mapping and assessment to inform and establish a referral system, including by engaging with all service providers in the local setting. Good practice suggests that a referral list should be updated regularly, at least every six months. In emergency settings, it may be necessary to update the referral pathway at least every three months, since services tend to change more rapidly.

In the context of a pandemic/ epidemic, referral pathways should be updated every month if service availability continues to change. Where partial or full lockdown is required, many service providers may shift their modalities of response or even suspend in-person services if they are not deemed essential or if resources are not available to make necessary adjustments to service delivery. These changes to the availability and scope of services must be reflected in updated referral pathways.

Updating referral pathways requires reviewing the services that existed prior to the crisis and determining which of them is still operational. If operational, an assessment of ongoing service must analyze whether the services are safe, particularly whether they comply with guidelines related to the pandemic/epidemic, as well as whether they are survivor centered. The assessment must also determine whether the modality of service has changed in any way, for example from in-person to remote service delivery. Even if organizations have not shut down yet due to restrictions, the assessment should include some analysis of whether organizations intend to shut down in the future based on different scenarios of pandemic/ epidemic response.

If resources are limited and it is necessary to update the referral pathway very quickly, it is recommended that the focus of the update prioritize providers of health, psychosocial, GBV and CP case management and safety and security services, including local women's organizations, in order to identify for survivors what essential GBV services will still be available. As much as possible updates should include information about services for specific sub-populations of women and girls, such as child survivors, adolescent girls, women and girls with disabilities, lesbian, bisexual and trans women and girls, pregnant women and girls, etc. In all cases, it is necessary to get approval from management of any organization that is listed in a referral pathway.

Key Considerations When Updating the Referral Pathway

Assessment of organizational capacity will help you determine which organizations to include in the updated referral pathway. Some of the key issues to explore include:

- ✓ Who is still providing services;
- ✓ The referral options and types of support each is able to provide;
- ✓ Whether services are in-person, or have shifted to remote or mobile response;

[16] GBV and CP coordination on referral pathways should include: mapping and incorporating child-focused services (such as child-friendly spaces, case management, and psychosocial support); assessing service capacity to respond to child survivors of sexual abuse, including staff training and child-safeguarding protocols; and identifying referral options for boy survivors, who may face specific barriers to accessing GBV services.

- ✓ Any limitations related to service provision within the context of the pandemic/ epidemic, such as:
    - Changes in times services are available.
    - Reduction in number of staff.
    - Risk of exposure to the disease (which has led to the pandemic/ epidemic) and efforts by the organization to address or reduce these risks.
    - Accessibility of services, including whether it is necessary to take public transport to the service, or if the service has any funds or other schemes available to facilitate safe transport for survivors, especially in settings with mobility restrictions.
    - Whether the service is considered essential or not.
- ✓ Other key issues related to safe and ethical care, such as whether the service has mandatory reporting requirements, e.g. in instances of abuse of children or illegal immigrants, or any other issues related to quality of care.

When assessing organizations, movement restrictions may mean that these assessments must be conducted remotely.[17] Some of the methods for updating referrals remotely include using phones, online internet platforms, or conference settings to conduct key informant interviews. If technology allows, it may also be useful to hold virtual focus group discussions with caseworkers to discuss any new risks encountered by service providers as well as issues of quality of care. GBV coordination partners should also be encouraged to update the '5Ws'[18] regularly (ideally through an online format) with relevant information about operating during the pandemic/ epidemic.

Other questions that should be a part of the referral pathway updating process will look at the larger community, particularly any available community support for survivors:

- ✓ What community activities will continue (if any)?
- ✓ Is emergency contraception available at pharmacies?
- ✓ What other organizations exist locally?
- ✓ Are there transport/movement restrictions?
- ✓ Are there curfews?
- ✓ Will there still be community-based/alternative safe transportation options?
- ✓ Do different populations have access to the necessary documentation to access services or to move if necessary?

[17] 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/.

[18] The humanitarian 5Ws ("Who is doing What, Where, When, and for Whom") is a vital information management tool used to coordinate emergency responses.

Box 1. Core elements of a functional referral system

- At least one service provider for health, psychosocial support, case management, safety and security, and, as appropriate and feasible, legal aid and other support, in a given geographical area.
- Referral pathways identify all available services and are documented, disseminated and regularly assessed and updated, in a format that can be easily understood (e.g., through pictures/diagrams).
- Services are delivered in a manner consistent with the GBV Guiding Principles, including the guiding principles of the CCS approach where survivors are children.
- All service providers understand where to refer survivors for additional services, and how to do so safely, confidentially and ethically.
- All service providers have a mechanism for following up on referrals to ensure referrals have been completed. For instance, a return slip or checklist should be used by referring service providers to indicate the status of services received by the GBV survivor.
- All service providers demonstrate a coordinated approach to case management, including confidential information-sharing and participation in regular case management meetings to ensure survivors have access to multi-sectoral services (see Standard 6: GBV Case Management).
- GBV data collection among all service providers, including standardized intake and referral forms, is safe and ethical.
- All service providers prioritize the response to GBV survivors.

From: GBV AoR and UNFPA, 2019. The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. https://www.unfpa.org/sites/default/files/pub-pdf/19-200_Minimun_Stan-_dards_Report_ENGLISH-Nov.FINAL_.pdf

Recommendations for Sharing the Referral Pathway

Just as mobility restrictions may prevent accessing services, these restrictions may present challenges in disseminating an updated referral pathway. Not only is it important that service providers have access to these updated referral pathways, it is also critical to share updated referral pathways with survivors and those at risk. Some of the strategies for dissemination include:

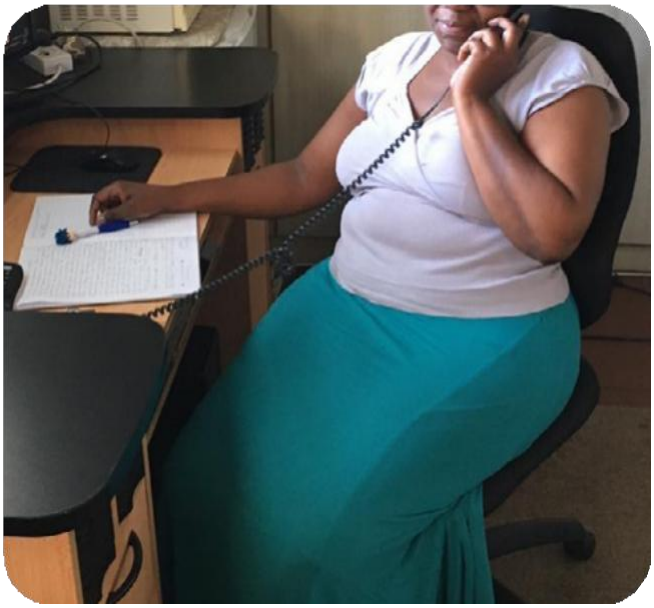
- Utilize multiple technologies, such as WhatsApp, SMS, Signal, Instagram, Facebook, MMS, Chatbots, etc.
- Ensure that content is produced in low resolution format because many survivors may have low access to internet;
- Provide training and other support to NGOs and government services about how to disseminate the referral pathways;
- Consider, where contextually appropriate, using public spaces and messaging to disseminate information for example with megaphones, or through mosque minaret speakers.

Finally, in settings where many services have been suspended, it may be useful to share one of the companion guides to the IASC GBV Guidelines, a 'pocket guide' on how to support survivors of GBV when a GBV actor is not available.[19]

3. Supervision and staff care considerations

Pandemics, epidemics and other similar types of crises create insecurity and change that is stressful and even traumatic for many individuals, families, and communities. This stress and trauma can be exacerbated by the sense of disconnection and isolation created by mobility restrictions. For GBV specialists whose work shifts to remote case management, or for frontline hotline operators also working remotely, the usual in-person support networks, including supervisory support and support from colleagues is disrupted. This can add to the already stressful job of responding the needs of GBV survivors.

All organizations have a duty of care to staff and volunteers on an ongoing basis. At times, however — and even unwittingly — organizations can exacerbate staff stress by setting up systems that foster disconnection. During pandemics/ epidemics, for example, when all communication about how organizations are managing the outbreak is conducted higher up in the organization, this can contribute to staff feelings of powerlessness. When staff are asked to under-take their work from home without sufficient support from supervisors, this can contribute to feelings of isolation. When staff are expected to assume usual (pre-pandemic/epidemic) workloads without recognition of this burden, or without support for managing the burden, this can contribute to burnout.



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Organizations, managers, and staff committed to staff welfare and quality of care for survivors must promote opportunities to keep staff connected — to their supervisors, to other staff, to their organization, and to their own mental health needs. For GBV caseworkers who have shifted to phone-based or other remote systems of survivor support, as well as for those working on hotlines receiving GBV calls, supervisors in particular have a critical role to play in staff capacity and well-being by ensuring that supervision is maintained for these workers and that staff care is given special attention, including promoting self-care. The information below highlights some of the important ways in which supervision responsibilities must be adjusted to the needs of caseworkers and hotline staff working remotely, as well as additional ways in which staff care can be supported.

[19] For the pocket guide and associated user guide, see https://gbvguidelines.org/en/pocketguide/

Key Considerations in Supervision of GBV Caseworkers and Hotline Staff

Supervision is the ongoing, regular meeting of a supervisor and a supervisee to assess and monitor skills and practice in a supportive manner.[20] All organizations providing GBV case management or crisis support through hotlines should have at least one supervisor, responsible for ensuring staff are trained and prepared for their case management or hotline role. The recommended ratio of supervisors to caseworkers is 1:5 and the minimum standard is 1:8 as per the Interagency GBV Case Management Guidelines (2017) and the Interagency Minimum Standards for GBV in Emergencies Programming (2019).

The supervisor facilitates regular support sessions to discuss cases and provide support needed for caseworkers and hotline staff to provide quality care and support. In accordance with safe and ethical GBV practice, supervisors are also expected to be available for immediate consultation in emergency client situations. Ideally, supervisors are people with years of direct experience working on GBV cases.

Regular supervision of GBV caseworkers is always important — for continued staff capacity development, to ensure quality of care and to support staff wellbeing given the psychosocial impacts of working on GBV. However, during a pandemic or epidemic when services are offered through a remote modality, it is likely that supervisors are not physically present where caseworkers or hotline staff deliver services to GBV survivors. This makes supervision more difficult, but not impossible.

Ideally, in fact, the level of supervision will increase in situations of remote case management and will be provided by the same supervisor that the caseworker or hotline staff person was working with prior to the shift to remote service delivery. Organizations can support supervisors to meet their responsibilities by ensuring that the following strategies are put in place and adequately resourced.

Prior to shifting to remote services

All supervisors and caseworkers shifting to remote work should be issued with an agency phone and communication allowances (topup phone cards/ airtime) to facilitate regular communication between caseworkers and supervisors at agreed times and as needed during hours of work designated for the caseworker.

Specific technology should be identified to facilitate ease of communication between staff and supervisors, as well as among staff, including WhatsApp, MS Teams and Zoom and staff should be trained in using this technology.

[20] Interagency Gender-Based Violence Case Management Guidelines Training Material, Module 18: Supervision.

Throughout the delivery of remote services

Regular supportive communication between supervisors and GBV caseworkers and hotline workers providing phone-based services is essential—this includes, but goes beyond, weekly supervision (see below). Supervisors must be available to their supervisees during the entire time that supervisees are working. For high-risk cases, supervisors must implement a fast-track process for caseworkers and hotline staff—through the phone, text or a messaging service such as WhatsApp. Procedures must be written and made available to all case management and hotline staff.

Supervisors should conduct daily group-based and/or individual check-ins and check-outs with their team members who are offering phone-based case management and crisis support. This check-in does not have to be lengthy, but it should be regular. The focus should not only be on any immediate survivor response and quality of care issues, it should also be an opportunity for supervisors to assess the well-being of supervisees.

Supervisors should set up standing weekly (or more frequent as needed) supervision calls with each individual supervisee. As with the regular check-ins, this more intensive supervision should go beyond review of cases and/or case documentation. Supervisors should explore the psychosocial impacts of the work and situation on the supervisee, as well as any support needs. Ensuring that this supervision continues (and increases in regularity as necessary) even in the context of remote work is a critical staff support mechanism. To facilitate this supervision, supervisors should adapt regular supervisory tools to meet the needs of new modalities of service delivery, such as the survivor centered attitude scale, case management knowledge assessment, and/or case management quality checklist.[21]

Supervisors should support group-based staff supervision sessions (e.g. through WhatsApp, MS Teams or Zoom). While group staff sessions are not necessary to hold weekly, they can be an important strategy for maintaining staff cohesion and mutual support. Group sessions also have the potential to facilitate peer-to-peer exchange. During group sessions, GBV caseworkers and/or hotline staff can be encouraged to share coping strategies and collectively support one another in managing the challenges of remote service delivery.

Organization and supervisors should identify and utilize tools that allow for on-going capacity building of staff. In the absence of face-to-face training and coaching, there are several capacity-building tools that organizations can consider. In contexts where staff have sufficient internet connection these training sessions can be provided over Zoom and similar platforms. If staff have internet connectivity and have been provided with data bundles to download materials; e-learning courses (such as the Introduction to Caring for Child Survivors course modules), podcasts and videos (including the GBVIMS podcast and video series) and short audio voice messages from

[21] These tools are available in the Interagency Gender-Based Violence Case Management Guidelines http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

Supervisors can be used to share key points and provide technical support that staff members can access at their own pace.

Supervisors must monitor and support self-care of staff, described further below. As noted within this guidance, providing case management and psychosocial support over the phone during a pandemic/epidemic, where survivors have few options and access to care, can be particularly challenging. GBV response staff can feel powerless to offer support to GBV survivors, which in turn can be very distressing. Establishing boundaries for staff when providing case management services from home can also be particularly challenging. Survivors, especially when hotlines are in place, might call at any time of the day and night, putting pressure on caseworkers to respond. Caseworkers might find it particularly challenging to disconnect and focus on other things to support their well-being. Caseworkers may face these challenges alongside additional stressors at home, as well as general fears linked to the pandemic.

> *"Duty of care" constitutes a "non-waivable duty on the part of the organization to mitigate or otherwise address foreseeable risks that may harm or injure its personnel."*
> *- Inter-agency Minimum Standards for GBV in Emergencies Programming, 2019. Standard 3: Staff Care and Support*

Every organization will need to develop its own strategies and approaches for staff care based on resources and structure.[22] In all cases, reactions to stress should be understood as normal, yet unique to every individual. It is important for organizations, managers, supervisors and caseworkers to recognize that stress may manifest in different ways for different people. Organizations must build up a variety of processes that facilitate staff care, such as those that help staff prioritize well-being, including nutrition, sleep, exercise, taking rest breaks, connecting with loved ones and building other support networks.

Supervision, discussed above, is a mechanism for staff care. The staff-supervisor relationship is a critical one for supporting staff well-being, such as through regular supportive communication to discuss experience and stressors, offer assistance with coping and boundaries, encourage staff to actively reach out for support and connect them to additional psychosocial supports available. Supervisors can also model self-care to their teams.

Self-care refers to the individual and peer group strategies we engage in to ensure our own well-being. It is something personal to each service provider and should be supported by supervisors and organizations. Supervisors can encourage staff to develop a self-care plan which outlines their daily and/or weekly self-care activities they will participate in, following the A,B,Cs:

- Become AWARE (and reflect) on what's getting to you and how those issuesare affecting you,

[22] Interagency Gender-Based Violence Case Management Guidelines, p.163.

- Seek BALANCE among work, rest, and play; time alone and time with others;giving and receiving,
- CONNECT with people (friends, family, co-workers) you trust, respect and care about.

Prior to shifting service delivery from phone-based case management or hotlines supervisors should discuss with GBV response staff how they will maintain boundaries when working from home. Supervisors need to assess:

- ✓ Are caseworkers and psychosocial staff comfortable providing case management and psychosocial services over the phone from their homes?
- ✓ What are the caseworker's living situation and caring responsibilities? What are their needs in terms of flexible working and reduced working hours to facilitate care?
- ✓ Do caseworkers and psychosocial staff have a separate confidential space in their homes to provide services where they will not be interrupted?
- ✓ How will caseworkers manage the call-back and other policies related to making and receiving calls?
- ✓ What resources do caseworkers have to support their wellbeing, including social/fun check-inactivities with the team to promote well-being?
- ✓ What can be done to foster collective care amongst team members.[23]

Additional examples of actions supervisors (and organizations) can take include:

- ✓ Managing workload and working hours, including ensuring supervisor oversight of workload and adjusting it as needed to ensure staff are not overloaded and do not exceed limits on contact hours. If a caseworker is supporting a number of clients with particularly complex needs, this may include discussing with them whether additional supports or a rebalancing of some of their caseload to other response staff might be helpful.
- ✓ Ensuring all hotline shift rosters include time for breaks, meals, administrative work, wrap up time and handover at the end of the shift.
- ✓ Keeping a regular supervisory schedule for check-in with staff to ensure their well-being.
- ✓ Using staff care tools to facilitate discussions about well-being with caseworkers and hotline staff, such as the Self-Care Inventory available in the IASC GBV Case Management Guidelines training material[24]. Supervisors can encourage staff to create self-care plans, which staff can keep confidential, or share with other staff (or supervisors) if they choose, as a way for colleagues to support each other in meeting their self-care goals.

[23] For further information relating to collective care see Creighton, J. (2024). Tipsheet: Collective Care. https://www.sddirect.org.uk/sites/default/files/2024-02/GBV%20AoR%20HD%2024%20-%20Collective%20Care%20Tip%20Sheet.pdf

[24] See Handout 19.4. Self-Care Inventory. Part of the Inter-Agency GBV Case Management Guidelines Training Materials. Originator source: Headington Institute. https://www.gbvims.com/gbv-case-management-guidelines/gbv-case-management-training-materials/

- ✓ Ensuring caseworkers understand they have the 'right to withdraw' if they feel uncomfortable with a client.[25]
- ✓ Discussing with case management and hotline teams whether it would be supportive to set up other systems for caseworkers to share self-care tips and resources. Clear boundaries should be established for and by any groups set up regarding the purpose of the group, what information to share and not to share (e.g. groups may decide not to share news articles, potentially distressing information or work-related tasks) and times for the group to be used or 'quiet times' when the group should not be used.
- ✓ Remote-offered Skill-building Application (ROSA) is an 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. The application can support caseworker 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.
- ✓ Consider / share with caseworkers other relevant e-learning courses such as the Caring for Child Survivors online modules to help support consistent practice and professional development.

Box 2. Specific considerations for hotline staff care

- It is recommended that hotline shifts be limited to 4 hours maximum, with staff completing no more than one shift in any 24-hour period. The total number of shifts per week should be determined based on what is practical and workable for all team members. Two staff should be on duty at any one time.
- If case managers with a current caseload are shifted to hotline services, but retain some of their case management responsibilities, careful consideration should be made about a reasonable number of clients/hours across both services.
- Supervisors should manage expectations related to potential low calling rates, especially if the hotline is new.
- Teams may want to consider establishing a buddy system where each staff member starts their shift with a handover with a staff member who is finishing after the previous shift. This would include checking in on
- any particularly challenging calls, ongoing actions or things the new staff member should be aware of or prepared for when starting the shift. This can also be an opportunity to check on the wellbeing of the staff member finishing the shift.

[25] A "Right to Withdraw" policy provides staff the permission and support to make decisions based on their own safety and wellbeing without cause for retaliatory practices. This should be written in organizational policy.

4. Setting up and operationalizing crisis counseling for GBV survivors via hotlines

A crisis hotline is an established phone service, usually toll-free, that provides crisis support and information to anyone who calls. It is open to the general public and sometimes, but not always, for extended hours, even around the clock. Hotlines can be developed to meet the urgent needs of specific population groups (e.g. children, people with disabilities, people living with HIV) or related to specific issues (e.g. suicidality, intimate partner violence, sexual assault, sharing tips with police, etc.).

During a pandemic/ epidemic, especially when movement restrictions prevent GBV survivors and those at risk from accessing in-person services, a crisis hotline with trained GBV staff may be a life-saving entry point for care and support. This is especially true when remote GBV case management services are not directly accepting new clients, due to challenges such as making public or otherwise sharing telephone numbers of remote caseworkers.

Depending on the setting and resources available, a specific GBV crisis hotline service can be developed, or GBV crisis services may be added to an already existing hotline. Planning should take into account the potential challenges of setting up a new hotline, especially if the hotline is initiated in order to replace or supplement remote case management in the context of a disease outbreak or other similar types of crises. Often it will be more challenging to establish a hotline than shift from in-person to phone-based case management.

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The scope of the services may vary somewhat from hotline to hotline, but **in general a GBV hotline will listen to callers and provide immediate psychological first aid (PFA)and crisis support; conduct safety planning and crisis management as is necessary; share information about available services for further support; and provide referrals to these services. Hotlines do not typically provide on-going care, support or case management to callers**, and it may not always be possible for a caller to speak to the same hotline operator if they call more than once. Even so, callers can certainly contact a hotline multiple times, whenever they are in crisis and/or need information about a potential referral.

Given the limited scope of services, GBV hotlines should never replace GBV case management. However, they can be an important supplemental service. There are several advantages to hotline services to address GBV. Some of these are:

- **Anonymity:** Hotlines can provide an anonymous way of first reporting GBV incidents and seeking immediate support. For some survivors it may feel safer to call a telephone hotline than to visit a service provider in person for the first time (if the providers are even available during the pandemic/ epidemic).
- **Accessibility:** Ideally, hotlines operate under a toll-free number, which can make the hotline more accessible to survivors who may not be able to afford transport to access in-person services.
- **Availability:** A hotline is often available beyond normal working hours. This can be especially important for survivors who are facing an emergency.
- **Confidentiality:** A hotline typically has built-in features and protocols that assure confidentiality when speaking with the caller.
- **Fast referrals:** Since hotlines are often focused on being able to provide a wide variety of referrals, a GBV hotline operator should have an up-to-date list of services and be able to expedite urgent assistance.

When designing and implementing hotline services for GBV, many issues must be considered in order to ensure the service is safe and effective for callers, and that the service aligns with the core survivor centered principles. Moreover, even in cases where it is possible to establish a stand-alone GBV hotline or incorporate GBV service provision into an existing hotline system, this does not mean that women and girls will want or feel to safe to access the hotline. Ensuring hotlines meet the needs of affected women and girls requires communication with them about whether this is a safe option and how they would most easily access the service.[26]

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The information below outlines some of the key issues to be considered when developing a hotline service, as well operational standards and processes.

Prerequisites to Establishing GBV Hotline Services

When considering whether to establish a hotline, or when determining how it should be designed, issues related to technology, as well as to safety and privacy must be among the first to be explored. There are also other issues to be considered, particularly related to the availability of staff, as well the existence of referral services for ongoing care and support for survivors, as outlined below.

[26] GBVIMS, 2020. Case Management, GBVIMS/GBVIMS+ and the COVID-19 Pandemic. https://reliefweb.int/sites/reliefweb.int/files/resources/interagency-gbv-case-management-guidelines_final_2017_low-res.pdf

Human resources:

Hotlines are about people and service. The people who manage and provide the service are key to its success. The number of hotline operators and supervisors will depend on the size as well as the hours of the service. In all cases, operators and supervisors must be appropriately trained to deal with GBV-related calls (see below). In places where multiple languages are spoken, it will be important to have operators with a variety of language capacities. In some settings, GBV caseworkers may be shifted to hotline services if a new service is opening up as a result of the pandemic/ epidemic, or they may be expected to split their responsibilities between working as a hotline operator and providing case management to existing clients. In this case, careful consideration should be given to the feasibility of staff to manage their shifting responsibilities, not only in terms of logistics, but also to ensure staff are not at risk of being overloaded.

Basic points to assess regarding human resources include:

- How many staff will be needed to cover the hotline?
- What is the density of the population in the area of coverage, and the expectation about number of calls?
- Is a multi-lingual service required?
- Are there GBV specialists available to staff the hotline, or do the operators need to be trained in GBV concepts and GBV-related standard procedures?
- Are there experienced GBV or Child Protection specialists available to staff the hotline for child/ adolescent survivors? Or do the operators need to be trained on the Caring for Child Survivors of Sexual Abuse guidelines, and assessed in relation to child-friendly attitudes?
- What management capacity is needed to oversee the hotline?[27]

Strong referral pathway and information resources:

Hotline operators must be equipped with a strong and up-to-date referral pathway, to be able to provide relevant information and conduct referrals quickly and efficiently while on a call (see Section 2). This requires that operators have available a written reference list of organizations and services that is regularly updated. Preparing this list requires mapping GBV services — not only for their availability, but also for quality.[28] Hotlines are also an important information resource for callers and therefore operators must have up-to-date and accurate information on GBV risk mitigation, prevention and response generally.

Basic points to assess regarding referrals:

- Are services available in the entire geographic area covered by the hotline?
- Is there an existing referral pathway(s) in the entire geographic area covered by the hotline?

[27] Large hotlines typically have a hotline coordinator, a trainer or training partner, and one supervisor for every ten hotline operators. Smaller hotlines usually have four or five caseworkers who also operate the hotline, and a supervisor whose role also encompasses that of a hotline coordinator and a trainer. See Kate Stratten and Robert Ainslie (2003) Setting Up a Hotline/Helpline: Field Guide; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; accessed on June 2020 through: https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

[28] Child protection services, and child-friendly GBV services should also be mapped for the referral pathway to support cases of child sexual abuse

- Does it need to be updated, especially in the context of the pandemic/ epidemic? Does it include quality of care information?
- Does it include services for child survivors?
- If the hotline is covering large geographic areas, how will updated information be accessed?
- Are limitations in referrals clear to the operators, so that those limitations can be shared with callers?

Operationalizing Hotline Services

In addition to assessing the key issues related to hotline functioning as described above, there are operational considerations that will be important to take into account when designing a hotline. As part of the design stage, it is recommended to hold several planning workshops that include managers, proposed hotline staff, IT staff (if needed), and applicable referral pathway partners. Consultations should also be held with women and girls in the community to address design and implementation questions.

Key operational issues to address as part of planning include:

- ✓ **Determine whether the hotline will accept calls directly from children** or is only for use by adults
- ✓ If the hotline is going to be accepting calls from children **determine the procedure for working with children** which aligns to guiding principles and best practice guidelines. E.g. the Caring for Child Survivors Guidelines
- ✓ **Determine procedures for managing devices staff will use.** How will they be charged? Where will they be stored at night? What apps are not allowed? What happens if one is lost/stolen?
- ✓ **Identify budget allocations** for hardware, phone credit, and operating a free line or reimbursing callers.
- ✓ **Determine hours of operation for the hotline.** Is 24 hours feasible, especially if hotline operators and supervisors must work from home?
    - Are there other emergency hotlines in the area to which calls can be diverted at night? If not, will the hotline use a voice answering machine during off hours? What would be the protocol for returning a call received through the answering machine?
- ✓ **Develop standards of privacy and safety for the hotline operators.**If staff are working from home, ensure they have a separate and private space to take calls. Develop a strategy for how this will be assessed by management. If staff are working from an office space, ensure distancing is maintained and protective equipment is provided to support safe safety and well-being during, to and from work in the context of COVID-19.
- ✓ **Determine time per shift and hours per week of staff.** Taking into account the needs and capacities in the setting, determine the maximum time per shift for hotline operators (recommended not to exceed four hours if staff are working from home), and the maximum number of shifts per week to ensure they do not get burnt out, especially if they are working from home.

- ✓ **Plan for delivery of supervision.** Identify how many supervisors will be needed so that hotline operators can not only call on them for emergencies but also have regular supervision to manage any issues related to the service. What technology (i.e. additional phone lines) will be required for hotline operators to maintain a call with a client while also calling a supervisor, if necessary?
- ✓ **Advertise the hotline.** Consult with women and girls to determine the best and safest way to advertise the hotline. How can the hotline be promoted in a way that is non-stigmatizing and promotes help-seeking?How will it be ensured that the information about the availability of the hotline reaches the most marginalized women and girls?
- ✓ **Update referral pathways and processes.** Make sure hotline operators are able to refer callers to appropriate services. This should include services for child/ adolescent survivors. Make sure referral partners understand how to share information about the hotline. (See Section 2.)

Developing Standard Operating Procedures

After questions regarding operationalizing the hotline have been addressed in a collaborative way with all relevant stakeholders, the hotline manager(s) should draw up an implementation plan that is shared with staff and any other relevant partners. Implementation plans should outline core activities and responsibilities of different staff; an overview of the hotline coverage schedule; outreach and information dissemination plans for staff and partners; training plans for staff and partners; and an overview of supervision processes and schedules.

An important part of the implementation plan will be to develop Standard Operating Procedures (SOPs), also referred to as service protocols. This guidance is critical to ensuring that operators and supervisors adhere to standards for safe and ethical operation of the hotline. Although it may take sometime to develop these protocols, a hotline should not attempt to function without them.

For hotline operators, Standard Operating Procedures should include policies and guidance on GBV and CCS principles; background information on GBV issues; call-answering procedures; how to respond to frequently asked questions; etc. Procedures should also address management and hotline administrative issues. This guidance can be compiled into a resource folder for staff. The key point to remember when compiling the information is how staff can access it quickly when they are on a call, in case they need prompts for how to deal with specific issues. It also means putting the information together in a way that it can be added to, as more guidance is developed in order to respond to the specific needs that emerge in the context. This might mean ensuring all staff have a large ring binder with tabs indicating different information that should be with them when they respond to all calls and that can be updated regularly.

Call-answering Protocols. Written guidance should include call-answering protocols that address the following (referring to and contextualizing the guidance in this document, as well as in other resources identified in Section 7):

- How to start a call (e.g. introductory statements, key messages that should be shared from the beginning of the call);
- Confidentiality, not only in terms of the communicating standards of confidentiality at the beginning of the call (and exceptions to confidentiality – including mandatory reporting), but also outlining what the responsibilities are of the hotline operators for ensuring confidentiality;
- Information that should and should not be collected by the hotline operator from a caller in a tracking sheet);
- How to ensure survivor safety during the call, to the extent possible (see Box 3);
- How to obtain verbal informed consent over the phone, or informed assent when working with a child survivor;
- Statements to reassure clients that violence is not their fault;
- How to conduct a safety plan;
- How to respond to callers who are children or adolescents, or non-offending caregivers of child survivors of sexual abuse; and a reminder that the best interests of the child principle applies when responding
- How to deal with calls that are cut short, including policies for call-back;
- What to do with clients who call back repeatedly;
- 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;
- When staff should immediately engage a supervisor for support and/or when they should engage security or the police;
- How the calls should be closed (e.g. what information and key messages should be shared when a call is ending).

General Reference Material. Written guidance should also include information that operators may need to reference throughout the call for the purposes of information-sharing with callers. Some of this guidance may take the form of 'frequently asked questions' tip sheets. Examples of reference materials include:[29]

- Types of GBV, including child sexual abuse;
- Common reactions a survivor may have to different types of GBV, the dynamics of intimate partner violence (IPV), the continuum of violence against women and girls (VAWG) across the life-course etc.
- Particular issues related to caring for child survivors;[30]
- Health factsheets (e.g. addressing emergency contraception, post-exposure prophylaxis, etc.);
- Explanation of mandatory reporting requirements;
- Basic legal statutes and processes related to rights in accessing justice;

[29] Many of the topics above are covered in the Interagency GBV Case Management Guidelines http://www.gbvims.com/gbv-case-management-guidelines/.

[30] Refer to the CCS Guidelines for details. https://www.unicef.org/media/155226/file/CCS%20Guidelines%20Final%20.pdf

- Suicide prevention plan;
- How friends and family can support survivors;
- Basic information related to the specific pandemic/ epidemic.

Box 3. Addressing safety issues arising during calls

If a caller expresses concern that she may be interrupted during the call by the perpetrator, the hotline operator can advise the caller to use a signal that they need to stop talking about violence and assume a different role/narrative, and then promptly end the call. For example, the hotline operator could tell a survivor 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.

Another useful strategy for survivors calling a hotline—one that works when someone is likely to be calling back to the hotline when urgent assistance is needed—is working with the survivor to activate an alert chain. In this approach, a survivor can dial the phone number for the hotline and make a request for assistance through disclosure or a code word – which in turn signals to the hotline operator that emergency assistance is needed. For example, a survivor could call and pretend to order a pizza (or something else relevant to the setting), and then provide the delivery address, which may signal the survivor's request for police intervention. This approach is not only relevant to hotlines; it can also be used by GBV caseworkers when a client is living in an active abuse situation.

However, we should not make calls to third parties on behalf of women using the hotline (outside of referrals), unless it has been explicitly agreed with the caller. This is to protect the safety of women using the hotline. Should a caller require emergency services, it is preferable that she make the call herself. In a situation where a woman feels unable to call the emergency service and requests a hotline operator do this for her, it may be important to stay on the line with the woman until the emergency service arrives. Especially in settings where police response is not survivor centered, it may be useful to identify another intervention to support the safety of the survivor, such as calling on trained bystanders to disrupt an escalation in violence.

For child survivors, if calls from children are accepted by the hotline, safety must be a paramount concern and call-handlers must advise child callers to hang up the line rather than continue to speak if the sound of an adult or another child, (other than a non-offending caregiver who is supporting access to the service in full knowledge) is heard in the background or a child mentions that another person is present. Prior to hanging up you can reassure the child they have not done anything wrong and they are welcome to call you back when they have privacy.

Referrals to Providers. Another key element to Standard Operating Procedures for hotline operators relates to referrals for services. It is important that hotline staff have a document accessible that outlines existing referral pathways including all service providers identified in

locations that arecovered by the hotline services. These should align with the multi-sectoral approach, and include, as possible, reference to healthcare, psychosocial support (including shelters and livelihoods), police desks, lawyers and the judiciary. Referrals should also exist for local women's organizations and networks. (See Section 2.)

Administrative Procedures. There are a number of additional issues that must be addressed in the Standard Operating Procedures that relate to administration of the hotline. These include:

- Standard expected working hours and core responsibilities for the operator. This information should detail daily schedules for operators, including break times and meals, time for taking any private calls, etc. This information should also detail responsibilities of operators for debriefing challenging issues at the end of a shift with the supervisor and/or the next shift operator, including those that may carry on to the next operator, and handover responsibilities, such as the procedures for call forwarding at the end of the shift and/or handover of sim card(s) to the next operator if multiple lines are not available. In addition to these standard procedures, supervisors will need to develop a roster schedule that is updated regularly (see Box 4).
- Expectations for staff in terms of paperwork and documentation. Staff should keep daily tracking sheets or logs identifying the number of calls, the time of each call, the age and sex of the caller, the type of violence reported, and referrals provided. Unless specifically required in order to provide a referral, operators should not take other identifying information from callers. If staff take any client information, there must be provisions to store the information safely and confidentially (e.g. on an app, or in a lockbox provided by the service delivery organization. Guidance must also be provided for how staff can store the call logs, and how to share call logs with supervisors. (See Section 4, documentation and data storage sub-section.)
- Expectations in terms of privacy in the workspace. For staff working from home, they must take calls in a private room, where no one can overhear the conversation, and they must be sure they will not be interrupted during the call. The workspace must be large enough to accommodate the reference materials they will need to access to provide the caller with information and referrals.
- Staff responsibilities regarding managing their phone(s). This will include information about how to manage and record any costs related to operating the phone, charging, storage, etc., and issues related to phone safety. For example, staff should not store any messages or other identifying information on phones or use the phone(s) for any purpose other than the hotline. Staff must also understand processes for reporting a lost phone immediately to a supervisor.
- Supervisor responsibilities in supporting staff. Supervisors must be available to operators during all hours that the hotline is open in case of an emergency, and staff must understand the specific protocols for contacting a supervisor when they are on a call with a client (i.e. using a separate phone to call the supervisor while the client stays on the hotline). In addition, supervisors should hold once-weekly supervision with each operator to review any issues, concerns, or learning needs of the operator. (Also see Section 3.)

- A list of interpreters in case staff do not speak the language of the caller, and how to connect with an interpreter for the call.
- Codes of conduct for all hotline staff, in line with global best practice.

To ensure that staff understand and accept this guidance, it is important that they are engaged in developing the guidance, and that they consent to it. For some issues, such as confidentiality, phone safety, and documentation processes, staff can sign off on documentation, either by signing a form directly, or in the case of lockdown where it is not possible to obtain signatures from staff, by giving verbal consent to a supervisor. Originals of these consent forms should be kept by management in separate staff files.

Box 4. Developing a hotline roster

A hotline roster is a schedule of hotline workers' working hours. It is usually made on a monthly basis and often takes several attempts before a workable schedule is devised. Small hotlines with one telephone line, a group of 20 volunteer operators or less, and limited operation hours will have a simple roster, where each operator works a certain number of hours per week. The larger the hotline, the more complicated the roster. For example, a hotline that has six lines, 30 full-time hotline operators, and is operational 10 hours a day requires careful planning to develop a roster.

Tips for developing a roster include:

- Record the time of day callers phone in to determine peak hours.
- Record the number of calls per day to determine the volume and the busiest days.
- Record the incident reported in order to track trends in reports.
- Know the number of hotline operators, both paid and volunteer, who are available each month.
- Know the hours of operation to schedule paid and volunteer hotline operators accordingly. (For instance, volunteers may work after hours or on weekends.)
- Based on a maximum shift of four hours, and a maximum number of five days worked per week per operator, determine the number of hours operators are to work in a month, factoring in vacation and sick leave.
- Schedule lunch and breaks so someone is always available to answer the phone.
- Decide when operators will receive ongoing training.

With this information, you can develop a roster that best matches the activity of your hotline. A well-managed roster should ensure that hotline operators do not suffer burnout or boredom and that the hotline can manage the peak periods. According to the Inter-agency Case Management Guidelines, one supervisor should oversee no more than 8 response staff. This may need to be adjusted for hotline services and according to the context.

Adapted from: Kate Stratten and Robert Ainslie (2003) Setting Up a Hotline/Helpline: Field Guide; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; accessed on June 2020 through: https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

Hotline related documentation/ data storage considerations

When GBV staff provide services (individual psychosocial support, case management and/or other services to survivors and those at risk of GBV), we often collect personal information. This may include:

- Survivor data, such as name, age, community, whether the survivor is living with a disability, etc.;
- Details of GBV incident(s), such as the type of violence, location of the incident, relationship of the survivor to the perpetrator etc.;
- Information about the resources and support provided to an individual survivor etc.

This personal information is sensitive; if it becomes known to members of the community, it will not only compromise a survivor's privacy, it may also put survivors at increased risk of retaliation, stigma, or other harm.

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Safety and confidentiality is a guiding principle of GBV work. Confidentiality is maintained through strict information-sharing practices that rest on the principles of sharing only what is absolutely necessary to those involved in the survivor's care with the survivor's permission. It is always necessary to protect written data about a survivor, or a case, through safe data collection and data storage practices.

In the context of a pandemic/ epidemic where remote support is provided through a hotline, hotline operators must take special precautions to ensure the safety of caller data, including not storing written case information in their homes or other places where they provide remote support. Hotlines will want to only collect data necessary to track general information about uptake of services, unless it is necessary to collect information in order to provide referrals.

The information below describes some of the key considerations for adhering to safe and ethical documentation and data storage when undertaking remote service delivery. Whether or not hotline services use digital entry applications, any Standard Operating Procedures must include guidance on data collection, analysis and storage to ensure it is in line with recommendations below.

Key Considerations Related to Documentation and Data Storage for Hotlines

Most hotlines will want to keep a record of callers in order to monitor and analyze trends in hotline uptake. Even so, in hotline provision it is not good practice to record identifying information; the service operates as a crisis support whereby such information is not required in order to offer the service. Instead, hotline staff should note only anonymized call details, such as the date and time of the call; the length of the call; the types of incident being reported/reason for request for assistance; and any referrals offered.

Hotline providers should not collect identifying information about callers, unless absolutely necessary in order to make a referral to services. For operators working from home, this information should be destroyed at the end of the call, or as soon as the referral is made. If this information cannot be safely destroyed, then it should be kept in a lockbox provided by the service agency untilit can be destroyed.

The only exception to this would be in contexts where hotlines are able to use the GBVIMS, or the Primero/GBVIMS+ (see Section 5, phone-based case management section of this guidance and the specific subsection relating to data and documentation for further information). If the GBVIMS or Primero/GBVIMS+ has already been rolled out and is being used as an inter-agency GBV data collection and management tool, then it may be possible to use the digital tool for online data entry if technology allows for this. It should be noted that for hotlines, however, operators will only need to fill out certain fields for the digital entry, and these need to be determined in advance and staff must receive sufficient training to adapt the digital tool for hotline use.

Information Sharing in the Context of Supervision

All hotline workers should be trained on how to adjust information- sharing with supervisors when participating in remote consults or weekly supervision meetings. Hotline staff and supervisors should be clear that when discussing cases via phone or in messages, survivor identifying information should not be shared, and supervisors must reinforce this practice whenever speaking with supervisees. Supervisors must also discuss with hotline staff the fact that safety and confidentiality protocols extend to any staff peer support spaces (e.g. WhatsApp groups, group calls) that are established during this time.

Supervisors can regularly share feedback on trends noted in call log summaries with the hotline operators. Supervisors should use software-flagging functions, one-on-one discussions, and group calls to discuss such feedback.

Training Hotline Staff

In order for hotline staff to be able to provide safe, ethical, appropriate and efficient support to callers they must receive preliminary training before they begin their job, as well as ongoing training to continuously refine their skills. As a minimum requirement to work on a GBV hotline, prospective operators should illustrate basic competencies such as interpersonal engagement, empathy, respect for the rights and needs of survivors, child-friendly attitudes etc., as well as reliability and responsibility. Skills building should be provided to all staff — even those with experience — that includes sessions on basic issues and concepts, as well as specific training on operating a hotline and responding to a call. Training should cover a review of all of the Standard Operating Procedures noted above. They should also include basic concepts, as well as opportunities for staff to engage in

roleplay so that they can practice, in real time, how to engage with a caller. Roleplays should offer the opportunity for the operator to respond to a variety of challenges.[31]

Training plans should be drawn up as part of the implementation plan for the hotline. During a pandemic this plan should include strategies for remote delivery of training and should accommodate the fact that online training must be offered in shorter intervals than in-person training(with two hours per training session as the rule of thumb).

[31] One method for ensuring operators have the opportunity for roleplay is the hotline supervisor calling an operator acting as a survivor seeking support on the hotline. Supervisors should disclose that it is a test call, and present different case scenarios so that hotline support workers can practice responding to a range of issues and potential survivors. All test calls should be followed by a feedback session to support the hotline operator to note good practices and what might be done differently in future calls, and whereby the supervisor can offer support and mentoring to the staff member.

Basic GBV knowledge and skills training may include:

- ✓ **Core Humanitarian Principles**
  - Do No harm
  - Participation and Empowerment
  - Meaningful Access
  - Accountability at all levels
  - Rights-based Approach

- ✓ **Guiding principles in work with survivors**
  - Safety
  - Confidentiality
  - Respect
  - Non-Discrimination
  - Informed consent/ assent
  - Best interests of the child survivor of sexual abuse
  - Perpetrator Accountability (e.g., ensuring that the survivor understands that the violence is not her fault, it is the responsibility of the perpetrator)

- **Basic concepts related to GBV**
  - Types of GBV, including intimate partner violence, child sexual abuse and the linkages between the two
  - Root causes of GBV
  - Contributing factors
  - Impact on individuals, familiesand communities
  - Why survivors do not seek help
  - The multi-sectoral approach tosurvivor care and support
  - Intersectionality

- ✓ **General Data Safety Standards**
  - Ethical and safety recommendations for documenting GBV (See section 4 documentation and data storage sub-section)

Training on hotlines as a service delivery modality may include:

- ✓ Introduction to hotlines as an entry point for services and how they work;
- ✓ Operation of the hotline and basic service delivery protocols;
- ✓ How providing support via hotline is different than in person, and what basic adaptations need to be made;
- ✓ Essential phone manners;
- ✓ Basic use and management of resource guides and referral pathways;
- ✓ Data responsibilities linked to hotlines;
- ✓ Meeting the needs of diverse callers, including friends and family who may call as co-survivors, and/or non-offending caregivers of child survivors, as well as those who are calling for reasons outside of the hotline focus.

Specific training to support GBV response may include:

- ✓ Basics of GBV case management;
- ✓ Overview of crisis support for GBV;

- ✓ Hotline listening skills – active listening and listening for changes in tone without body language; use of silence; building trust and rapport on hotline;
- ✓ Survivor crisis support intervention - psychological first aid, immediate safety and facilitating accessing to urgent health care and services;
- ✓ Standard call-handling protocols;
- ✓ Managing a call with a child survivor, and/or their non-offending caregiver;
- ✓ Safety planning;
- ✓ Understanding informed consent, referral pathways and facilitating referrals, including for child survivors;
- ✓ Awareness of own biases, including personal attitudes around marginalized groups of survivors;
- ✓ GBV data management for crisis support hotlines;
- ✓ Personal boundaries in hotline crisis management support;
- ✓ Protocols for managing suicidal callers;
- ✓ Protocols for other challenging calls (see below);
- ✓ Working with translators (if translation facilities are incorporated into the hotline service).

General Guidance for Responding to a Call

The basic elements of a call-answering protocol include:

1	Answering the call according to a standardized script;
2	Outlining and explaining the standards and limits to confidentiality;
3	Collecting intake information, including understanding what the caller's key concerns are;
4	Providing emotional and psychosocial support;
5	Providing accurate information about the issues affecting the caller;
6	Identifying referral needs, soliciting informed consent and referring callers to resources;
7	Ending the call in a supportive manner;
8	Completing paperwork as required.

As relatively straightforward as the process may seem, there are many important elements to ensuring the caller is assisted in a safe, supportive and ethical way. Some tips related to assisting the survivor are outlined below.

Techniques for Answering a Call

Dos for Answering Calls

- Let the phone ring a couple of times before you answer it. This will give the survivor time to relax. Remember that this may be the first time they have contacted the hotline or disclosed the abuse to another person, and they may be feeling very anxious.
- Have an opening statement to help put the survivor at ease e.g. *"Hello, this is [name of person or name of hotline, whatever is most appropriate], how can I help you?"*
- If the survivor offers their name use it during the call to help build trust.
- You may wish to tell the survivor your first name if they are very anxious or a child survivor.
- Assure the survivor that the hotline is confidential, if this is appropriate, but ensure to explain any associated risks.
- Find out where the survivor is calling from and establish that the survivor can talk without anyone listening to her conversation. Ask her whether she is alone. If the survivor indicates they are with someone ask, *"Is it safe to talk right now?"* This allows the survivor to answer yes/no and not give away the conversation to the abuser or anyone else listening.
- If you cannot hear or understand the survivor, do not be afraid to say so in a gentle fashion. It is worse for the survivor if she later thinks you did not pay attention to what she said, and it leaves her feeling ignored.
- Use plenty of pauses to give the survivor space to talk. Remember that it may be the first time that they have had an opportunity to speak about the abuse, or they may not be used to seeking support on the phone.
- Use active listening skills, making acknowledging sounds when the survivor speaks.
- If you are giving specific information to the survivor related to how to access services etc. ensure that they have a pen and paper if necessary, and check that it is safe for her to write information down. Be aware of potential literacy issues when giving out information. If you are unsure of information, then tell the survivor you need to check the information and can call them back (if safe to do so) or they can call you back.
- Where appropriate, provide grounding and relaxation techniques.
- Be aware of the services and agencies you can refer a survivor to and be realistic about what they might be able to do for her.
- Be aware of personal boundaries and holding them.

Don'ts for Answering Calls

- Do not ask for the survivor's name unless you need it for referral.
- Do not talk too much, a lot of the work on a hotline is listening.

- Never give out referral or any other type of information you are not certain of.
- Do not overload the survivor with too much information. If they are upset during the call it may be more appropriate to focus on listening, rather than giving information.
- Do not share your personal contact information. Never give out or take calls from survivors on your personal phone.

Techniques for Ending a Call

When the phone call comes to an end, ask the caller if she has any other questions. Be sure that you have covered the following:

- Established safety for the survivor;
- Provided support;
- Given requested information and made referrals;
- Reviewed safety plan;
- Reminded survivors to delete the call record from their phone and any messages (if messages are used);
- Ensured that the caller knows how to access services again if he/she needs or wants to;
- Thank the caller for calling and encourage the caller to call back again if necessary.
    - *"I am so glad you called."*
    - *"I know it took a lot of courage for you to call tonight."*
    - *"Remember this is not your fault."*
    - *"Please call back if you need to."*
    - *"Be careful. Stay safe."*

Remember, NON-VERBAL COMMUNICATION IS DIFFERENT on the phone.

Because the hotline operator and caller cannot see each other, some types of non-verbal communication important in face-to-face conversation or case management are less important in telephone conversations (i.e., body posture, eye contact, facial expressions).

Other types of non-verbal communication are more important. For example, the hotline operator's voice and speaking patterns are of utmost importance during the telephone conversation. This includes the tone of the voice, breathing patterns, pauses, pace of speaking and hesitation.

The hotline operator also needs to rely on the tone of voice of the caller, and other clues like how long the person is pausing, because it is not possible to see their facial expressions or body position. When the caller's tone or cadence changes, the operator might ask something like, *"Is it okay for us to continue.?"* Or *"Is this still a good time to talk?"* The caller's safety is crucial, so at any point during the phone conversation check in with the caller to ensure they are still able to talk. If you are asking a question, remind the caller that they are free to skip

any question. This helps with building trust and ensuring that there is no breach in ethics. (Also see information below about silent callers.)

Responsibilities After a Call

- All calls must be recorded on a tracking sheet or call log with only basic non-identifying information for the purposes of tracking the total number and type of calls;
- Finalize the tracking sheet or call log according to safety and ethical guidelines and share forward with the supervisor;
- Contact the supervisor to debrief after particularly challenging or difficult calls;
- Debrief any particularly challenging calls in the handover in the event the caller calls back during the next hotline operator's shift.

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Communication strategies for supporting a survivor:

- ✓ Let the survivor know they are not alone in their experience.
- ✓ Help the survivor focus on positives, e.g. the fact they made the call etc.
- ✓ Praise and validate the steps they have taken already to manage the situation.
- ✓ Use words of encouragement and affirmation.
- ✓ Use healing statements such as *"I am happy you called. This is* not your *fault. It is normal to feel the way you do." "I'm here to listen."* This can help reassure the survivor, including child survivors, that they are not at fault for what has happened to them.
- ✓ Reflect back over matters discussed at each step of the call.
- ✓ Bring the survivor back to original issue they called about if the call is losing focus (recognizing that survivors may not immediately disclose their core or primary concern, so always listing for the most pressing concerns).
- ✓ Be honest with a survivor about the reality of their situation and the availability of assistance.
- ✓ Avoid any impulse to provide advice to a survivor.
- ✓ Bring the survivor back to present after the call. Perhaps saying*"How are you now?"*
- ✓ Suggest survivor does something nice or kind for themselves afterthe call.
- ✓ Encourage the survivor to think of their needs, they have rights and deserve to be happy etc.

- ✓ If the caller is upset with how the call is going and is obviously annoyed perhaps saying something like. *"I can hear that you are frustrated/ disappointed with our service at the moment, but you know we are always here if you need to talk."*
- ✓ Empower the survivor to take small steps for themselves – when they feel there is nothing they can do to change the situation, or it all seems like so far away, it's good to give them ideas of tiny steps they can take to edge toward their goal.

When working with a child survivor, additional communication strategies include:

- ✓ Adjust communication based on age and development to be simple, clear and reflect the understanding of the child. Sense-check children understand what you've said by asking them to repeat information back to you in their own words.
- ✓ Ensure there is plenty of time in the discussion for children to ask questions
- ✓ Give children the choice to have a trusted adult (e.g. non-offending caregiver) with them
- ✓ Support the non-offending caregiver; their emotional state will impact the child's emotional state and ability to communicate

Managing Particularly Challenging Hotline Calls

Every hotline call will be unique. For this reason, it is important that hotline operators and supervisors have the skills and personal capacity to be creative and quick-thinking. It is also important that hotline providers have written strategies for managing particularly challenging calls — and that all hotline operators and their supervisors are trained in and comfortable using these strategies.

For information about how to address safety issues for a caller at immediate risk of perpetrator violence, or who is indicating feelings of suicidality, this is covered below. Key points related to managing other types of challenging calls are also included below.

Missed Calls /Disrupted Calls

If a hotline operator received a missed call (e.g. while on another call, or if the hotline has an answering machine), or if a call is disrupted, the hotline operator must determine whether or not to call back. This determination must be based on hotline policy. In settings where connectivity issues mean that calls are likely to be disrupted often, or where survivors have to pay for the calls and are therefore likely to run out of credit, benefits to calling back must be weighed against risks. If it is a policy of the hotline to call back in specific instances, it must be explained at the beginningof every call, and procedures for confirming that it is safe to talk (e.g. through a code word) must be agreed upon with the caller.

Distressed Caller

Sometimes hotlines can receive calls from people who are very distressed, and this can be challenging for the hotline operators. A distressed caller may be very upset, audibly crying and sounding panicked, or may sound confused, incoherent and hard to understand. First, ensure that

the survivor is safe. After this is assured, a few key things for hotline operators to remember when dealing with a distressed caller include:

- Do not panic – you have got this.
- Take deep breaths, be aware of your breath and ground yourself, feet on the floor.
- Slow things down for the caller and yourself – *"I can hear how upsetting this is for you/ how upset you are, take your time…"; "I am here to support you."*
- Be aware of the caller's breathing – notice if the caller's breathing is short and panicked, if so, note this and support them to take a few deep breaths, e.g. *"I can hear how upset you are right now, let's take a few breaths and then we can continue"* guide them in taking a few deep slow breaths.
- Use active listening, allowing the person to pour out their emotion and respond using simple verbal cues such as *"Uhuum", "I see", "Mhmmm"* to allow the caller to know that you are listening.
- Tell the caller that you can hear how upset they are, and that you understand this – this can validate their feelings.
- Do not ask too many questions, as this may feel challenging for a person in distress and may worsen their distress.
- When things have calmed a little, try to establish the cause of the distress e.g. *"I can hear how upset you are, tell me what has happened/why you called the hotline?"*

Angry Caller

Angry callers can be particularly difficult to manage, but with practice, it is possible to be supportive to even the most aggressive callers. Staying calm when faced with anger is very important, as most callers will calm down if the hotline operator is calm and when they feel listened to and validated. Remember that many survivors cannot take their anger and frustration out on their abusers. Sometimes this results in them taking it out on others instead. A few key things for hotline operators to remember in this situation include:

- Listen to them and try to establish what it is that they feel angry about. Remember their anger is not directed at you or caused by you. It is likely because of their situation and experiences. Let them have their outburst of anger and listen to them using small verbal cues such as *"I see", "uhumm"* etc. to let them know you are listening.
- Acknowledge their anger through identifying statements such as *"I can hear you feel angry about…", "I can understand why you feel so angry…"*
- Help the caller to understand they can seek support for what is happening, and we can continue with the call as a support call.
- If a caller's anger does not dissipate, or is directed towards you, this makes the call difficult and you should end the call as soon as possible. Remember that you should not be exposed to abuse or anger from any caller, even if the caller is a survivor of violence.

Silent Calls

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Silent calls are where you answer the phone and sense that there is someone on the line, but they do not speak to you. Maybe you can just hear their breath or movement. Silent calls can be very valuable support calls and should be managed on the basis that it is a woman or girl calling for support. She just may not be able to find the words to speak right now.

- Managing the call is a balance between offering support and not staying on too long. It is also important to recognize that the silence may be from a perpetrator trying to track a call, so care has to be given about sharing too much information about the service. Some helpful things to say in a silent call can include;
    - *"I know it can be difficult to find words to talk about what is happening, take your time, I am here to listen to you if you want to talk to me."*
    - *"I know that it can be difficult to find words to talk about what is happening, just to let you know that I will not share any personal information."*
    - *"I know that it can be difficult to talk about what is happening, so if you don't feel like talking now, you can call back at any time."*
- There is a balance between a silent call being supportive and moving into a space where it no longer feels supportive. The operator will know this space as it will begin to feel uncomfortable, maybe even repetitive. You can move to gently end the call by saying something like, *"Just to remind you that we are here to listen and support you when you feel ready to talk. For now, I am going to end this call, but please know that we are here to support you anytime you need to call."* Pause in case the caller now chooses to speak, and if they don't then hang up the call. You can end the call knowing that the caller will have felt supported, listened to, and has been provided the option to call back.

Long Calls

Some support calls to a hotline can be long, but when is a call too long? There are a number of times where a call might be considered too long, including:

- When the caller starts to go around in circles and/or lose focus.
- Where the caller starts to talk about unrelated matters.
- Where the worker starts to lose concentration or focus or feels tired.

Taking steps to end a call that has become too long is important as it will become an unsupportive call if we allow it to continue without focus. We can end these calls in a respectful manner while still maintaining the service as available to the caller at another time. Some helpful phrases to end a call include:

- *"We've talked about a lot in this call, how are you feeling now?"*
- *"We've talked about a lot in this call, have I answered all of your questions?"*

- *"Perhaps you would like to take some time to think about all that we have talked about today and you can call back another time to talk a little more."*
- If the caller does not respond to these closing cues you can be more direct, and note; *"We have been talking for a long time now, I hope that you have found this supportive, but as the hotline is very busy I need to go now. You can call back any time if you would like further support."*
- *"I'm afraid that the hotline is very busy right now, so I'll have to let you go, you know that you can call back again if you need support."*

Calls from a Child Caller Without a Trusted Adult

A child calling a hotline without a trusted adult present requires particular care. The hotline operator must prioritize the child's immediate safety while remaining calm and reassuring so the child is listened to and does not disengage. Key things for hotline operators to remember include:

- Staying calm and using simple, clear language. Let the child know they have done the right thing by calling.
- Establishing whether the child is in immediate danger and, if so, prioritize connecting them to emergency services or a trusted adult as quickly as possible.
- Not pressurizing the child to disclose. Allow them to share what they feel comfortable sharing and avoid probing questions.
- Asking whether there is a safe adult the child trusts — a relative, teacher, or neighbour — and gently encourage the child to go to that person if so.
- Refering to the relevant child protection (CP) agency or case management service. Hotline operators should have CP referral contacts readily available.
- Being aware of mandatory reporting obligations. Depending on the local legal context, operators may be required to report disclosures of abuse involving children to the relevant authorities. Operators must be trained in the requirements of their specific setting and follow hotline policy accordingly.
- Documenting the call and escalate to a supervisor immediately following the call, in line with hotline safeguarding policy.

Calls from Adult Male Survivors

A GBV hotline primarily offers support to women and girls experiencing violence and psychosocial distress. However, the hotline will never refuse to offer support to any individual calling in distress and in need of support. When the caller is a man or boy, they should receive the same level of empathic and supportive response as all callers. If the caller discloses that they have or are experiencing violence the hotline operators should listen to them and support them to look at their options for support, similarly to any other survivor. It is a responsibility of the hotline to have a list of referral numbers for issues that a GBV hotline may not be specifically equipped to address, such as specialized MHPSS and other support for male callers, people with disabilities, violence or abuse related to sexual orientation or gender identity, etc.

Calls from a Perpetrator

At times a hotline will receive calls from perpetrators of violence. These may come in different guises. The man may pretend to be a victim of GBV seeking support, or he may directly ask for information about a woman that used the hotline service, e.g. a sister, mother, a wife who called this number. He may also be calling to challenge the service.

If you suspect a male caller is a perpetrator but he is seeking support as a victim of violence, it is important to assume that the request for support is real and to manage the call as any other support call is managed. However, if it becomes evident that the call is from a perpetrator, you should shift to managing it as you would a hoax call or an angry caller.

If the male caller is seeking information about a person who used the hotline service, it is crucial that the hotline operator maintain confidentiality in all instances. You can note that it is policy that the hotline does not discuss anyone who uses the services. You should then reiterate the purpose of the hotline and end the call.

In cases where a perpetrator has grabbed the phone from a survivor and demands to know what the call is about, the hotline operator must neither confirm nor deny they talked with or know the survivor. In this moment, the hotline operator can say the hotline is used for variety of services, including to provide information to callers about healthcare services for women and girls as well as where to access information about additional services available in the community. Staff do not need to share any information but can just repeat the same information and keep a positive and good attitude with the caller, while at the same time moving to end the call.

Hoax/Prank Calls

A hoax call is one that is intended by the caller to be a 'joke', where someone is contacting the service but is not in need of support. This can happen to hotlines where the number is toll free. It is important if you think that the call is a hoax that you remain polite and respectful towards the caller until you are sure that it is a hoax, so that it does not escalate the call into an angry or abusive call. If you are certain that the call is a hoax, you can move to end the call by noting that the hotline is for people in distress and that you are going to end the call. You can do so in confidence knowing that if you are engaged on a hoax call a woman in need of the service may not be able to get through.

If a hoax caller repeatedly calls the service, it can be a good idea to stop answering calls for a short period of time, so that they do not get their call answered, in which case they may get bored and move on. Hotlines can also flag certain numbers on internal systems, if the technology permits this and has callerID enabled, so that caseworkers can be aware that this has been a hoax number - not ban them in case survivor needs to connect, but this can be a helpful form of information to caseworkers.

Calls that do not relate to GBV

Calls to the hotline that focus on issues unrelated to GBV, such as program complaints,

Pandemic/ epidemic-related queries, etc., are not the responsibility of the hotline. In order to not hold up the line for women and girls who need assistance, it is important to end these calls quickly.

Wherever possible, information should be provided if the operator has it available, such as where to get relevant information about the disease.

Sometimes a new caller may 'test' the hotline by talking about non-abuse related issues. If you think this might be the case, some helpful questions to check if caller needs support include:

- *"What is the issue that is most important for you today?"*
- *"What did you hope to get from the call today?"*

If the caller identifies issues unrelated to GBV, then respectfully inform them that the hotline is not in a position to support them, refer them to an appropriate service if possible, and move to end the call. However, be careful not to identify that the hotline serves survivors of violence, in case the call is from a perpetrator.

- *"Unfortunately, that is not something I can support you with, I can give you the details of "XX", if you would like to contact them to see if they can support you with that issue."*

If the caller does not respond to these cues, then:

- *"I'm afraid the lines are very busy now, so I'll have to let you go."*

If the caller becomes challenging about the service:

- *"I can hear that you are upset with this response, I am sorry that I am unable to support you with this issue."*
- *"I can hear that you are upset with this response, if you are unhappy with the service, I would be happy to ask my manager to call you so that you may speak to her about this."*

Call from the media/journalists

Journalists may from time-to-time contact hotlines looking for information about GBV. A hotline should never give any comments to journalists under any circumstances. All calls should be referred to supervisors or, where they exist, to the administration line.

Safety planning via a Hotline - Supporting safety of callers in crisis

Safety planning is also a useful tool for hotline staff to have on hand in case a caller expresses concerns about immediate or future risks of exposure to violence. The safety plan is an intervention that helps survivors analyze the risks for harm in their lives and identify specific actions that may be taken to reduce those risks. Safety plans may reduce survivors' future likelihood of being harmed, but in order to be effective, each plan requires an individualized approach.

Safety planning generally focuses on the following issues:

- The survivor's perception of her own safety;
- The exact circumstances in which the survivor (and her children, if relevant) are in the most danger;
- Whether or not the survivor is at risk of life-threatening physical harm;

- Existing strategies and resources the survivor has and ways these can be deployed if safety risks escalate;
- If relevant, strategies to include the survivor's children in safety planning.

The process of developing a safety plan is particularly relevant during a pandemic/ epidemic as movement restrictions and lockdowns mean many survivors, especially survivors of intimate partner violence (IPV), are confined in their homes with their abusers. When conducting safety planning through a hotline service, safety planning can be a very important and concrete part of the process of assisting the survivor. The information below serves as a reminder of key considerations and key elements of safety planning, as well as how to contextualize safety planning to movement restrictions.

Key Considerations in Safety Planning

It is always important to remember that by creating a safety plan, we are in no way suggesting that the survivor has responsibility for managing (or having control over) when and where they experience violence. Any hotline operator working with a survivor should reiterate with the survivor that the violence is NOT her fault. Only the abuser can control when he chooses to be violent. Hotline staff should focus on safety planning in relation to the information they receive relating to the current crisis/threats the survivor (or their non-offending caregiver shares) recognizing that they may only be speaking to a survivor one time and may need to keep the safety plan basic and then try to refer a survivor with their informed assent /consent to a GBV caseworker for case management where a more detailed safety plan can be developed.

- ✓ **Safety planning can be a challenging process.** Many hotline operators may want to 'solve' the safety problems of the survivor; however, this is often not possible.
- ✓ **Safety planning is about trying to make a potentially dangerous situation less dangerous**. It is also about helping a survivor recognize her strengths and resources.
- ✓ Given the challenges associated with safety planning, **it is very important that hotline operators review safety planning processes as a regular part of supervision in order to ensure that the operator is supported on an ongoing basis to build skills in safety planning**. For high-risk cases, hotline operators should have a system for contacting supervisors while they are on the call with the client to discuss any emergency concerns. When a hotline operator is not working in the same physical space as the supervisors, protocols and procedures must be clear about how hotline operators can reach supervisors for immediate support as necessary (e.g. on a separate phone line). (See Section 3.)
- ✓ In many humanitarian contexts, and particularly during pandemics/ epidemics that limit mobility, there will be few safe and sustainable options for a woman / married adolescent girl to permanently leave an abuser. Even if they want to leave, there are many barriers to doing so. **As such, hotline operators should never assume or communicate that leaving is going to be better for the survivor.** The worker´s primary role is to focus on ways survivors can reduce their and their children´s risk of physical violence, and to help them think through what they would do in a crisis situation that required them to move.
- ✓ Safety planning is most commonly referenced in relation to risks associated with IPV. However, **safety planning can be a valuable process when addressing other forms of violence as well, including sexual violence, child marriage, violence targeted at women and girls with diverse sexual orientation and or gender**

identity, women and girls of specific ethnic, religious or other groups, and women and girls with disabilities.

- ✓ If a hotline is accepting calls from child survivors and/or the non-offending caregivers of child survivors who are in crisis, hotline operators will need to jointly develop a basic safety plan which includes referrals (with assent/consent) to case management and which accounts for the best interest of the child and any specific mandatory reporting requirements.
- ✓ Safety plans for survivors with disabilities must be highly individualized and should take into account the individual's specific disability and living situation and ways in which a perpetrator may try to exploit the survivor's disability to isolate them, prevent them from leaving or further harm them. It is important to consider how the survivor's impairment may impact execution of their safety plan, and adjust the plan as necessary, looking at what disability-specific items the person may need if they implement their safety plan, such as medication, assistive devices or equipment, or relevant documentation for health or legal support.

IMPORTANT

Remind a survivor that her role in mitigating violence is for her own safety and IN NO WAY indicates that she is responsible for any violence perpetrated against her or can directly control when her abuser becomes violent. The abuser is 100% in control and responsible for the acts of violence and abuse they perpetrate.

Basic Safety Planning

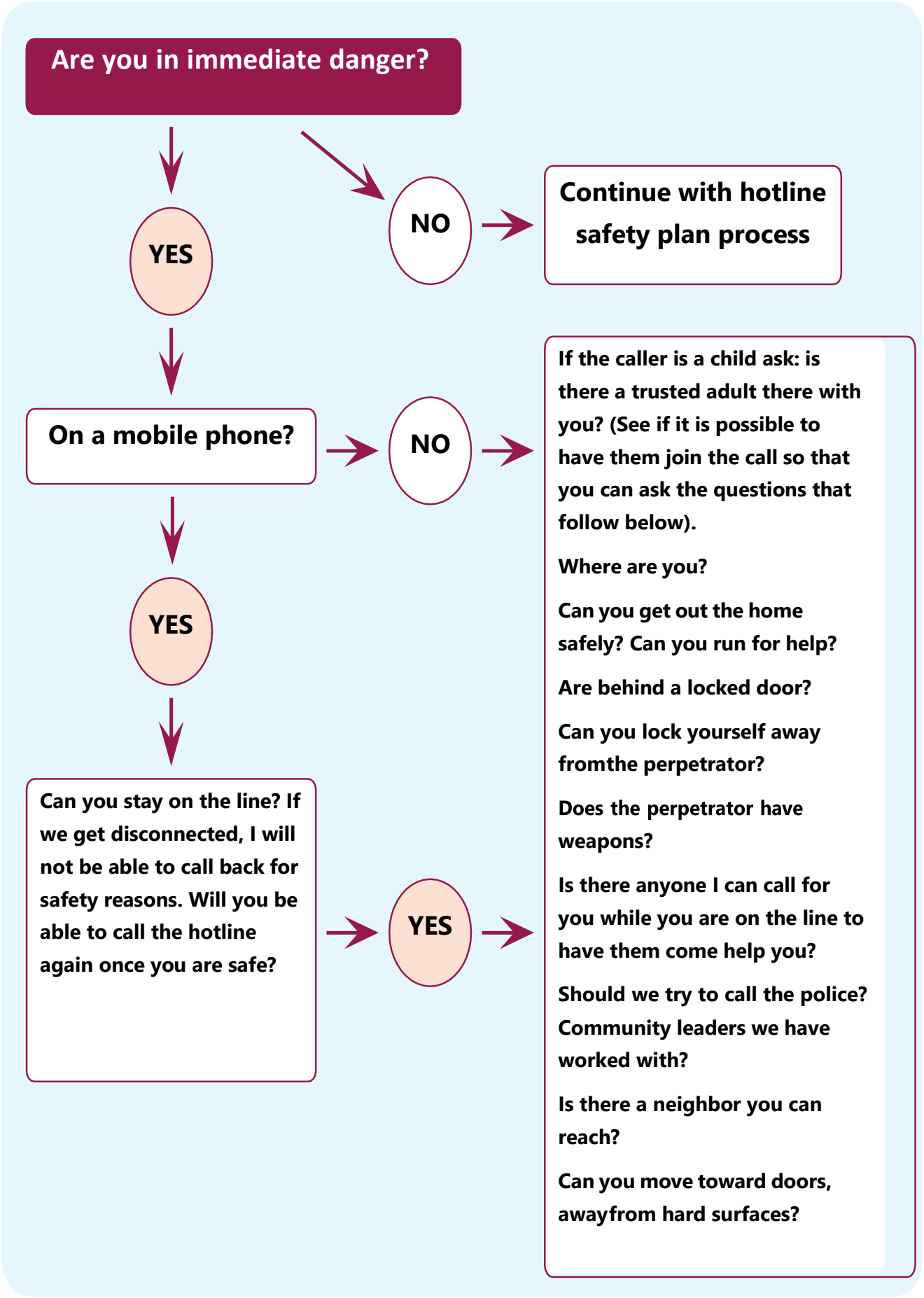
If you are a hotline operator, it can be useful to have a guide for safety planning to use as a prompt to ask about safety-related issues and to complete a basic safety planning document with the survivor.

The safety planning steps outlined further down in this section may need to be even more accelerated or abbreviated on a hotline if a caller is in immediate danger. Hotline operators may not be familiar with callers, and because callers may reach out to a hotline when they are at high risk, the hotline operator may need to prioritize essential safety planning with the caller in the limited time available on the phone, or in case the call ends abruptly. Try to note the key information about her situation as you help develop her safety plan and repeat it back to her.[32]

You may be able to follow up with further details if time permits later in the call. Figure 1 provides a flow-chart to support hotline operators in identifying callers in immediate danger and provides some prompts for questions which can potentially guide survivors to safety / reduce imminent risks.

[32] However, in all cases, it is critical to follow good practices for remote GBV documentation including how to codify and store confidential information, especially when a hotline operator is working from home. If you document anything make sure to follow the remote GBV information management guidelines.

Figure 1: Identifying callers in immediate danger.



Step 1. Remind her that she knows her situation best

Reassure the survivor that she is the expert and she is her own greatest resource. She is a survivor – — she has strength and resilience — and she is already implementing many tactics to mitigate abuse. What does she do to mitigate violence before it happens? In cases of IPV, even though the restrictions are newly imposed, she may have been living with her abuser and may have previously been confined at home with him, or by him.

Those experiences can inform her current situation.

For child survivors try to engage non-offending caregivers and also affirm this message with them.

Tips / prompts for hotline operators:

- ✓ What are the signals that suggest that the abuser is becoming aggressive?
- ✓ What is she able to do to mitigate violence before it happens?
- ✓ What does she do to dissuade / dissipate violence once it is already happening?

Step 2. Help her identify the 'Safest Room.'

In case of violence, identify an area of the home she can move to where there are no weapons (such as knives in the kitchen), and has an exit such as a door or window to get to another room or outside the home. For some survivors, especially those quarantined at home with an abuser during a pandemic/ epidemic, no room may feel safe, so we refer to it as the 'safest room'.[33] The goal is to identify the lowest risk areas with the intention of reducing harm. Help her identify rooms or spaces that have multiple entry points (i.e. windows and doors). Help her identify dangerous rooms or spaces that contain weapons or other objects that can be used as weapons. If no rooms feel safest, then at minimum help her identify rooms to avoid (again like the kitchen which has knives and large pots, or small closets with no escape, etc.). Depending on country-specific laws and context, a survivor should be legally allowed to escape from violence in the home, even during a lockdown. It is important for a hotline operator to know the rights of survivors and how restrictions affect them in crisis situations.

Tips / prompts for hotline operators:

- What rooms or spaces are open and have multiple access points (i.e. doors or windows)?
- If no rooms feel safe, then let's identify rooms to avoid. Are there weapons in your home? Do you keep knives or any other sharp tools anywhere other than the kitchen? Remind her to avoid small closets or other small spaces with no escape.
- Is there any furniture or specific things that your abuser has used in the past tocause harm?

If the hotline accepts calls from children, be aware that child survivors may lack strength or capacity to take specific actions. Children may also become fearful during the safety planning process so it is important to provide reassurance and explain that the purpose of it is to support preparation in the event of something happening, it does not mean that the situation will happen. It is optimum to

[33] Sanctuaries for Families, Safety Planning Covid-19: https://sanctuaryforfamilies.org/wp-content/uploads/2020/04/Safety-Planning-EN.pdf

include a non-abusive caregiver on the calls, when feasible and to seek informed assent/ consent for referral to case management for ongoing support.

Step 3. Help her plan with children (if applicable).

If the survivor has children, help her think through how she communicates urgency or danger with them. Some survivors prefer a 'physical code signal.' For example, a survivor opens her arms and her daughter knows this means to come running to her for safety.

Others create a 'verbal code word' with their children that means they should go to the 'safest room' in the home that has already been designated. Discuss with her whether her children are old enough and whether she feels safe sharing emergency contact names or phone numbers with her children in case of emergency. Considerations vary by context and availability, but age and ability of children should also be a factor in this decision. If the violence becomes life threatening, children may be able to call the police or alert a neighbor. Consideration should be taken on what and how to inform children noting that they may also be victim(s) of the abuser, and may accidentally inform the abuser of safe words, or safety plans.

For survivors who are completely isolated, with limited to no support, and no way to leave their homes, explore psychological wellbeing and safety through self-empowerment:

- ✓ Identify a goal or something the survivor wants to achieve or learn she can work towards;
- ✓ Invite her to create a space for herself;
- ✓ Remind her about the power of positive thinking (help her see how she is important to her family, community, and/or neighborhood);
- ✓ Help her practice self-care; remind her to be kind to herself and not be too critical about herself throughout the day, in particular when violence happens or immediately afterwards.

Step 4. Help her identify her support system (especially under new restrictions).

The level of restrictions related to pandemics/ epidemics vary country-to-country. Depending on her situation, a survivor may not be able to access her current support system and resources. Help her identify a new support system or new access points for support. In cases where the violence is getting severe, and the survivor fears for her life, she could agree that if she misses two or three calls from a friend, that the friend would then find a way to come check on her and/or send someone to her home.

Ensure she has a code word or code sign to signal a neighbor, family member, or trusted confidant in case abuse intensifies or becomes life threatening.

Ensure she knows where and when to access help through trusted GBV focal points in her community, or where to seek help from GBV staff.[34]

[34] For additional guidance for GBV specialists on low-tech ways to reach and support women and girls at risk of violence, or for women and girls to access care and support, please refer to the UNICEF guidance note on

Tips / prompts for hotline operators:

- ✓ Does she have a phone to make phone calls?
- ✓ If she has a phone but no credit, can she have people check in on her on a regular basis?
- ✓ Can she leave the house to go to the grocery store or a pharmacy?
- ✓ Who can she see?
- ✓ What services can she access while out of the house for an acceptable[35] time period?
- ✓ Does she have a code word or signalto notify a trusted neighbor or familymember in case abuse intensifies or becomes life threatening?
- ✓ What resources does she still have access to?
- ✓ Could it be a shop keeper that she sees regularly?
- ✓ Could she slip a note under the door of a neighbor in case of emergency?
- ✓ For child survivors: What can a non-offending caregiver / trusted person do to support you right now?

Step 5. Help her talk through an exit plan if she decides to leave.

Always help her outline a plan in case she decides leaving is the safest option. It is important to weigh benefits, risks and realities during a pandemic/epidemic, and **remind her** that leaving an abusive partner is often the most dangerous moment for the survivor. Ensure she has a go-bag pre-packed and hidden in the house or with a trusted confidant, ready to go for a sudden exit, as well as a plan on where to go, who to notify (if anyone), and finally a plan for her children (if she has children). **Remind her** not to leave anything in the go-bag that she may need to keep in the house, so her abuser does not suspect she is planning to leave. Remind her she should always be ready to answer any questions if the go-bag is found by her abuser. Help the survivor identify people she can stay with, and who have been supportive in the past, or somewhere the abuser will not know where to find her. Discuss the best time to leave, while the abuser is not around and preferably will not notice her missing for some time.

For child survivors under 18, who are considering leaving an abusive situation, this is usually a step which would require engagement and support from non-offending caregivers/ guardians and service providers. It may also likely involve state actors e.g. State Social Worker or Police support to facilitate the child's safe relocation and placement in alternative care. Married adolescent girls may not require the engagement of a caregiver, depending on the context, but will likely need specialized and ongoing support to enable safe relocation to new housing / shelter. Given the complexities of the situation for child and adolescent survivors it is recommended that they be referred with their assent / consent to case management to support effective case coordination and detailed assessment of options which is not feasible via a hotline.

this topic: Not Just Hotlines and Mobile Phones: Gender-based violence service provision during COVID-19, https://www.unicef.org/documents/gender-based-violence-service-provision-during-covid-19

[35] According to the perpetrator's perception which is warped. In reality and actuality women and girls should have freedom of movement, although during a pandemic/ epidemic recognizing there may be Government restrictions on movement in order to contain infection spread.

Step 6. Ask her to memorize the plan, or key components most relevant to her situation.

Writing things down can be dangerous for the survivor so talk the plan over with her so she memorizes key components. Remind her to review her plan (in her head) during moments of panic or if she is feeling helpless and alone, to help find calm, focus and a sense of empowerment. For child survivors, if it is safe for them to do so, ask them (and their non-offending caregiver, if on the call) to repeat what they picked up from the safety plan so you can check their recall and level of cognition and clarify anything that may require further explanation/ support.

RECAP

Help a survivor focus on (1) mitigating violence and identifying 'safer' areas of the home; (2) identifying support – even if more limited or restricted; 3) reaffirming the safety plan – and what to do in case she decides to leave.

Remind her she is not alone even if isolated!

Hotline-based crisis counselling for clients who self-harm or are at risk of self-harm (including suicide)

One of the most serious consequences of GBV is a survivor's risk of self-harm including suicide. It can be expected that some survivors will have feelings of wanting to die, end their life or "disappear." If a survivor is expressing such feelings, it is important that a more in-depth assessment be carried out. It can be a shock and upsetting when a survivor talks about feeling suicidal or taking actions to end their life. It is normal for a hotline operator to feel afraid or feel numb and panicked. While these are normal feelings, they should not get in the way of assisting a caller; listening and

offering support can be very helpful to callers who are distressed, feeling powerless and/or feeling like life may no longer be worth living.

The most important immediate task is to determine whether this is a feeling only, or a feeling with an intention to take action to end one's life. Some staff worry that if they ask a person whether they are having suicidal thoughts, they may encourage the person to think about suicide. There is no evidence to suggest this is true. If a survivor expresses any desire for their life to end, hotline operators should assess the current or past thoughts about suicide, the risk of the person progressing these thoughts to actions, and safety supports that can be put in place based on the following steps. However, before beginning to explore this with the client, it is important to reassure her that it is okay to have feelings of sadness or wanting to die, and that whatever she is feeling is normal. It is also critically important if a client indicates that they are considering taking action on their feelings, to immediately engage a supervisor to determine the best course of action in addressing the issues. This means having a protocol for contacting the supervisor, as well as having a separate phone to call the supervisor while remaining on the call with the client.

To begin a suicide assessment:

- Ask the caller to tell you how they are feeling.
- Be aware of your voice – the tone and language used.
- Avoid using the word 'suicide' unless the caller uses it first.
- If the client discloses that she feels like killing herself, consider asking a closed (yes/no) question:
    - *"Would you like to talk about how you feel?"*
    - *"Would you like to talk about what you are thinking about?"*
- If yes, encourage the client to tell you how she feels, and why she feels that way. Consider whether anything specific has happened today, or in the last few days to create these thoughts.
- Check whether she has felt like this before. If she has had this feeling before, explore how she dealt with the feelings before and whether she thinks this will pass or whether she might feel differently later on.
- Explore if she has more than thoughts of suicide, for example has she thought about how she would harm herself, what she would do? Explore if she has ever attempted (taken action) to take her own life before.
- If the client is unable to explain a plan for how she would take her own life and/or has no history of attempts, the risk is less immediate. At this point, you should support the person by exploring strategies for coping with difficult feelings and thoughts, and if needed, develop a safety agreement with the survivor – this might include someone she might connect with if she has these thoughts; something she might do to distract herself from the thoughts; something nice she might do to support herself to feel cared for e.g. take a walk, read a little etc.

If the caller tells you or you suspect that she has been contemplating or planning suicide:

- Affirm her courage in talking about this and the fact that these feelings are not unusual, many people feel them e.g. *"I understand that you are feeling this way and I am sorry. I know that it was hard for you to share that. You are very brave for telling me. It is very important to me that you do not hurt yourself. And I would like us to come up with a plan together for how we can help you to not do this. Is this okay with you?"*
- Support the caller to explore and identify triggers for thoughts and feelings of suicide and what happens to her mood or behavior when she has these.
- Encourage the caller to talk about what she has been thinking and/or planning to do e.g. *"Tell me about how you would end your life? What would you do, do you think about when or where you would do this?"*
- If she mentions a specific method, explore with her if this method (e.g. gun, pills) is at home or easy to get?
- Identify strategies that she has used, or can develop to support herself when she has these thoughts and feelings, for example;
    - Connecting with others, family, friends, hotline etc.
    - Engaging in supporting behavior e.g. cooking with family, activities that you enjoy e.g. walking, reading.
    - Being safe – staying away from things that can be used to self-harm; staying away from alcohol or other drugs that may numb out feelings.
    - Identifying a safe person she could reach out to if her strategies do not alleviate the thoughts and feelings. For children this may be a trusted adult or older sibling – it is important to sense-check that this is not the same person who is their abuser. If the risk is high, discuss contacting this person to be with the survivor for the immediate period (24 hours) to support them: *"I want to help you stay safe. Can you think of someone in your family or a friend who could stay by your side? Can we work together to get that person to agree to stay by your side in order to keep you safe?"*
    - If the person cannot identify someone to be with her, explore if she would like you to support her to access a health worker or mental health professional for further support? *"Can you tell me where you are? Can I send help?"*

Additional Considerations for Addressing Suicidality on a Hotline Call

Occasionally a hotline operator might receive a call from a distressed caller who has taken an action (e.g. taken pills) to end their own life just before calling. In these calls it is really important to stay calm, even if your instinct is to panic.

- Ask the caller to share her name with you.
- Tell her you are very worried for her safety and ask if you can call someone to come to her and support her: "*I want to help you stay safe. Can you think of someone in your family or a*

friend who could stay by your side? Can we work together to get that person to agree to stay by your side in order to keep you safe?"

- If the caller cannot identify someone to be with her, explore if she would like you to support her to access a health worker or mental health professional for further support? Note you will need to have the person's name and location to make a referral: "*Can you tell me where you are? Can I send help?*"
- If the caller is not forthcoming with this information, try asking her how you can support her, what did she hope for when she called you?
- Explain that you cannot support her if you do not know who she is or where she is? Ask again if she feels able to share this information with you so that you can support her to get help.
- If the person will not share her name or location or the contact details of a supportive family member, consider telling her she needs to call someone who knows where she is and can come to support her, or to call an ambulance/health worker.
- Be sure in these situations that the supervisor is on the line, or on a separate phone, to help you with the caller while the call is taking place.
- Supervisors should recognize that hotline operators may need to decompress (e.g., take a short break) and seek their support through a debrief after receiving these types of calls.

5. Setting up and operationalizing phone-based case management for GBV survivors

Mobility restrictions related to pandemics/ epidemics may make it difficult for women, adolescent girls and child survivors to access usual entry points for case management services. In some pandemic/ epidemic situations regulations may require static and/or mobile services to temporarily close. For these reasons, and when it is feasible, GBV service providers in humanitarian settings can elect to shift to remote case management services that can be continued even when movement restrictions are in place, particularly phone-based case management.

While this approach ensures continuation of care, transitioning to remote service delivery through phone-based case management requires considerable thought and planning. There are a number of challenges associated with remote case management that should be understood and addressed from the design stage forward. **Most importantly, remote case management should be provided *only* if measures are put in place to assure the safety and confidentiality of caseworkers and survivors.** A service that puts a survivor or the caseworker at further risk will do harm and therefore should not be implemented.

The information below details some of the key considerations when shifting case management from in-person to phone-based case management services, including necessary preparation for the shift, as well as adaptations that must be made to service delivery. It also provides recommendations for

updating case management standard operating procedures to include considerations for phone-based case management, as well as training topics for staff, and tips for managing calls. In addition, there is information on how to operationalize a shift to phone-based case management services.

Prerequisites for Phone-based GBV Case Management Services

When considering whether and how to shift to phone-based GBV case management services, it is important to consider the benefits and risks/limitations of doing so within the context you are operating. Here are some potential benefits and risks/limitations associated with this service delivery modality.

Potential benefits
Increased Accessibility • Reaches survivors in remote, insecure, or conflict-affected areas. • Supports those with mobility limitations, disabilities, or restricted freedom of movement. **Safety and Convenience** • Can reduce exposure to perpetrators during travel. • Allows survivors to choose safer moments to engage. • Useful during movement restrictions **Potentially Faster Response Time** • Eliminates travel delays; survivors may receive initial support more quickly. • Potential to enable quick follow-ups, check-ins, and safety plan updates. **Cost-Effective / Potential for cost-savings** • Lower transport expenses for both survivors and service providers. **Comfort /Privacy for some survivors** • Some survivors may feel more comfortable disclosing when not physically observed and/or from their own familiar home surroundings.
Potential risks / limitations
Limited Ability to Assess Risk and Non-Verbal Cues • It is harder to gauge survivor's (and in the case of child survivors, also the non-offending caregiver's) emotional state, environment, or coercion. • Child survivors may be excluded from support if they are non-verbal (e.g. infants) and/or do not have a non-abusive caregiver enabling / supporting contact. • Non-verbal cues—so critical in trauma-informed work—are missing.

Higher Safety Risks in Shared Living Spaces or Living spaces which lack privacy

- Survivor (and non-offending caregiver in the case of child survivors) may be overheard by perpetrator or family members.
- It is harder to maintain confidentiality.

Technology and Connectivity Barriers

- Survivors may lack a private phone, airtime, or networks may be unreliable.
- Phones may be monitored or controlled by abusers.
- Phones may be monitored or controlled by third parties.

Rapport-Building is More Difficult

- Trust, empathy, and grounding techniques are harder to convey.
- Building trust with new clients / survivors may be more challenging, a longer process without body language cues.
- Many survivors prefer human presence for emotional safety.

These challenges are particularly pronounced when working with child and adolescent survivors and their caregivers, for whom non-verbal cues, physical presence, and face-to-face engagement are especially important in establishing safety and trust.**Limited Scope for Immediate Practical Support**

Can't physically accompany survivors to services, police, or health facilities if only delivering case management support via phone.

It is also necessary to consider core service, staffing, funding and organizational flexibility issues. Issues of technology and safety have also been outlined in Section 1, above, as well as throughout this guidance.

Core Principles and Considerations When Adapting GBV Case Management during a Pandemic/ Epidemic

When considering whether and how to transition to phone-based services, key principles and considerations include:

1. **Prioritize the safety and wellbeing of all staff and clients.** This is true in any GBV program and remains true during a pandemic/ epidemic response. As is detailed further throughout this guidance, it is important to constantly monitor staff and client safety—as a part of the design phase, in order to anticipate and address any potential safety issues, as well as during the implementation phase through staff supervision, client safety planning, and overall program monitoring.
2. **Ensure solidarity with the most vulnerable.** Some GBV clients will be more vulnerable than others, and some community members more vulnerable. Examples could include child survivors of sexual abuse, adolescent girls (particularly out of school adolescent girls) women and girls with disabilities). Remember that physical distancing and other measures are not just about protecting clients, but about everyone doing their part to protect each other. Keep this in mind when making decisions. For clients who are particularly vulnerable, prioritize early safety planning and regular follow-up.
3. **Focus on humanity over productivity.** Remember that these are stressful times, and that the changes and uncertainty add to stress levels for staff, their families, clients and communities. As GBV service providers make changes to programming, it is important not to over-emphasize the need for seamless transition and high productivity. Staff will need time to slow down and figure out what the next days and weeks look like, and to be supported to manage the transitions and the changes that follow. It will be necessary to change expectations and operations related to the workload. Strengthening a culture of care — starting from the top of the organization and across all staff — is essential.
4. **Be prepared, not panicked.** This paper highlights the importance of preparing for all scenarios urgently in anticipation of the possibility of rapid changes. However, changes should be planned for as calmly as possible, and presented as proactive and well-considered steps rather than panic reactions.
5. **Advocate for increased gendered analysis across the response.** This paper focuses on GBV case management. However, a gendered analysis is essential to a strong response for all communities and in particular to women and girls. GBV specialists should feel empowered to share their expertise in relevant fora in order to provide guidance to build a more gendered response to pandemics / epidemics.

Excerpted from *GBV Area of responsibility (AoR) Research Query on GBV Case Management and the COVID-19 Pandemic*

Staffing.

Delivering remote services often requires staff to work from home, especially in the context of a pandemic/ epidemic when movement restrictions are in place. Because of challenges with working

at home, and also because many staff will be dealing with their own issues related to the disease outbreak, it is not good practice to expect home-based staff to carry the same caseload as they do when providing services at a static center, like a women's center or safe space. In some cases, staff simply will not be able to work from home due to child or other responsibilities, lack of privacy, lack of phone network reception, etc. For staff who are able to continue case management via phone-based services, they will likely need to reduce the number of clients they serve, especially if they had a full caseload prior to lockdown. In order to cover caseloads of staff who are not able to transition to remote service delivery, or in order to receive any new clients, the number of staff may need to be expanded.

Basic points to consider regarding staffing:

- Are staff - both supervisors and caseworkers - willing and able to transition to phone-based case management? Can services be provided on a rotational basis and with proper protective precautions in a static center, or will staff need to work from home?
- How many staff are able to make this transition? If working from home, can privacy and confidentiality be assured? Is there sufficient space to create a home office where staff can set out reference materials they need to use when on calls?
- Are staff able to participate in training necessary to make this transition from face-to-face service delivery to phone-based case management? Are there sufficient resources for the training and supervision needed?
- Do staff have mobile network coverage in their homes? If they are using an app for data management, or for other activities that require internet, can staff access the internet in their homes?
- Is it necessary and feasible to add new staff? Are there sufficient resources for the additional training and supervision that new staff may require?

Funding availability and flexibility.

While many donors suspended reporting requirements in the context of COVID-19, (and may do the same in future for other pandemics that impact at scale), this may not always be the case moving forward. It is important to assess whether donors currently funding in-person case management are willing to allow for a shift to remote service delivery. If current donors are not able to make adjustments in requirements related to project-based funding, this will require identifying new donors, which may take time, in turn impacting the feasibility and timing of transitioning to phone-based case management.

Basic points to consider regarding flexibility and availability of funding:

- Will current donors allow for changes in service modality? Is advocacy required to ensure donors are flexible and adaptive?
- If additional funds are needed for new equipment, staff, or training of staff, will current donors support these costs, or allow for changes in current budget allocations in order to accommodate these costs?
- Do donors require a beginning and/or end-date to remote services?

- Are there any other donor requirements that might affect delivery of phone-based case management services?

Organizational flexibility.

Not only do donors have to be willing to adapt to a new type of service modality, organizations also have to support this transition, and from the highest levels of management. Without full agency support, the likelihood of being able to successfully transition to remote service delivery is limited. Support may include advocacy with the donors; advocacy with government and other partners about the life-saving value of continued GBV case management through remote service delivery; organizational adaptations to human resources regulations that allow, for example, staff to work from home; clearance for hiring new supervisors and caseworkers to supplement existing staff as necessary; activating rapid supply chain in order to purchase technology necessary to facilitate a transition to phone-based case management (including phones, solarchargers, internet routers, etc.).

Basic points to consider regarding organizational flexibility:

- Are all levels of the organization on board with shifting case management to phone-based service delivery?
- Will management support strategies that supervisors and caseworkers determine are the best to support the safety and well-being of staff and clients?
- Is the organization flexible or agile enough to facilitate the change rapidly, including meeting all the logistical and human resources needs to make the change?
- If the shift is made to remote case management, will the organization be able to shift back to in-person case management quickly when the situation allows?

Operationalizing Phone-based Case Management Services

In addition to assessing the key issues related to remote case management functioning as described above, there are operational considerations that will be important to take into account when designing phone-based services. Transitioning GBV programming from an in-person case management model to a remote case management model includes an important triad of Consultation, Coordination and Communication.

Consultation and Coordination

As part of the design stage, it is recommended to hold several planning workshops that include supervisors, caseworkers, managers, IT staff (if needed), and applicable referral pathway partners. Consultations should also be held with clients to address design questions, as well as with other women and girls in the community who may access the service at some point. In all of these consultations, plenty of time should be allotted for brainstorming, as well as for any expressions of concern or fear. For many, this process will be unprecedented and even scary; planning discussions should therefore allow time for reflection and engagement.

Questions for supervisors, caseworkers,and IT

- What devices will staff use and how will they be managed (i.e. how will staff ensure they are only used for work; how they be charged; where will they be stored at night; what apps are not allowed; what happens if one is lost/stolen; etc.)? Is mobile coverage assured? If staff determine that WhatsApp is a preferable way to manage calls, is internet available?[36] How will staff top up their phones as necessary? Do staff need solar chargers or battery packs?
- What are the budget allocations for hardware, phone credit, reimbursing clients for calls, etc.?
- What should be the standards of privacy for the caseworkers? If they are working from home, how will the home setting be assessed by management? If they are working from an office space, how will staff distancing be maintained and protective equipment be provided to ensure safe safety and well-being during, to and from work?
- How will caseworkers shift their cases to remote care? Will all cases be shifted or only the most high-risk cases? If some will be closed, how will that be determined? What will be the process for consulting with clients about these decisions? Are there changes that can be phased in, or will everything happen at one time?
- What will be the maximum case load for caseworkers and supervisors to ensure they do not get burnt out, especially if they are working from home? Will some clients need to be shifted to other caseworkers?
- Will the service take on new clients, or only serve existing clients? If the service takes on new clients, how will new clients reach caseworkers, and how will caseworkers receive calls?
- If the service is only seeing high-risk clients for remote case management, how will this be determined with new clients?
- How will supervision be delivered and how often? How can caseworkers immediately access a supervisor should an emergency arise that requires consultation? What technology (i.e. additional phones, internet) will be required for caseworkers to maintain a call with a client while also calling a supervisor, if necessary? (Also see Section 3.)
- How can risks associated with caseworkers storing paper forms at home or in locations that are unsafe be mitigated? Can digital case management tools such as Primero/GBVIMS+[37] be rolled out? (Also see Section 5, documentation and data storage sub-section) If not, can lockboxes be provided to caseworkers to safely store any documentation?

Questions for women and girls who may access the service

- Do existing clients feel comfortable shifting to a new modality?

[36] Because WhatsApp requires phone numbers to be saved as part of accessing the service, codes will need to be developed to conceal the WhatsApp number and/or prevent it from being traced. For this reason, WhatsApp may not be the preferred approach; decisions about whether to use WhatsApp must be determined according to context.

[37] For more information on Primero/GBVIMS+ you can watch the intro video: https://www.youtube.com/watch?v=qRCaDOgBVAQ or visit https://www.gbvims.com/primero/

- What are some of the anticipated safety and privacy issues women, adolescent girls and child survivors may face? What concerns exist about perpetrator backlash? What steps need to be put in place to manage these safety and privacy issues?
- What kind of mobile service do women, adolescent girls and children have access to? What kind of coverage do they have? Is their access to these devices independent or requires permission from others? Will their phone usage be monitored or tracked by the perpetrator?
- If clients do not have access to phones, are there places in their community where they would feel comfortable going to in order to make a call? Is this possible given any movement restrictions?
- Will there be particular challenges for adolescent girl survivors in using a remote case management service? How can these be addressed safely?
- Will there be particular challenges for child survivors using a remote case management service? And their non-offending caregivers? How can these be addressed safely?
- If the case management services are going to be offered to new clients, what is the best and safest way to advertise the services? How will it be ensured that the information about the availability of case management reaches the most marginalized women and girls?

Note: These are preliminary questions for women and girls that can help guide decisions about feasibility of shifting to phone-based case management, as well as inform design. They can be used with existing clients as well as women and girls in the community. Once the phone-based case management service is established, it will be important for caseworkers to consult separately with each existing client to identify specific safety and logistical issues and processes related to transitioning to phone-based services, as described above.

Questions for referral pathway partners

- Which current referral pathway partners (e.g. service providers already identified in the existing referral pathway) continue to be open for services? Are referral pathways up to date? Which client groups do these partners provide services to? I.e. adult, adolescent girl and child survivors? (See Section 2.)
- How will caseworkers work with referral partners? How will referral partners communicate to caseworkers about any changes to their services, including contact information, etc.?
- If phone-based case management services are able to take new clients from referral partners, how will referral partners share information with prospective clients about the remote case management services? How will referral partners share information with caseworkers/supervisors about new referrals?
- Is it possible or appropriate for those service providers that are remaining open and have appropriate transmission precautions in place (e.g. healthcare providers) to have phones and private calling spaces available where clients can call their caseworker?
    - If so, are staff available to clean these spaces and sanitize equipment after each call?

Communication

Once basic plans for shifting to phone-based case management have been determined and agreed upon, it is important for the GBV program to facilitate clear and transparent communication about

how the service will be implemented — among staff, with donors, with clients, with referral partners and, in situations where new clients may be included in remote case management services, with women and girls in the broader community. For staff, any verbal communication should be supplemented with written information that details the implementation plan for remote service delivery, as well as training tools and other technical guidance for caseworkers.

For external clients and partners, key strategies for communication might include:

- ✓ Preparing a donor document that summarizes shifts that are being made and how those shifts will affect budget needs and allocations.
- ✓ Preparing a discussion guide for caseworkers to reference when talking with clients about the transition to remote case management, as well as a client handout that summarize the details of the transition that clients can take with them if it is safe for them to. Topics covered might include when the transition will take place; what it will mean for on-going clients; how to access remote case management; how to access phones remotely, and/or how to install relevant apps on client phones; hotline numbers; other critical services; etc. Discussions about safety concerns and safety planning are an important part of this engagement between caseworkers and clients, including questions around how to make and receive calls safely; how to code caseworker and client names; how to delete evidence of phone calls as well as messages; etc.
- ✓ Preparing a revised referral pathway guidance document for referral partners, as well as any Information, Education and Communication (IEC) materials that referral pathway partners can safely share forward about the transition to remote case management.
- ✓ Preparing IEC materials for women and girls in the community to ensure they are aware of the remote services (in the case where remote case management services will be made available to new clients), using depictions that are inclusive of young and adolescent girls, women and girls with disabilities, etc.
- ✓ Preparing IEC materials for the broader community to help them understand the changes that are being made.
- ✓ Devising a strategy for sharing the IEC materials at the community level that is safe in the context of the specific pandemic/ epidemic, such as radio and social media distribution; using megaphones and speakers to deliver information; etc.

Developing Standard Operating Procedures

After questions and concerns regarding operationalizing the shift to phone-based case management have been addressed in a collaborative way with all relevant stakeholders, the GBV supervisors and caseworkers should work together to draw up an implementation plan that is shared among staff and any other relevant partners. Implementation plans should outline core activities and responsibilities of different staff; an overview of the client coverage schedule; outreach and information dissemination plans for staff and partners; training plans for staff and partners; and an overview of supervision processes and schedules. With consideration given to the range of clients served e.g. child survivors of sexual abuse, survivors with disabilities etc.

An important part of the implementation plan will be to develop Standard Operating Procedures, also referred to as service protocols. This guidance is critical to ensuring that caseworkers and supervisors adhere to standards for safe and ethical case management in the context of phone-based services. In many cases, staff will already have guidance related to Standard Operating Procedures that they use for case management. These should be updated to address the particular issues and challenges that may emerge when providing phone-based services. **GBV case management should not be shifted to phone-based services without these updates.** Even when lockdown happens quickly, it is still important to ensure that staff have basic guidance and trainingbefore they start conducting GBV case management over the phone.

For caseworkers working from home, this guidance can be compiled into a resource folder, available online or in hard copy for those who may have difficulty accessing the internet. The key point to remember when compiling the information is how staff can access it quickly when they are on a call, in case they need prompts for how to deal with specific issues.

Call-answering Protocols. Written guidance for caseworkers (accompanied by staff training on this guidance) should include call-answering procedures and protocols that are contextualized for the setting, but that address the following basics:

- How to start a call (e.g. introductory statements, key messages that should be shared from the beginning of the call);
- Confidentiality, not only in terms of communicating standards of confidentiality at the beginning of the call (and exceptions to confidentiality – including mandatory reporting), but also outlining what the responsibilities of the caseworkers are for ensuring confidentiality;
- How to ensure survivor safety during the call, to the extent possible;
- How to obtain verbal informed consent over the phone, or informed assent when working with a child survivor;
- Whether the organization has set a recommended minimum age for providing phone-based case management support;[38]
- Statements to reassure clients that violence is not their fault;
- How to conduct a safety plan over the phone;
- How to respond to callers who are children or adolescents, or non-offending caregivers of child survivors of sexual abuse;
- How to deal with calls that are cut short, including policies for call-back;
- How to respond to survivors in immediate danger;
- How to respond to callers with suicidal ideation;

[38] There is no defined minimum age set by this guidance given the plurality of service provider skill sets and specialisms (including working with child survivors), and the individuality of each child survivor globally, however, the CCS assessment guidelines framework, based on age and developmental stage, can serve as a useful basis for indicating that, subject to exceptional circumstances and developmental capacity, it may be challenging to engage in phone-based case management support with a child under six years of age. Case workers should also bear in mind that children aged 6-9 years of age may have difficulty answering questions and, therefore, engaging non-offending caregivers will be important. See CCS Guidelines Updated Edition (2023) pp.109-110.

- When staff should immediately engage a supervisor for support and/or when they should engage security or the police, including in relation to any mandatory reporting requirements;
- How the calls should be closed (e.g. what information and key messages should be shared when a call is ending).

Guidance should be included about what to do if a client sends a text message, as well as what to do if a client calls and leaves a message requesting a call-back. Service delivery decisions about the various options for making and receiving a call, such as survivor-initiated calls, client call-backs, etc. should be determined by service providers in consultation with women and adolescent girls in the community, and then adapted for each client according to their specific situation.

Updated Referrals to Providers. Another key element to Standard Operating Procedures relates to referrals for services. Most caseworkers will already have written referral pathways, but these will likely have changed considerably because of the pandemic/ epidemic. It is important that caseworkers have an updated document that includes, as possible, reference to healthcare, psychosocial support (including shelters and livelihoods), child protection, child friendly safe spaces, police desks, lawyers[39] and the judiciary and the services these sectors are offering (or not) based on restrictions (See Section 2). It is also important to distinguish where these services are accessible and available to child / adolescent survivors.

Box 5. Making and receiving calls.

One program in regional Syria response worked with clients to determine the best way to make and receive calls safely. The clients identify a time that works best for them. While most clients initiate the call, in instances where the client cannot afford the call or does not have airtime, the client has the option of flashing or texting the caseworker and the caseworker will call back immediately. In other settings around the world, call-backs were deemed unsafe so were not included as an option. With any option, both caseworkers and clients receive training on how to delete texts and call history.

Administrative Procedures. There are a number of additional issues that must be detailed as part of developing standard procedures that relate to administration of remote case management. These include:

- An explanation of expected working hours and case load for the caseworkers. The Inter-agency Case Management Guidelines recommend a maximum of 20 active cases per caseworker, with the ideal number being 15 cases. However, this standard is for "normal" operations, and will likely need to be shifted based on caseworker availability, also taking into account additional potential stressors for caseworkers related to a pandemic/ epidemic and related to working from home. Total caseloads should also be balanced to account for

[39] The global GBV AoR has developed guidance for the legal sector on how to safely provide legal aid in the context of COVID-19. See https://gbvaor.net/sites/default/files/2020-07/Key%20Guidelines%20for%20Providing%20Remote%20Legal%20Aid%20to%20GBV%20Survivors.pdf

type/range of cases being handled with recognition that higher risk cases (e.g. clients with suicidal ideation) or cases involving a child/adolescent who has experienced sexual abuse etc. may be resource intensive and carry higher risk of vicarious trauma to caseworkers. Staff should also be encouraged to maintain standard working hours as much as possible. Supervisors should discuss with their teams what is feasible and monitor regularly. (Also see Section 3.)

- What the expectations are in terms of paperwork and safe and ethical case documentation.
- What the expectations are in terms of privacy in the workspace and setting up a separate workspace if working from home.
- How staff should manage their phone(s) in terms of costs, charging, storage, etc., and issues related to phone safety (e.g. not storing any messages or other identifying information on phones; not using the phone(s) for any purpose other than case management; reporting a lost phone immediately to a supervisor; etc.).
- The role of supervisors in supporting staff, and the expectations around supervision, as well as emergency procedures for contacting a supervisor. The Inter-agency Case Management Guidelines recommend a ratio of one supervisor per 8 caseworkers, but this may need to be reduced if supervisors are responsible for training and other responsibilities related to shifting to remote care. (Also see Section 3.)
- Codes of conduct for all staff, in line with global best practice.

To ensure that staff understand and accept this guidance, it is important that they are engaged in developing the guidance, and that they consent to it. For some issues, such as confidentiality, phone safety, and documentation processes, staff can sign off on documentation, either by signinga form directly or, in the case of lockdown where it is not possible to obtain signatures from staff, by giving verbal consent to supervisors. Originals of these consent forms should be kept by management in separate staff files.

Documentation / data storage considerations

When GBV staff provide services (individual psychosocial support, case management and/or other services to survivors and those at risk of GBV), we often collect personal information. This may include:

- Survivor data, such as name, age, community, whether the survivor is living with a disability, etc.
- Details of GBV incident(s), such as the type of violence, location of the incident, relationship of the survivor to the perpetrator etc.
- Case management data, including information about the support provided to an individual survivor through the case management process, notes of psychosocial support sessions etc.

This personal information is sensitive; if it becomes known to members of the community, it will not only compromise a survivor's privacy, it may also put survivors at increased risk of retaliation, stigma, or other harm.

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In GBV case management, confidentiality is maintained through strict information-sharing practices that rest on the principles of sharing only what is absolutely necessary to those involved in the survivor's care with the survivor's permission. It is always necessary to protect written data about a survivor, or a case, through safe data collection and data storage practices.

In the context of a pandemic or epidemic where remote case management is conducted, caseworkers must take special precautions to ensure the safety of client data, including not storing written case information in their homes or other places where they provide remote case management.

The information below describes some of the key considerations for adhering to safe and ethical documentation and data storage when undertaking remote case management. It also offers information about the PRIMERO/GBVIMS+ application, which has many advantages related to data collection in the context of remote case management. Any Standard Operating Procedures must include guidance on data collection, analysis and storage to ensure it is in line with recommendations below.

Key Considerations Related to Documentation and Data Storage for Phone-based Case Management

- ✓ Organizations providing GBV case management must weigh risks versus benefits of different types of data collection and data storage based on the duration and scope of the lockdown and the requirements of service provision. Because the use of paper files introduces the opportunity for breach of confidentiality and data loss, **it is strongly recommended that no hard copies of GBV case files or any other identifying information be stored in a caseworker's or supervisor's home.** This includes consent, intake, and any other case management forms such as action plans and safety plans.
- ✓ **Consent should instead be obtained verbally for case management**, referrals, and in order to record data using mobile applications such as PRIMERO/GBVIMS+ (see below).
- ✓ **Caseworkers should avoid taking written notes.** As well, supervisors should not take notes during remote supervision with GBV caseworkers. Both caseworkers and supervisors who shift to remote case management should sign a data protection agreement.[40]

[40] A sample of a data protection agreement is available at http://www.gbvims.com/wp/wp-content/uploads/Staff-Data-Protection-Agreement.pdf

- ✓ If survivors' phone numbers need to be recorded in order for caseworkers to remember how to contact their clients, **it is recommended that caseworkers use anonymized codes in their phones**. Separate password-protected files on caseworkers' laptops can connect names to phone numbers when absolutely needed.
- ✓ Information that *must* be recorded to facilitate a survivor referral or access to cash assistance (e.g. a survivors' name and phone number), should be written down and shared only to facilitate the assistance needed **and then destroyed**, preferably by burning so no evidence of documentation remains.
- ✓ Organizations typically reliant on paper files should consider shifting to new technologies that support safe and confidential collection of data during remote service delivery. PRIMERO/GBVIMS+ is the latest application that allows GBV humanitarian workers to safely collect, store, manage and share data for case management and incident monitoring. It also includes a mobile application to allow frontline workers to track GBV incidents and progress in case management services. The mobile application has been designed to ensure that case management data cannot be obtained by a third party. (See more information below.)

Information Sharing in the Context of Supervision

All caseworkers should be trained on how to adjust information- sharing with supervisors when participating in remote consults or weekly supervision meetings. Caseworkers, hotline staff and supervisors should be clear that when discussing cases via phone or in messages, survivor identifying information should not be shared, and supervisors must reinforce this practice whenever speaking with supervisees. Supervisors must also discuss with caseworkers the fact that safety and confidentiality protocols extend to any staff peer support spaces (e.g. WhatsApp groups, group calls) that are established during this time.

If using a digital GBV case management tool, supervisors should set up a schedule for re-view of a randomly selected number of files from each caseworker, or from a few caseworkers, or review two files per caseworker per week. They should make note of any challenges a caseworker is having with case documentation, or any common challenges that emerges among files across the team. Supervisors can also regularly share feedback on trends noted in case file review with the caseworkers. Supervisors and caseworkers should use software-flagging functions, one-on-onediscussions, and group calls to discuss such feedback.

Using Primero/GBVIMS+ for Data Collection and Storage for Phone-based Remote GBV Case Management

Primero/GBVIMS+ is a protection-related information management system. It is an application developed to enable humanitarian actors to safely and securely collect, store, manage and share data for protection-related incident monitoring and case management. Primero/GBVIMS+ is a survivor centered module within the system that

utilizes technology enhancements to accompany the full GBV case management process, manage individual cases and referrals, as well as aggregate incident monitoring.[41]

Rollout of Primero/GBVIMS+ requires sound, pre-existing case management capacity. Therefore, prior to engaging in the rollout of Primero/GBVIMS+, organizations and/or interagency coordination personnel should ensure that organizations are providing quality case management services. The GBVIMS global team also undertakes a review of quality of care by administering an integrated case management-information management quality checklist with each potential user organization.

Primero/GBVIMS+ is particularly well suited to ensuring and strengthening GBV case management service provision during the COVID-19 pandemic if GBV service provision is needs to be delivered remotely through mobile phones, versus in person or static service provision, for the following reasons:

- It allows for use in low/infrequent internet connectivity contexts - which may be the case if GBV caseworkers are based at home with no regular internet connection - and it allows caseworkers to go 'paperless', which will provide a solution to paper file storage issues that GBV caseworkers may face when working from home. While the web version of Primero/ GBVIMS+ can be used from an internet-connected computer and enjoys the highest level offunctionality, Primero/GBVIMS+ can also be used offline for data entry on a mobile device, such as a smartphone or tablet. This version works entirely offline and can later sync data to the cloud once the user is able to access with a secure internet connection. This means no data is stored on paper or on the user's desktop. Furthermore, if mobile devices are used, a Mobile Device Management (MDM) solution can be used to ensure the safety andconfidentiality of data stored.
- Where caseworkers and their supervisors may be confined to their homes, limiting in-person supervision, supervisors of caseworkers can use Primero/GBVIMS+ to conduct remote supervision, such as case file review for each caseworker they supervise. Findings from case file reviews can be discussed in individual or group supervision sessions. Supervisors can also use the 'approvals' feature, by which a caseworker can request supervisor approval, review and feedback for an action plan, or case closure. They can also benefit from the 'flagging' feature, whereby supervisors can add a 'flag' to a case to draw attention to a particular issue and insert a reason. In order to efficiently use the remote supervision functionality of Primero/GBVIMS+, Case Management SOPs would need to berevised accordingly.
- When caseworkers are working from home and mobility is limited, it may be challenging to consolidate data from each staff member. With Primero/GBVIMS+, data is hosted on an internet Cloud, meaning that it eliminates the need to compile data internally in an organization – data

[41] Since 2015, under the leadership of UNICEF, the GBVIMS Steering Committee has developed and endorsed Primero/GBVIMS+ as an inter-agency GBV case management tool, used in conjunction with the 'legacy' GBVIMS. Currently, Primero/GBVIMS+ is being implemented in Bangladesh, Libya, Lebanon, Iraq and Nigeria, and is used by over 250 service provision personnel across seven organizations. For more information, see http://www.gbvims.com/primero/ and https://www.primero.org/. For any specific questions, please contact the GBVIMS Global Team at gbvims@gmail.com

from each caseworker is automatically compiled online. This data can beexported, by the user organization's focal point, from the Primero/GBVIMS+ platform to the Incident Recorder (IR), and then analysis (and inter-agency sharing of aggregate, anonymizedstatistics) can be conducted as per the usual GBVIMS process.

- Primero/GBVIMS+ features heightened security. This was a crucial part of the development of this system. Primero is built in a secure framework and before it was even field-tested had threat tests conducted.

If you are already using Primero/GBVIMS+, adapting it to remote case management is relatively simple (see Figure 4). Caseworkers simply must have access to the web, a way of entering data privately, and access to supervisory support in order to troubleshoot any issues arising. When adapting it for use in hotlines, the fields that operators will be expected to complete need to be agreed upon in advance of implementing digital data entry, as many fields related to case management may not be relevant to hotline data collection.

Training GBV Caseworkers to Provide Phone-based Services

At minimum, training for caseworkers when shifting to phone-based services should cover a review of all of the Standard Operating Procedures noted above. This should include opportunities for staff to engage in roleplay so that they can practice, in real time, how to engage with a client over the phone. If caseworkers are supporting child or adolescent survivors this should include roleplays with vignettes featuring these client groups. If time permits, and if necessary or beneficial, it may also be useful for a supervisor to provide revision sessions on basic GBV issues and concepts and information regarding caring for child survivors of sexual abuse. It will also be important to provide training for staff on any new technology or approaches to be used for remote case management.

Teams may need to get acquainted with systems used for phone or internet service provision, new apps for data management, etc.

If lockdown means that in-person training is not possible, then staff can be trained over video-conferencing platforms (e.g. zoom, MS Teams etc.), with practice calls between supervisors and caseworkers also conducted over the phone. Training plans should be drawn up as part of the implementation plan for shifting to remote case management and should accommodate the fact that online training must be offered in shorter intervals than in-person training (with 90 minutes - two hours per training session being optimum).

Essential Training for Caseworkers Transitioning to Phone-based Service Delivery:

- ✓ Operation of relevant apps to provide remote services (e.g. WhatsApp);
- ✓ How providing support via phone is different than in person, and what basic adaptations need to be made;

- ✓ Essential phone manners, e.g. initial greeting, speaking clearly and slowly, not speaking over the client, etc;
- ✓ Reminders that voice and speaking patterns are of utmost importance during telephone sessions. This includes the tone of the voice, breathing patterns, pauses, pace of speaking and hesitation.
- ✓ Phone listening skills, e.g. active listening and listening for changes in tone without body language; use of silence; building trust and rapport.
- ✓ Standard call-handling protocols in line with basic case management steps (e.g. introduction, assessment, case and safety planning, referrals, call closure).
- ✓ Managing a call with a child survivor; demonstrating child-friendly attitudes, applying child-friendly communication techniques and conducting a refresher training using the Introduction to Caring for Child Survivors of Sexual Abuse (2nd Edition) e-learning course[42]
- ✓ Managing calls when clients are at immediate risk and/or when a call is picked up by a perpetrator (See Section 4);
- ✓ Managing calls when clients are distressed or suicidal (See Section 4);
- ✓ Review of updated referral pathways and providing referrals over the phone (See Section 2);
- ✓ Data collection and management responsibilities (See Section 5, sub-section on documentation and data storage).

Shifting Existing Clients to Phone-based Case Management

When shifting to phone-based case management as a result of a pandemic/ epidemic, caseworkers will be working primarily (sometimes exclusively) with existing clients. This means that the caseworker will already have a rapport with the client, and at minimum will have undertaken an initial assessment, developed a basic case plan and, where necessary, developed a safety plan. Referrals may also have been provided during the in-person case management.

When working with existing clients, the focus of the phone-based case management will be determined by where the case was before the shift to phone-based services. The process of engagement with the client must also take into account changes in context for the survivor and in relation to the availability of services due to the health crisis. This may require that the caseworker review the client safety plan and action plan, as well as develop specific safety protocols with the client about speaking over the phone.[43]

[42] It is optimal for all caseworkers to have a refresher on the CCS training, if feasible.

[43] More detailed information about the steps in GBV case management can be found in the Interagency Guidelines for Mobile and Remote GBV Service Delivery https://gbvresponders.org/response/mobile-and-remote-gbv-service-delivery/

Conducting Phone-based Case Management with New Clients

For those caseworkers who are taking on new clients, phases of client engagement may shift to an abbreviated mode — one that aligns more closely to a model for crisis case management — in order to ensure survivor needs are addressed as efficiently as possible given the limitations of the current context. Crisis case management refers to an adaptation of the standardized GBV case management process due to the limited time that caseworkers have with each survivor as a result of a shift in context (e.g. the current COVID-19 pandemic) and/or service delivery (e.g. transition from static safe spaces to remote, phone-based service provision). The key issue to bear in mind with this abbreviated case management is that the caseworker and the client will move more quickly into assessment of immediate concerns, safety planning, and the design and implementation of the action plan than might be the case when undertaking case management in person, over a longer period of time.

Figure 2: GBV case management steps

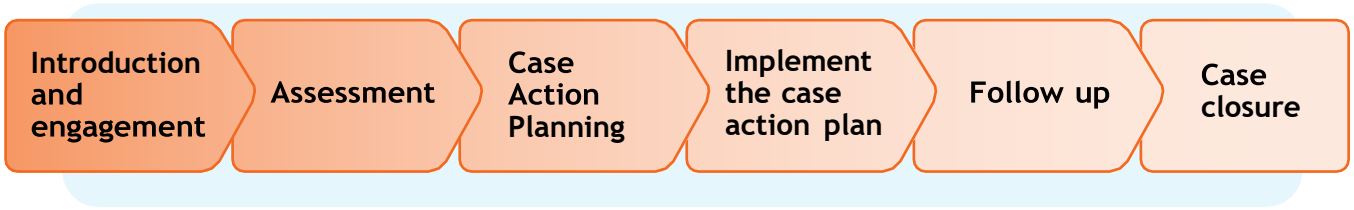


Figure 3: GBV case management steps during crisis

Steps for Managing Calls with Adult Survivors

Whether working with existing or new adult clients, the caseworker will want to bear in mind a few key steps for each call, outlined below. These general steps will need to be adapted for each setting. Information related to managing particular challenges, such as safety issues and difficult calls are covered in Sections 1, 4 and 5 of this guidance.

Once it is clear that it is safe to proceed with the call, the caseworker should review some basic safety measures that can be implemented should the call be interrupted. The caseworker and the survivor can agree on a safe word or a code indicating the need to shift to a neutral topic or end the call. The caseworker and the survivor can also discuss other potential courses of action related to various scenarios, including:

- Someone asks what the survivor is doing and/or to whom they are talking to over the phone.
- Someone in the household picks up the phone.
- The survivor needs to stop the call.
- The survivor needs to switch to an alternative phone.

REMEMBER: If the survivor does not sound comfortable and/or you hear any sound from others in the middle of the call, please do not continue and give them an option to contact you when they do feel more comfortable speaking, through means that havebeen pre-established, such as a missed-call, text message or texted password, or any other strategy that has been deemed safe.

Step 1: Short Introduction and Engagement

During in-person case management, the caseworker will often take more time for introduction. In remote case management it is important to move through the introduction more quickly, while still being sure to cover the most critical points. For the first call with a client after shifting to the remote modality, especially if there has been a gap in contact for a while (or when speaking with a new client), it may be useful to review standard points such as issues of confidentiality, mandate to report, expected length of the call, etc.

It is also critically important as the first step in a call to determine whether the client is able to speak on the phone at the designated time of the call, because even if the time for the call is scheduled in advance, circumstances may change. Potential questions to confirm the safety and security of the caller can be asked in way that require **"yes" or "no"** responses so that if the survivor is not in a safe place, no one will know what she is speaking about:

- Are you comfortable talking right now? Do you agree to continue this talk now over the phone? Or do you prefer we schedule at a different time? Do you prefer to miss this call? Do you prefer to text me when you are ready?
- Is this the right number to call? Or do you prefer me to call any other alternative numbers?
- Are you taking the call from a room that can ensure privacy and confidentiality of the conversation?
- Do you think someone might walk in during our conversation?
- Do you feel safe and have enough privacy for our conversation?
- Are you fine talking now?

Box 6. Call passwords.

In Uganda during the COVID-19 pandemic, IRC partner Karamoja Women Umbrella Organization worked with survivors to establish "verbal passwords" at the beginning of every GBV case management call. If a caseworker heard the password, they knew it is not a safe time to talk and re-directed the conversation to COVID-19 prevention measures.

International Rescue Committee, 2020. The Essentials for Responding to Violence Against Women and Girls During and After COVID-19. https://www.rescue.org/sites/default/files/document/4981/essentialsofgbvduringandaftercovid-19625vfupdat- ed629.pdf

Step 2: Assessment of Concerns

In this step, the caseworker will assess any new or on-going concerns, such as safety and security at home, medical/health needs or any other issues related to safety and well-being. In the context of a pandemic/epidemic, when challenges arise in accessing services, it is especially important to determine how the client is managing with the changes. At this stage, the caseworker should:

- Listen, be sure to dedicate time to ensure the survivor has been heard;
- Provide emotional support through healing messages, validation, and compassion, as well as any useful information-sharing that helps the survivor to cope;
- Reflect back and summarize to the survivor what you understand to be her safety and other needs.

Step 3: Safety Planning

Safety planning is a critical part of remote case management. Even if a survivor has not already expressed concerns about her safety, it is very important to check in about whether the survivor has any safety concerns for the future. During this process, the caseworker can:

- Identify the circumstances in which the survivor is most in danger.
- Assess risks of escalated violence.
- Focus on topics related to keeping safe during a situation of escalation, creating safe zones in the home, avoiding being in rooms with weapons, etc.
- Help her identify her support system and resources—this may include people she can go to if she needs to escape.

Introduction to Safety Planning

Safety planning is an integral component of GBV case management, whether the case management is delivered in person or remotely. Safety planning is also a useful tool for remote caseworkers to have on hand in case a caller expresses concerns about immediate or future risks of exposure to violence. The safety plan is an intervention that helps survivors analyze the risks for harm in their lives and identify specific actions that may be taken to reduce those risks. Safety plans may reduce

survivors' future likelihood of being harmed, but in order to be effective each plan requires an individualized approach.

Safety planning generally focuses on the following issues:

- The survivor's perception of her own safety;
- The exact circumstances in which the survivor (and her children, if relevant) are in the most danger;
- Whether or not the survivor is at risk of life-threatening physical harm;
- Existing strategies and resources the survivor has and ways these can be deployed if safety risks escalate;
- If relevant, strategies to include the survivor's children in safety planning.

The process of developing a safety plan is particularly relevant during a pandemic/ epidemic as movement restrictions and lockdowns mean many survivors, especially survivors of intimate partner violence (IPV), are confined in their homes with their abusers. Caseworkers who are working with existing clients may need to review and revise safety plans, accounting for increased risks, restrictions in movement, and limitations in services. When working with new clients via phone-based case management, or when conducting safety planning through a hotline service, safety planning can be a very important and concrete part of the process of assisting the survivor. The information below serves as a reminder of key considerations and key elements of safety planning, as well as how to contextualize safety planning to movement restrictions related to the pandemic/ epidemic.

Key Considerations in Safety Planning

- ✓ It is always important to remember that by creating a safety plan, we are in no way suggesting that the survivor has responsibility for managing (or having control over) when and where they experience violence. Any caseworker working with a survivor should reiterate with the survivor that the violence is NOT her fault. Only the abuser can control when he chooses to be violent.
- ✓ Safety planning can be a challenging process. Many caseworkers may want to 'solve' the safety problems of the survivor; however, this is often not possible.
- ✓ **Safety planning is about trying to make a potentially dangerous situation less dangerous**. It is also about helping a survivor recognize her strengths and resources.
- ✓ Given the challenges associated with safety planning, **it is very important that caseworkers work with their supervisors to troubleshoot issues, particularly for cases where risk is moderate to high**. For high-risk cases, caseworkers should have a system for contacting supervisors while they are on the call with the client to discuss any emergency concerns. Where remote case management means that the caseworker is not working in the same physical space as the supervisors, protocols and procedures must be clear about how caseworkers can reach supervisors for immediate support as necessary (e.g. on a separate phone line). (See Section 3.)
- ✓ In many humanitarian contexts, and particularly during a pandemic/epidemic that limits mobility, there will be few safe and sustainable options for a woman / married adolescent girl to permanently leave an abuser. Even if they want to leave, there are many barriers to doing so. **As such, caseworkers should never assume or communicate that leaving is**

going to be better for the survivor. A caseworker´s primary role in working with survivors on safety is to focus on ways survivors can reduce their and their children´s risk of physical violence, and to help them think through what they would do if they had to leave temporarily or permanently.

- ✓ Safety planning is most commonly referenced in relation to risks associated with IPV. However, **safety planning can be a valuable process when addressing other forms of violence as well, including sexual violence, child marriage, violence targeted at women and girls with diverse sexual orientation and or gender identity, women and girls of specific ethnic, religious or other groups, and women and girls with disabilities**. For example:
    - Women and girls who disclose sexual violence may be at high risk of further violence or harm from perpetrators, people protecting perpetrators, or members of their own family due to notions of family 'honor'. Safety planning in this case may focus on whether the perpetrator has access to her, who knows about the incident, who knows that she has come for help, and what the reactions of family members are likely to be.
    - In the case of child marriage, safety planning should be done with the girl if you identify together that there are current or potential safety risks from either her (current or future) husband, family members or community members. Safety will be a key consideration for women and girls with diverse sexual orientation and or gender identity, particularly in contexts where there are laws that criminalize LGBTQI identities. Caseworkers may wish to explore with the survivor her experiences with the police and other authorities, as well as in the community. Due to the stigma involved, the survivor may not have a support network and already be isolated. This may make it difficult for the person to come up with people whom they can trust and can go to for safety. LGBTQI survivors may be at high risk of suicide, particularly if they have been ostracized from family and community and are isolated. This does not mean you should assume that women and girls with diverse sexual orientation and/or gender identity who are GBV survivors are suicidal, but you should carefully look for warning signs, and as with any survivor, take expressions of suicidal thoughts seriously.
- ✓ In cases of child survivors, the caseworker and the child and/or the non-offending caregiver will jointly develop an action plan that includes referrals to protection and security agencies supplemented with an individual safety plan. Caseworkers may have to assess whether alternative care arrangements are necessary, first pursuing options with other family and friends (if safe to do so) and then through state or other organization's temporary shelter services.
- ✓ Safety plans for survivors with disabilities must be highly individualized and should take into account the individual's specific disability and living situation and ways in which a perpetrator may try to exploit the survivor's disability to isolate them, prevent them from leaving or further harm them. It is important to consider how the survivor's impairment may impact execution of their safety plan, and adjust the plan as necessary, looking at what disability-specific items the person may need if they implement their safety plan, such as medication, assistive devices or equipment, or relevant documentation for health or legal support.

IMPORTANT

Remind a survivor that her role in mitigating violence is for her own safety and IN NO WAY indicates that she is responsible for any violence perpetrated against her or can directly control when her abuser becomes violent. The abuser is 100% in control and responsible for their acts of violence and abuse.

Basic Steps in Safety Planning

If you are a caseworker speaking over the phone with a survivor who is currently within your case load or someone you have supported in the past, you have likely already developed a safety plan with her. In fact, as part of the shift to remote case management, you will hopefully have had the opportunity to meet with all clients in order to share information with them about the shift, as well to discuss any safety issues that might arise as a result of the shift to remote case management, and any safety issues that might occur as a result of lockdown or other restrictions of movement related to pandemics/ epidemics (see Box 7).

Box 7. Safety Planning with Current Clients Before Shifting to Remote Case Management

It is important that caseworkers help their clients prepare for the possibilities ahead and to feel a sense of control in a chaotic moment particularly for high-risk clients. Key issues and measures to explore include:

- ✓ Do clients have someplace safe to stay other than with the abuser now or in case of lockdown?
- ✓ If not, are there any steps clients can take to help minimize harm at home? Are there any weapons at home that can be removed?
- ✓ Do they have trusted friends or relatives they can keep in touch with?
- ✓ How can they alert someone that they need help in a safe way? Are there ways clients can plan with their neighbors to signal that they need support?
- ✓ Do clients have a place where they can safely keep the numbers of caseworkers, hotline, or other support providers? (Suggest that if they have phones, they may store the number under a code name, or the caseworker may print tiny cards that can easily be hidden.)

If you have shifted to remote GBV case management as a result of a pandemic/ epidemic, you will want to ***adapt this plan*** to ensure it reflects the current restrictions and context. Some of the specific concerns might be, is she allowed to leave her house? If not, does she interact at a distance with anyone other than her intimate partner/abuser? What resources in the previous safety plan are still available? Has the violence changed or increased? How do components of her existing plan need to be changed to her new reality?

If you are a caseworker working with a new client, it can be useful to have a guide for safety planning to use as a prompt to ask about safety-related issues and to complete a safety planning document with the survivor. When appropriate, the safety plan can be documented as part of the case action plan or can be documented separately. However, in all cases, it is critical to follow good practices for remote GBV case management documentation including how to codify and store confidential information, especially when a GBV caseworker or hotline operator is working from home (see Section 5, sub-section on documentation and data storage, below). If you document anything make sure to follow the remote GBV information management guidelines.[44]

Step 1. Remind her that she knows her situation best

Reassure the survivor that she is the expert and she is her own greatest resource. She is a survivor – she has strength and resilience — and she is already implementing many tactics to mitigate abuse. What does she do to mitigate violence before it happens? In cases of IPV, even though the restrictions are newly imposed, she may have been living with her abuser and may have previously been con- fined at home with him, or by him. Those experiences can inform her current situation. For child survivors try to engage non-offending caregivers and also affirm this message with them.

Tips / prompts for GBV caseworkers:

- ✓ What are the signals that suggest that the abuser is becoming aggressive?
- ✓ What does she do to mitigate violence before it happens?
- ✓ What does she do to dissuade / dissipate violence once it is already happening?

Step 2. Help her identify the 'Safest Room.'

In case of violence, identify an area of the home she can move to where there are no weapons (such as knives in the kitchen), and has an exit such as a door or window to get to another room or outside the home. For some survivors, especially those quarantined at home with an abuser during a

[44] See also, GBVIMS COVID-19 Series/Episode 6: Confidentiality and documentation: http://www.gbvims.com/covid-19/

pandemic/ epidemic, no room may feel safe, so we refer to it as the 'safest room'.[45] The goal is to identify the lowest risk areas with the intention of reducing harm. Help her identify rooms or spaces that have multiple entry points (i.e. windows and doors). Help her identify dangerous rooms or spaces that contain weapons or other objects that can be used as weapons. If no rooms feel safest, then at minimum help her identify rooms to avoid (again like the kitchen which has knives and large pots, or small closets with no escape, etc.). Depending on country-specific laws and context, a survivor should be legally allowed to escape from violence in the home, even during a lockdown. It is important for a GBV caseworker to know the rights of survivors and how restrictions affect them in crisis situations.

Tips /prompts for GBV caseworkers:

- What rooms or spaces are open and have multiple access points (i.e. doorsor windows)?
- If no rooms feel safest, then let's identify rooms to avoid. Are there weapons in your home? Do you keep knives or any other sharp tools anywhere other than the kitchen? Remind her to avoid small closets orother small spaces with no escape.
- Is there any furniture or specific things that your abuser has used in the past tocause harm?

Step 3. Help her plan with children (if applicable).

If the survivor has children, help her think through how she communicates urgency or danger with them. Some survivors prefer a 'physical code signal.' For example, a survivor opens her arms and her daughter knows this means to come running to her for safety.

Others create a 'verbal code word' with their children that means they should go to the 'safest room' in the home that has already been designated. Discuss with her whether her children are old enough and whether she feels safe sharing emergency contact names or phone numbers with her children in case of emergency. Considerations vary by context and availability, but age and ability of children should also be a factor in this decision. If the violence becomes life threatening, children may be able to call the police or alert a neighbor. Consideration should be taken on what and how to inform children noting that they may also be victim(s) of the abuser and may accidentally inform the abuser of safe words, or safety plans.

[45] Sanctuaries for Families, Safety Planning Covid-19: https://sanctuaryforfamilies.org/wp-content/uploads/2020/04/Safety-Planning-EN.pdf

For survivors who are completely isolated, with limited to no support, and no way to leave their homes, explore psychological wellbeing and safety through self-empowerment:

- Identify a goal or something the survivor wants to achieve or learn she can work towards;
- Invite her to create a space for herself;
- Remind her about the power of positive thinking (help her see how she is important to her family, community, and/or neighborhood);
- Help her practice self-care; remind her to be kind to herself and not be too critical about herself throughout the day, in particular when violence happens or immediately afterwards.

Step 4. Help her identify her support system (especially under new restrictions).

The level of restrictions related to pandemics/ epidemics vary country-to-country. Depending on her situation, a survivor may not be able to access her current support system and resources. Help her identify a new support system or new access points for support. In cases where the violence is getting severe, and the survivor fears for her life, she could agree that if she misses two or three calls from a friend, that the friend would then find a way to come check on her and/or send someone to her home.

Ensure she has a code word or code sign to signal a neighbor, family member, or trusted confidant in case abuse intensifies or becomes life threatening.

Ensure she knows where and when to access help through trusted GBV focal points in her community, or where to seek help from GBV staff.[46]

Tips / prompts for GBV caseworkers:

- Does she have a phone to make phone calls?
- If she has a phone but no credit, can she have people check in on her on a regular basis?
- Can she leave the house to go to the grocery store or a pharmacy?
- Who can she see?
- What services can she access while out of the house for an acceptable[47] time period?
- Does she have a code word or signal to notify a trusted neighbor or familymember in case abuse intensifies or becomes life threatening?
- What resources does she still have access to?
- Could it be a shopkeeper that she sees regularly?
- Could she slip a note under the door of a neighbor in case of emergency?

[46] For additional guidance for GBV specialists on low-tech ways to reach and support women and girls at risk of violence, or for women and girls to access care and support, please refer to the UNICEF guidance note on this topic: Not Just Hotlines and Mobile Phones: Gender-based violence service provision during COVID-19, https://www.unicef.org/documents/gender-based-violence-service-provision-during-covid-19

[47] According to the perpetrator's perception which is warped. In reality and actuality women and girls should have freedom of movement, although during a pandemic/ epidemic recognizing there may be Government restrictions on movement in order to contain infection spread.

For child survivors: What can a non-offending caregiver / trusted person do to support you right now?

Step 5. Help her talk through an exit plan if she decides to leave.

Always help her outline a plan in case she decides leaving is the safest option. It is important to weigh benefits, risks and realities during a pandemic/ epidemic; and **remind her** that leaving an abusive partner is often the most dangerous moment for the survivor. Ensure she has a go-bag pre-packed and hidden in the house or with a trusted confidant, ready to go for a sudden exit, as well as a plan on where to go, who to notify (if anyone), and finally a plan for her children (if she has children). **Remind her** not to leave anything in the go-bag that she may need to keep in the house, so her abuser does not suspect she is planning to leave. Remind her she should always be ready to answer any questions if the go-bag is found by her abuser. Help the survivor identify people she can stay with, and who have been supportive in the past, or somewhere the abuser will not know where to find her. Discuss the best time to leave, while the abuser is not around and preferably will not notice her missing for some time.

For child survivors, who are considering leaving an abusive situation, this is usually a step which would require engagement and support from non-offending caregivers/ guardians and service providers. It may also likely involve state actors e.g. State Social Worker or Police support to facilitate the child's safe relocation and placement in alternative care. Married adolescent girls may not require the engagement of a caregiver, depending on the context, but will likely need specialized and ongoing support to enable safe relocation to new housing / shelter. Given the complexities of the situation for child and adolescent survivors it is recommended that this step is discussed, assessed and handled through in-person case management, and that the child's case be transitioned to in-person case management, rather than these matters be dealt with solely by phone.

Step 6. Ask her to memorize the plan, or key components most relevant to her situation.

Writing things down can be dangerous for the survivor so talk the plan over with her so she memorizes key components. Remind her to review her plan (in her head) during moments of panic or if she is feeling helpless and alone, to help find calm, focus and a sense of empowerment.

RECAP

Help a survivor focus on (1) mitigating violence and identifying 'safer' areas of the home; (2) identifying support – even if more limited or restricted; (3) reaffirming the safety plan – and what to do in case she decides to leave.

Remind her she is not alone even if isolated!

Step 4: Implementation Planning

This step entails providing immediate emotional support as well as identifying referrals. In this step, it is very important that the caseworker is equipped with up-to-date referral information and is able to inform the survivor about any delays in services. For each referral that a survivor requests, verbal informed consent should be obtained if the caseworker is going to initiate contact with a provider on behalf of the survivor. The caseworker should also establish whether and how the service provider (or caseworker) can follow up with the client about the referral service, as necessary.

Step 5: Provide Resources and Key Messages

This step entails closing the call with the survivor safely. This includes providing information and key messages on issues such as:

- Relevant (i.e. suited to the phone modality) psychosocial support e.g. healing statements, useful relaxation/stress reduction techniques.
- Briefly summarizing what was discussed and agreed on the call and the plan for transitioning to in-person case management support (if feasible).
- Information about how and when she can call/ text you, including how to use silent alerts (if feasible with the technology the survivor is using), as well as providing her information about what to do if she cannot reach you. Information about arranging in-person support sessions, where this is feasible.
- Making contact with service providers on behalf of the survivor, or providing the survivor with the contact information of the provider—including how this information can be shared in a way that does not further endanger the survivor, if the perpetrator is likely to get a hold of her phone—such as using code words for different providers.
- Assessing the survivors' feelings, sensations and thoughts – to the extent feasible on a phone- in order to end the remote case management session in a safe, secure and supportive manner.

Always remember:

1. The client is the primary actor in case management, even when conducting case management over the phone.
2. Action plans are developed in collaboration with the client and must reflect her wishes and choices. In a pandemic /epidemic, when services may be limited, it is important to be able to offer up-to-date information about services so that the client can make realistic choices.
3. The goal is to empower the client and ensure that she is involved in all aspects of the planning and service delivery.

Summary

The basic elements of a phone-based case management session with an adult survivor will likely include:

1	Making/answering the call at the appointed time and in accordance with a standardized session opening script;

2	Outlining (or if a repeat session reminding the survivor of) the standards and limits to confidentiality;
3	Collecting intake information (if this has not been done prior), including understanding what the survivor's key concerns are;
4	Providing emotional and psychosocial support;
5	Providing accurate information about the issues affecting the caller;
6	Identifying/ following up on referral needs, soliciting informed consent for new referrals and referring survivors to resources;
7	Ending the case management session in a supportive manner; and reminded survivors to delete the call record from their phone and any messages (if messages are used).
8	Completing case management paperwork/ GBVIMS+ as required.

Steps for Managing Calls with Child Survivors

Whether working with existing or new child survivor clients, the caseworker will want to bear in mind a few key steps for each call, outlined below. These general steps will need to be adapted for each setting. For phone-based case management calls with/relating to child survivors it is important to bear in mind the following over-arching points:

- Calls will either be with the child only, with the child and non-offending caregiver, or, with just the non-offending caregiver depending on the age and developmental understanding of the child. Calls will likely and typically, have a caregiver present who mediates/ enables the calls, particularly in the first instance. Caseworkers will need to be assured that the caregiver is able to act in the best interests of the child and not be an abusive caregiver in order to engage them in the process. This can be challenging to ascertain with certainty through phone-based contact alone. Caseworkers may need support from their supervisors to make a determination about whether they can offer phone-based case management support to child survivors with their caregivers before proceeding beyond an initial conversation.
- **Phone based case management is not optimum for child survivors of sexual abuse and delivery of in-person case management for child survivors of sexual abuse should be prioritized during pandemics/ epidemics – to the extent that restrictions permit-,**with social distancing and other IPC measures put in place to enable this and mitigate against disease transmission.
- Phone-based case management for child survivors during a pandemic/ epidemic may be feasible for initial introduction/ receipt of referral, for specific psychosocial support (e.g. relaxation technique) and limited follow-up but is not an equivalent for the quality of care that can be provided through in-person case management especially for this at-risk and

vulnerable group. Specific parts of the case management process e.g. assessment, detailed MHPSS assessment, range of MHPSS interventions and case closure really warrant survivor to caseworker contact, in order to support safe engagement and to understand the range of needs a child may have, support rapport / trust-building and reduce risks of re-traumatization. **Therefore, it is important to try and transition child survivors to in-person sessions, as soon as feasible.**

- If caregivers are attending phone-based case management with the child survivor caseworkers will need to be mindful of this, the dynamic it may create, and be cognizant to seek input from both (according to the age and developmental capacity of the child) so that there is active participation.
- If only the caregiver is participating in the phone-based case management sessions caseworkers (due to the young age of a child or their developmental capacity e.g. non-verbal) they will need to be aware that the information they are receiving is only through the lens of the caregiver and that this is a limitation which potentially misses key information which a caseworker would pick up on through in-person sessions with a child survivor and a caregiver (e.g. body language of a child, their dynamic with their caregiver, potential strengths and resources a child may have) which would be made clear during in-session activities and interactions.
- Information related to managing particular challenges, such as safety issues and difficult calls are covered in Section 4 and 5.

A caseworker must first check and confirm with the child survivor/ non-offending caregiver or both (if both are on the call) that it is safe (including in a private location where the call will not be overheard) and a good time to speak. Once it is clear that it is safe to proceed with the call, the caseworker should review some basic safety measures that can be implemented should the call be interrupted. The caseworker and the survivor can agree on a safe word or a code indicating the need to shift to a neutral topic or end the call. The caseworker and the survivor can also discuss other potential courses of action related to various scenarios, including:

- Someone asks what the survivor/ caregiver/both is/are doing and/or to whom they are talking to over the phone.
- Someone else in the household picks up the phone.
- The survivor / caregiver / both need to stop the call.
- The survivor / caregiver / both need to switch to an alternative phone.

REMEMBER: If the child survivor and/or their non-abusive caregiver do not sound comfortable and/or you hear sound from others in the middle of the call, please do not continue and give them an option to contact you when they do feel more comfortable speaking, through means that have been pre-established, such as a missed-call, text message or texted password, or any other strategy that they have stated is safe for them.

Step 1: Introduction and Engagement

Caseworkers should continue to take time for the introduction and engagement step in accordance with the CCS Guidelines given the importance of building trust and rapport with children and ensuring that they receive all the necessary information regarding the service provider and the way in which the service is offered. Reassuring a child when they are help-seeking is crucial as they may be fearing reaction of service providers as abusers may have told them they will be 'in trouble' if they report the abuse. Calls will likely and typically, have a caregiver present who mediates/ enables the calls, particularly in the first instance.

It is also critically important as the first step in a call to determine whether the client (child survivor) and their non-abusive caregiver is able to speak on the phone at the designated time of the call, because even if the time for the call is scheduled in advance, circumstances may change. Potential questions to confirm the safety and security of the caller can be asked in way that require **"yes" or "no"** responses so that if the survivor is not in a safe place, no one will know what she is speaking about:

- Are you (both)[48] comfortable talking right now? Do you (both) agree to continue this talk now over the phone? Or do you (both) prefer we schedule at a different time? Or do you both prefer to register a missed-call (on the caseworker's work phone) or text me when you are ready?
- Is this the right number to call? Or do you prefer me to call any other alternative numbers?
- Are you taking the call from a room that can ensure privacy and confidentiality of the conversation?
- Do you think someone might walk in during our conversation?
- Do you (both) feel safe and have enough privacy for our conversation?
- Are you (both) fine talking now?
- (If only the child survivor is calling and this is an initial contact call) do you have a trusted caregiver who could support you in joining this call? Do you have a trusted caregiver who could support you with coming to our center and accessing the services we provide?

It is also important to explain the limits of confidentiality to the child, any mandatory reporting requirements and how these are navigated and explain what it means in your role when you are required to act in the best interests of the child to enable the child and their non-abusive caregiver to make informed decisions about what they choose to share with you and what they do not.

If a disclosure of sexual abuse is received it is preferable to offer in-person support for child survivors and to understand if the child is able to travel safely to access in-person support with a non-offending care giver or may require accompaniment support to access the service delivery site. This is given the age, vulnerability and risk associated with cases of child sexual abuse and the importance of trying to support action in the best interests of the child and enable a more effective assessment of concerns than is likely to be possible via phone-based case management.

[48] Child survivor and their non-abusive caregiver

Step 2: Assessment of Concerns

In this step, the caseworker will aim to assess any new or on-going concerns, such as safety and security at home, medical/health needs or any other issues related to safety and well-being. In the context of pandemics/ epidemics, when challenges arise in accessing services, it is especially important to determine how the client (child survivor) and their non-abusive caregiver (when applicable) is managing with the changes. However, as specified previously within this guidance **phone-based case management is not optimum for child survivors of sexual abuse and delivery of in-person case management for child survivors of sexual abuse should be prioritized during pandemics/ epidemics – to the extent that restrictions permit-,with social distancing and other IPC measures put in place to enable this and mitigate against disease transmission. Specific parts of the case management process like assessment**, detailed MHPSS assessment, range of MHPSS interventions and case closure really **warrant survivor to caseworker contact, in order to support safe engagement and to understand the range of needs a child may have, support rapport / trust-building and reduce risks of re-traumatization. Therefore, it is important to try and avoid doing assessments by phone, if possible, and to transition child survivors to in-person assessment and case management sessions, as soon as feasible**. If phone-based assessment is the only option e.g. due to Government movement restrictions and delay will cause harm then exercise great care and attention throughout the process following the pointers provided within this section. As indicated prior, it may be that a phone-based case management assessment with the non-abusive caregiver on the call or mediated / enabled through them. At this stage, the caseworker should:

- Listen actively and be sure to dedicate time to ensure the survivor (and their non-abusive caregiver, if applicable) has been heard;
- Provide age and developmentally appropriate emotional support through healing messages, validation, and compassion, as well as any useful information-sharing that helps the survivor to cope;
- Consider whether the non-abusive caregiver is also impacted by the violence and abuse. For example, caseworkers should be aware of the links between child sexual abuse against children and intimate partner/domestic violence – without shifting the primary focus from the child it is also feasible to consider and explore whether the non-abusive caregiver may benefit from a referral to support services by discussing this option with them, either on the same call or a separate follow-up call.
- Reflect back and summarize to the survivor (and the non-abusive caregiver, if on the call) what you understand to be her safety and other needs.

In cases of child sexual abuse, especially if the sexual abuse happened at home or with a family member, caseworkers should ask the child (if aged six years or older) about their safety concerns privately. This allows the child to speak without a parent/caregiver on the call or in the room and may elicit more information than would have been obtained otherwise. If a child refuses to speak with the caseworker alone and/or the child and caregiver sound upset or agitated, the caseworker

should use their judgment and determine whether to proceed with the safety assessment jointly. The most important question for caseworkers to answer during the safety assessment is whether the child is safe from further abuse. Information gathered during the initial assessment phase about the perpetrator will help answer this question.

When the survivor is a very young child, the perpetrator is most often known to the child and may have ease of access to them, even after a non-offending caregiver seeks services. In addition, the non-offending caregiver may not know who the perpetrator is or even that their child was sexually abused when they seek services. They may seek services because they feel they need support with the child's subsequent behaviors and not recognize the underlying cause of these behaviors. These points underscore the complexity of effectively supporting child survivors of sexual abuse and their non-offending caregivers and why in-person support is a more effective modality for being able to engage and provide effective interventions which are in the best interest of the child.

Remember: it is preferable to offer in-person support for child survivors and to find out if the child is able to travel safely to access in-person support with a non-offending caregiver or may require accompaniment support to access the service delivery site. This is given the age, vulnerability and risk associated with cases of child sexual abuse and the importance of trying to support action in the best interests of the child and enable a more effective assessment of concerns than is likely to be possible via phone-based case management.

Step 3: Case action planning for child survivors of sexual abuse (including safety planning)

In addition to the above points made in relation to case action planning for adults when supporting a child survivor of sexual abuse, caseworkers will need to understand what types of support the child survivors needs and their resources/strengths/capacities, (including those of a non-offending caregiver). As part of this the caseworker may have to assess whether alternative care arrangements are necessary, first pursuing options with other family members or friends (if safe to do so) and then through State or other organization's temporary shelter services.

Tips / prompts GBV caseworkers can potentially use with non-offending caregivers of child survivors and child survivors (depending on their age and developmental capacity):

- What are the signals that suggest that the abuser is becoming aggressive?
- What is feasible to do to mitigate violence before it happens?
- What does she do to dissuade / dissipate violence once it is already happening?
- What rooms or spaces are open and have multiple access points (i.e. doors or windows)?
- If no rooms feel safest, then let's identify rooms to avoid. Are there weapons in your home? Are there any knives or any other sharp tools anywhere? Remind her to avoid small closets or other small spaces with no escape.

- Is there any furniture or specific things that your abuser has used in the past to cause harm?
- Does she have a phone to make phone calls? Or, does she have access to a non-offending caregiver's phone to make phone calls?
- If she has a phone but no credit, can she have people check in on her on a regular basis?
- Can she leave the house to go to school or to play?
- Who can she see?
- What services can she access while out of the house? E.g., health clinic? School?
- Does she have a code word or signal to notify a trusted family member or neighbor in case abuse intensifies or becomes life threatening?
- What resources does she still have access to?
- Could she knock on a neighbor and ask for access to safety in their house in case of emergency?
- For child survivors: What can a non-offending caregiver / trusted person do to support you right now?

Note: the feasibility of survivors/caregivers being able to answer these questions will likely be related to the age and developmental capacity of the child survivor.

When safety planning, be aware that child survivors may lack strength or independent capacity to take specific actions identified as essential within a safety plan. Children may also become fearful during the safety planning process so it is important to provide reassurance and explain that the purpose of it is to support preparation in the event of something happening, it does not mean that the situation will happen. It is optimum to include a non-abusive caregiver on the calls, when feasible as they may also be able to reassure the child after the call and support implementation of the safety plan.

Throughout the case action planning and safety planning the caseworker should listen for any indications that a survivor has feelings about harming herself. If there is any suggestion that the survivor is suicidal, the caseworker should be prepared to undertake a suicide assessment, as outlined in Section 4. When talking through safety planning processes with a child it is important to do so in a way which is in accordance with their age and developmental stage and to engage non-offending caregivers where feasible. Children may be fearful and scared, and it is important to offer reassurance and explain the purpose of the safety plan is not to alarm them but to help them prepare and know what actions to take to help them in case they should need to act quickly.

Remember: it is preferable to offer in-person support for child survivors and to find out if the child is able to travel safely to access in-person support with a non-offending caregiver or may require accompaniment support to access the service delivery site. This is given the age, vulnerability and risk associated with cases of child sexual abuse and the importance of trying to support action in the best interests of the child and enable a more effective assessment of concerns than is likely to be possible via phone-based case management.

Step 4: Implementation Planning

This step entails providing immediate emotional support as well as identifying referrals. In this step, it is very important that the caseworker is equipped with up-to-date referral information and is able to inform the survivor about any delays in services. For each referral that a survivor requests, verbal informed consent should be obtained if the caseworker is going to initiate contact with a provider on behalf of the survivor. Where a caseworker is working with a child survivor and their non-offending caregiver, informed consent should be obtained from the caregiver, while also seeking the child's informed assent. This is also the stage where the caseworker will complete any mandatory reporting procedures in line with the best interests of the child. The caseworker should also establish whether and how the service provider (or caseworker) can follow up with the client about the referral service, as necessary.

Remember: it is preferable to offer in-person support for child survivors and to find out if the child is able to travel safely to access in-person support with a non-offending caregiver or may require accompaniment support to access the service delivery site. This is given the age, vulnerability and risk associated with cases of child sexual abuse and the importance of trying to support action in the best interests of the child and enable a more effective assessment of concerns than is likely to be possible via phone-based case management.

Step 5: Provide Resources and Key Messages

The fifth step entails closing the call with the survivor safely. This includes providing information and key messages on issues such as:

- Relevant (suited to the phone modality) psychosocial support e.g. healing statements, useful relaxation/stress reduction techniques
- Briefly summarizing what was discussed and agreed on the call and the plan for transitioning to in-person case management support (if feasible). And, in relation to safety planning (e.g. for a caregiver to assemble a bag with the child's essentials in there may be a need for emergency relocation / temporary alternative care arrangement)
- Information about how and when she can call/ text you, including how to use silent alerts (if feasible with the technology the survivor is using), as well as providing her information about what to do if she cannot reach you. Information about arranging in-person support sessions, where this is feasible.

- Making contact with service providers on behalf of the survivor, or providing the survivor with the contact information of the provider—including how this information can be shared in a way that does not further endanger the survivor, if the perpetrator is likely to get a hold of her/ the non-offending caregiver's phone—such as using code words for different providers.
- Assessing the survivors' feelings, sensations and thoughts – to the extent feasible on a phone- in order to end the remote case management session in a safe, secure and supportive manner.

Always remember:

1. The client is the primary actor in case management, even when conducting case management over the phone.
2. Action plans are developed in collaboration with the client and must reflect her (and when applicable the non-offending caregiver's) wishes and choices. During pandemics/ epidemics, when services may be limited, it is important to be able to offer up-to-date information about services so that the client (and their non-offending caregiver) can make realistic choices.
3. The goal is to empower the client (and the non-offending caregiver) and ensure that she is/ they are involved in all aspects of the planning and service delivery.

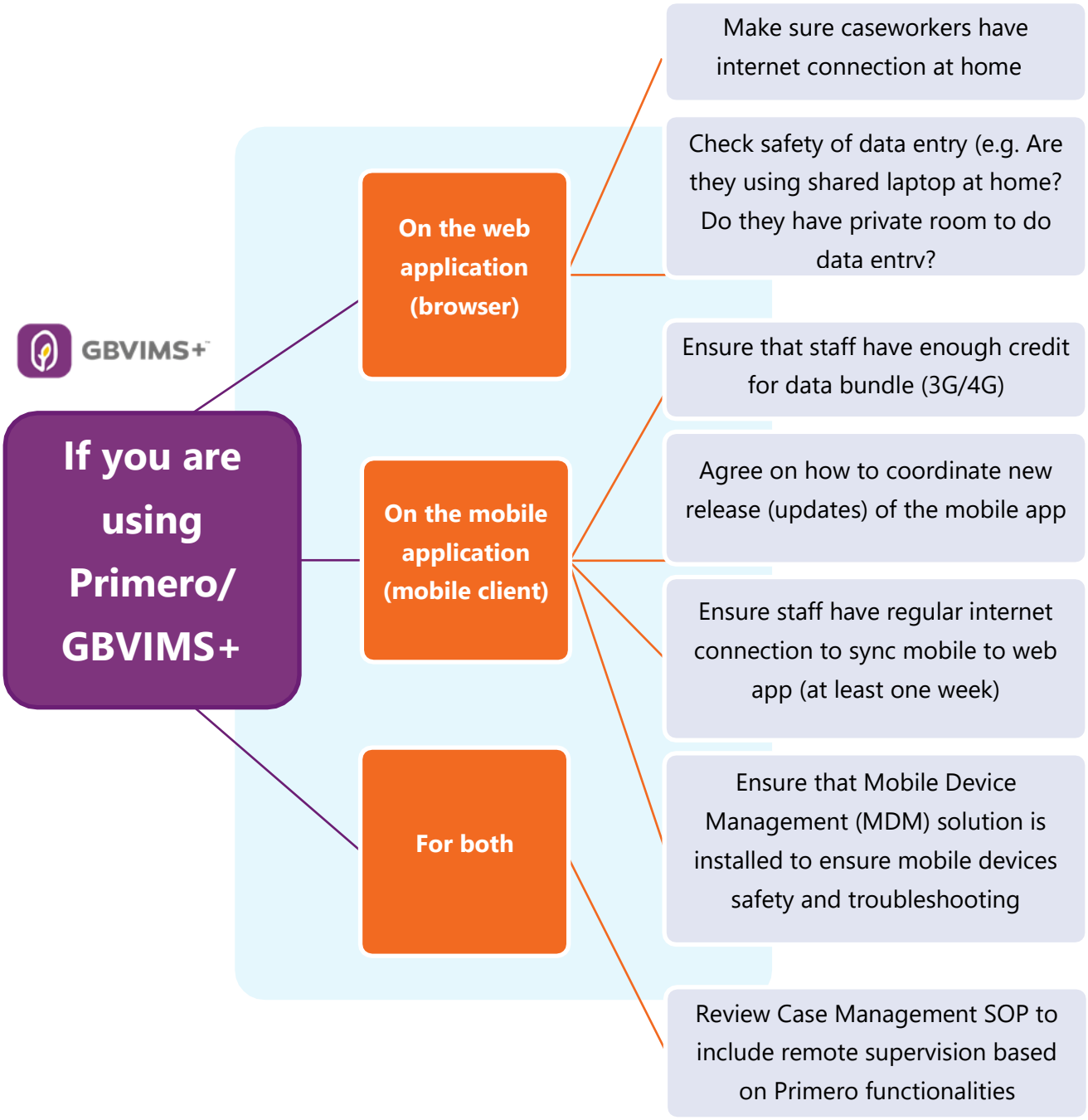
Summary

The basic elements of a phone-based case management session with a child survivor (and their caregiver, when applicable) may include:

1	Making/answering the call at the appointed time and starting the call in accordance with a standardized session opening script;
2	Explaining in age and developmentally appropriate language the standards and limits to confidentiality for child survivors (including any mandatory reporting requirements). If this is not the first session with the child (and their non-offending caregiver) nevertheless repeat this information each time and go through the safety protocol (e.g. hanging up the call, verbalizing that must be a wrong number or other pre-agreed script) if another person enters the space where the child (and their caregiver) are having the call which may result in them being overheard.
3	Collecting basic intake information (if this has not been done prior), including understanding what the survivor's key needs are. Explaining that it would be important to transition to in-person case management (where this is feasible) to continue a thorough assessment of needs.
4	Providing basic emotional and psychosocial support relevant to the age and developmental stage of the child and the modality. E.g. healing statements,

	abbreviated relaxation techniques, grounding techniques etc. rather than extended activities which require time and extended input/ supervision of a caseworker to be conducted safely.
5	Listening for and trying to understand the resources (strengths and capacities) the child (and their non-offending caregiver has) and assessing for risk, create / update a safety plan together and provide accurate information in relation to relevant resources or sources of further support for the child survivors (primary concern) and non-offending caregiver (for example, if they are a co-survivor).
6	Identifying/following up on referral needs, soliciting informed assent/consent for new referrals and referring survivors to resources;
7	Ending the case management session in a supportive and child-friendly manner; Reminded them/ their non-offending caregiver of how to delete the call record from their phone and any messages (if messages are used).
8	Completing case management paperwork/ GBVIMS+ as required.

Figure 4: Adaptation to the GBVIMS and/or Primero/GBVIMS for remote service delivery



6. Addendum note regarding video-based GBV related case management for adult and child survivors

This guidance primarily addresses remote GBV case management delivered through phone-based or other audio-only modalities. While video-based case management may also be conducted via mobile devices, the scope of this guidance has not been expanded to systematically cover video-based approaches nor fully examine its benefits, risks/limitations. Although video could be useful to support case management for adult and child survivors, there are multiple practical considerations, including higher bandwidth requirements and the reduced reliability of video connectivity in many humanitarian and emergency settings, which may limit its suitability for consistent, effective and safe case management. As such, the guidance remains focused on phone and audio-based support.

7. Further reading and resources

Phone-based Case Management

Ceri Hayes; Tackling Gender-Based Violence with Technology: Case Studies of Mobile and InternetTechnology Interventions in Developing Contexts; STATT; accessed on June 2020 through: http://www.gendermatters.co.uk/pdfs/STATT%20Tackling%20GBV%20with%20Technology.pdf

Dorcas Erskine (2020) Not just Hotline/Helplines and mobile phones: GBV Service provision during COVID-19; UNICEF; accessed on June 2020 through: https://www.unicef.org/media/68086/file/ GBV%20Service%20Provision%20During%20COVID-19.pdf

Kate Stratten and Robert Ainslie (2003) Setting Up a Hotline/Helpline: Field Guide; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; accessed on June 2020 through: https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

GBV AoR (2019) Handbook for Coordinating Gender-based Violence Interventions in Emergencies; accessed on June 2020 through: https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/handbook-for-coordinating-gender-based-violence-interventions-in-emergen- cies/Handbook_for_Coordinating_GBV_in_Emergencies_fin.01.pdf

GBVIMS, 2020. Case Management, GBVIMS/GBVIMS+ and the COVID-19 Pandemic. http://www.gbvims.com/wp/wp-content/uploads/GBV-Case-Management-GBVIMS-GBVIMS-and-the-Covid-19-Pandemic_GBVIMS_March_2020.pdf

GBVIMS Case Management & COVID-19 Video Series: Taking a crisis call - what to say & how to say it. https://www.youtube.com/watch?v=LQtAEB0b2Jw&feature=youtu.be

Gender Based Violence Sub Sector; Nigeria (2020) Gender Based Violence (GBV) Helpline Management Rapid Assessment Report; accessed on June 2020 through: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/gbv_helpline_mgt-rapid_assessment_report._final.pdf

Interagency GBV Case Management Guidelines (2017) and Training Tools. https://gbvresponders.org/response/gbv-case-management/

IFRC, 2020. Hotline in a Box. https://www.communityengagementhub.org/wp-content/uploads/sites/2/2020/02/200128_Full-toolkit.pdf

IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery; International Rescue Committee; accessed on June 2020 through: https://gbvresponders.org/wp-con-tent/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

ILO; Practical workplace initiatives to prevent and respond to sexual harassment and violence, briefing 7.1 Point 5: Setting up and running Hotline/Helplines and helplines; International Training Center at the International Labor Organization; accessed in June 2020 through: https://gbv.itcilo.org/index.php/briefing/show_paragraph/id/107.html

New Jersey Division of Criminal Justice (1994) Handling a Domestic Violence Call In-Service Training for Police Dispatchers: Instructor Manual; accessed on June 2020 through: https://www.njpdresources.org/dom-violence/dv-dispatcher-instr.pdf

Robyn Yaker and Dorcas Erskine (2020) Gender-Based Violence Case Management and the COVID-19 Pandemic; SDDirect for the GBV AoR Helpdesk; accessed on June 2020 through: http://www.sddirect.org.uk/media/1968/gbv-case-management-and-covid-19-pandemic-updated-ver- sion-19052020.pdf

Silent solution guide; Independent Office for Police Conduct; United Kingdom police; Accessed on June 2020 through: https://www.policeconduct.gov.uk/sites/default/files/Documents/re- search-learning/Silent_solution_guide.pdf

WHO, 2020. Setup and Management of COVID-19 Hotlines.

SGBV WG Jordan, April 2020. Provision during COVID-19 in Jordan and a forward look to safe resume of services, https://reliefweb.int/report/jordan/guidance-note-gbv-service-provision-during-covid-19-jordan-and-forward-look-safe

Miscellaneous resources, https://gbvguidelines.org/cctopic/covid-19/

Hotlines

Ceri Hayes; Tackling Gender-Based Violence with Technology: Case Studies of Mobile and Internet Technology Interventions in Developing Contexts; STATT; accessed on June 2020 through: http://www.gendermatters.co.uk/pdfs/STATT%20Tackling%20GBV%20with%20Technology.pdf

Dorcas Erskine (2020) Not just Hotline/Helplines and mobile phones: GBV Service provision duringCOVID-19; UNICEF; accessed on June 2020 through: https://www.unicef.org/media/68086/file/ GBV%20Service%20Provision%20During%20COVID-19.pdf

Kate Stratten and Robert Ainslie (2003) Setting Up a Hotline/Helpline: Field Guide; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; accessed on June 2020 through: https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

GBV AoR (2019) Handbook for Coordinating Gender-based Violence Interventions in Emergencies; accessed on June 2020 through: https://www.un.org/sexualviolenceinconflict/wp-content/uploads/2019/06/report/handbook-for-coordinating-gender-based-violence-interventions-in-emergen- cies/Handbook_for_Coordinating_GBV_in_Emergencies_fin.01.pdf

GBVIMS, 2020. Case Management, GBVIMS/GBVIMS+ and the COVID-19 Pandemic. http://www.gbvims.com/wp/wp-content/uploads/GBV-Case-Management-GBVIMS-GBVIMS-and-the-Covid-19-Pandemic_GBVIMS_March_2020.pdf

GBVIMS Case Management & COVID-19 Video Series: Taking a crisis call - what to say & how to say it. https://www.youtube.com/watch?v=LQtAEB0b2Jw&feature=youtu.be

Gender Based Violence Sub Sector; Nigeria (2020) Gender Based Violence (GBV) Helpline Management Rapid Assessment Report; accessed on June 2020 through: https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/gbv_helpline_mgt-rapid_assessment_report._final.pdf

Interagency GBV Case Management Guidelines (2017) and Training Tools. https://gbvresponders.org/response/gbv-case-management/

IFRC, 2020. Hotline in a Box. https://www.communityengagementhub.org/wp-content/uploads/sites/2/2020/02/200128_Full-toolkit.pdf

IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery; International Rescue Committee; accessed on June 2020 through: https://gbvresponders.org/wp-con- tent/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

ILO; Practical workplace initiatives to prevent and respond to sexual harassment and violence, briefing 7.1 Point 5: Setting up and running Hotline/Helplines and helplines; International Training Center at the International Labor Organization; accessed in June 2020 through: https://gbv.itcilo.org/index.php/briefing/show_paragraph/id/107.html

New Jersey Division of Criminal Justice (1994) Handling a Domestic Violence Call In-Service Training for Police Dispatchers: Instructor Manual; accessed on June 2020 through: https://www.njpdresources.org/dom-violence/dv-dispatcher-instr.pdf

Robyn Yaker and Dorcas Erskine (2020) Gender-Based Violence Case Management and the COVID-19 Pandemic; SDDirect for the GBV AoR Helpdesk; accessed on June 2020 through:

http://www.sddirect.org.uk/media/1968/gbv-case-management-and-covid-19-pandemic-updated-ver- sion-19052020.pdf

Silent solution guide; Independent Office for Police Conduct; United Kingdom police; Accessed on June 2020 through: https://www.policeconduct.gov.uk/sites/default/files/Documents/re- search-learning/Silent_solution_guide.pdf

WHO, 2020. Setup and Management of COVID-19 Hotlines.

Safety Planning and Other Support to High-Risk Clients

GBV AoR (2019), Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies, https://www.unfpa.org/sites/default/files/pubpdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf

Interagency GBV Case Management Guidelines (2017) and Training Tools, https://gbvresponders.org/response/gbv-case-management/

IRC, UNICEF (2023), Caring for Child Survivors of Sexual Abuse Resource Package (Second Edition), https://knowledge.unicef.org/child-protection/caring-child-survivors-sexual-abuse-ccs

IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery; International Rescue Committee; accessed on June 2020 through: https://gbvresponders.org/ wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

GBVIMS (2020), Case Management and COVID-19 Video Series: Safety planning with GBV survivors over the phone: https://www.youtube.com/watch?v=ZBZxf9j6jTg&feature=youtu.be

Silent solution guide; Independent Office for Police Conduct; United Kingdom police; Accessed on June 2020 through: https://www.policeconduct.gov.uk/sites/default/files/Documents/re- search-learning/Silent_solution_guide.pdf

Updating Referral Pathways

GBVIMS, 2020. Case Management and COVID-19 Video Series: Adapting Referral Pathways. https://www.youtube.com/watch?v=4SV17TQQCDg&feature=youtu.be

IRC, 2018. Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery. https://gbvresponders.org/wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Deliv- ery-Guidelines_-final.pdf

GBV AoR and UNFPA, 2019. The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. https://www.unfpa.org/sites/default/files/pub-pdf/19-200_Minimun_Standards_Report_ENGLISH-Nov.FINAL_.pdf

GBV SC- Iraq Referral Pathways during the time of COVID-19 Outbreak https://drive.google.com/drive/folders/16N5ytjys7RSeANC0RAIX-da3ZIoK946t

Documentation and Data Storage

GBVIMS COVID-19 Series/Episode 1: COVID-19, The GBVIMS, and Case Management Data Management and Storage: This podcast episode kicks off a new series dedicated to the current COVID-19 pandemic. The GBVIMS technical team discusses how COVID-19-related restrictions and lockdowns impact the GBVIMS and case management data collection and storage. In addition, we discuss how our new digital platform, Primero/GBVIMS+, can allow service providers to continue delivering lifesaving case management services to GBV survivors. The podcast can be found here.

GBVIMS COVID-19 Series/Episode 6: Confidentiality and documentation: When shifting case management services from safe spaces to remote service delivery over the phone, this will have an implication on how to manage confidentiality, and the documentation of GBV cases. This episode presents strategies on how this adaptation can be managed and what organizations need to consider. The video short can be found [English] [French] [Arabic] [Spanish] and the podcast can befound here [English] [French] [Arabic] [Spanish].

Supervision and Staff Care

Inter-agency GBV Case Management Guidelines and Training Materials, Module 19: Staff Care https://gbvresponders.org/response/gbv-case-management/

GBV AoR Helpdesk (2024) Tip Sheet: Collective Care. https://sddirect.org.uk/resource/tip-sheet-collective-care

GBV AoR Helpdesk (2024) Annotated Bibliography: Collective Care Processes and Practices. https://sddirect.org.uk/resource/annotated-bibliography-collective-care-processes-and-practices

Gender-based Violence Area of Responsibility. (2019). The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. Retrieved from

https://gbvaor.net/sites/default/files/2019-11/19200%20Minimun%20Standards%20Report%20EN-GLISH-Nov%201.FINAL .pdf

IASC. (2020). Interim Briefing Note: Addressing mental health and psychosocial support aspects of COVID-19 outbreak (Version 1.5). Retrieved from https://interagencystandingcommittee.org/iasc-ref- erence-group-mental-health-and-psychosocial-supportemergency-settings/interim-briefing

IASC. (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Retrieved from https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007. pdf

IASC. (2008). Guidelines on Mental Health and Psychosocial Support in Emergency settings: checklist for field use. Retrieved from https://interagencystandingcommittee.org/system/files/legacy_files/Checklist%20for%20field%20use%20IASC%20MHPSS.pdf

Smit, H., Creighton, J. and UNICEF (2026). Global Caring for Child Survivors' Supervision Support: Coaching Manual.

UNICEF. (2020). Seven ways employers can support working parents during the coronavirus disease. (COVID-19) outbreak. Retrieved from https://www.unicef.org/coronavirus/7-ways-employ-https://www.unicef.org/coronavirus/7-ways-employers-can-supportworking-parents-during-coronavirus-di