# Increasing Access to Care and Healing for Gender-based Violence (GBV) Survivors: Innovative Approaches to GBV Case Management in Insecure Emergency Environments

The European Civil Protection and Humanitarian Aid Operations (ECHO) and the Bureau of Population, Refugee and Migration (BPRM) supports IRC with the "Increasing Access to Care and Healing for Gender-based Violence (GBV) Survivors: Innovative Approaches to GBV Case Management in Insecure and Emergency Environments" encompassing mobile and remote-technology based approaches to GBV service delivery. The project includes four components, with anticipated timelines outlined below:

**1) Developing tools, platforms and program guidance for using mobile and technology-based approaches for GBV service delivery**

- Input from GBV expert practitioners informed initial program guidance (January-February 2017)
- Workshops held in Myanmar and Iraq to design contextually relevant program models (February-March 2017)
- Tools and platforms developed (January-November 2017)
- Program guidance adapted based on ongoing learning (June 2017-August 2018)

**2) Building the capacity of staff to pilot models and tools in urban and out-of-camp displacement contexts in Myanmar and Iraq (with co-funding from ECHO supporting piloting in Burundi)**

- Initial training workshops held in Iraq and Myanmar (April-May 2017)
- Continued capacity building of staff (June 2017-February 2018)

**3) Implementing and testing program models for feasibility and acceptability**

- Partnership established with University of Colorado-Boulder affiliated researchers, L. James and C. Welton- Mitchell (April 2017)
- Research tools developed for IRB submission (April-October 2017)
- Study launch (February-May 2018)

**4) Disseminating learning, program guidance, and tools to the humanitarian community**

- Finalization of guidelines according to study results and expert practitioner review (June 2018)
- Dissemination of learning, program guidance, and tools (August-September 2018)

Project Duration: September 1, 2016 – August 31, 2018

## What is mobile GBV service delivery?

Mobile programming allows trained staff to travel to targeted areas to provide in-person GBV services in an emergency or protracted displacement context where static GBV services do not exist or are inaccessible to the population. Depending on the displacement density and population per site, the number of mobile teams and the visitation schedule will vary. Likewise, activities offered by mobile teams will also vary according to the context and the phases of the intervention. Ultimately, a goal to promote sustainability is to shift to a more static, community-led service model with consistent access to caseworkers, trained in GBV case management and remotely supervised and supported by the program. In order to reach that goal, in addition to direct GBV service delivery for beneficiary populations, capacity-building and remote supervision opportunities are prioritized in current programming for community focal points. Where it is deemed safe, community focal points will take on more direct roles in the provision of case management after they demonstrate skills and knowledge about safe, confidential GBV service delivery through training, skills assessments and remote supervision.

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## What do mobile GBV teams provide?

Mobile GBV teams provide immediate lifesaving services to displaced populations. Prioritized GBV services include: essential health, case management and psychosocial support (PSS) services, safety options, GBV risk mitigation, coordination, and advocacy. These are adapted to the context based on the availability of services, the needs of women and girls, and the risks and patterns of violence, as determined from rapid assessments.

Three models of mobile GBV service delivery are commonly utilized. The "Safe Space Model" provides PSS activities in temporary safe spaces for women and girls with confidential access to case management in an adjoining room. The "Embedded Services Model," on the other hand, may not be a stand-alone GBV program, but may instead integrate essential GBV services into existing programming including health, protection, and child protection (CP).[1] While the "Safe Space Model" is the most comprehensive model for women and girls because it allows for PSS services—a key component for survivor recovery—as well as case management, the "Embedded Services Model" allows for a better entry point for male and LGBTI survivors, but requires additional staff, more cross-sectoral training and strong coordination, dedication to ensuring private space, and targeted information dissemination within static or mobile health clinics for safe referrals. To achieve the benefits of both approaches, a third model of mobile GBV service delivery offers a combined "Safe Space" and "Embedded Services" model. This model offers support for PSS activities, and integrates staff within health services. With phone access and network, all program models require remote support through phones or hotlines while the mobile team is not in site.

**In Northern Shan State of Myanmar**, the IRC operates a combined model of "Safe Spaces" and "Embedded health services" in 19 IDP sites. The IRC works with a women's organization to expand outreach to 14 focal point-led safe spaces and offers remote supervision and case management support through a hotline. All members are trained in emergency GBV mobile response for cyclical displacements characteristic of the conflict dynamics of Northern Shan State.

**In Iraq** IRC provides programming through partner organizations in Baghdad and in 11 mobile sites in the targeted area of Al-Hussainys (between Karbala and Al-Najaf road).

Mobile safe space or embedded GBV service models are planned based on vehicle space, contact time in the community, security protocols, rotation schedule between mobile sites, structures used to deliver services (tents, community buildings, etc.), and opportunities to work with community service providers. Regardless of which model is used, for the safety and community acceptance of GBV teams, mobile GBV team members should be introduced to the community and seen as facilitators of group activities for women and girls, or as health response actors to avoid stigmatizing GBV services.

## What are the minimum requirements for a mobile response?

- Dedicated vehicles, drivers, and fuel to transport staff to sites
- Minimum security conditions and agreements such as daily assessments for "go or no go" deployment, authorization for travel, and assurances that mobile teams and communities will not be targeted by combatants
- Staff trained on GBV guiding principles and core concepts, rapid GBV assessments, case management and crisis support, and basic PSS or psychological first aid (PFA)
- Private spaces identified, improved through dedicated budgets if required, and made available for service provision*
- Staff engaged in other activities and one on one discussions with other community members to mitigate stigma and guard against unintentional disclosure of survivors seeking services
- Means of communication (mobile phone and/or tablets with credit) to engage with mobile teams during and in-between scheduled visits
- Sufficiently-funded resources available for the level of risk to women and girls

A mobile team has to be transported to a site in a vehicle. Many vehicles will only safely accommodate a driver and 3 staff members. The number of mobile teams and mobile sites depends on the target population and displacement density. In insecure locations, for safety considerations mobile teams should consider driving in a convoy.

[1] IRC, 2012. GBV Emergency Response and Preparedness Toolkit.
*It is not recommended that GBV Case Management is done through home visits.

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International Rescue Committee

# Mobile Approaches to Gender-based Violence (GBV) Service Delivery: Providing Services to Populations without Access

## Mobile Teams

**Teams drive out to remote and hard-to-reach communities** a set time each week. The number and composition of mobile teams needed depends on displacement density and population per site, the distance between sites and assessed needs for direct program support.


## Safe Spaces

**The team runs services at safe spaces** with locations chosen by the community that are comfortable and accessible for women and girls.

- **Group and Individual support and empowerment**
- **Community risk assessment, safety planning and community mobilization**
- **Case management for survivors of GBV.**

## Embedded GBV Services

Mobile Team Members work with health clinics and other services to ensure access to case management and life-saving services.

## Hotlines &Training

Hotlines and the training of community focal points to refer survivors increases access, effectiveness and sustainability when mobile teams are not on site

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## What is remote technology-based GBV service delivery?

Remote technology-based services are provided over a technology platform (i.e. hotline, chat, or SMS) rather than in-person. This technology greatly expands the reach of programs to provide access to case management and crisis support. Remote technology-based services can be provided as a separate stand-alone intervention, but can also be utilized to support mobile programming when direct mobile services are not on-site.

## What services are provided through remote technology-based platforms?

Crisis intervention, referrals, and case management can be provided through remote technology-based interventions. Remote programming models can be particularly effective to meet the needs of highly stigmatized populations. Any hotline targeting GBV survivors should cover these essential actions: prioritize safety planning, provide accurate and timely information, reduce the immediate impact of violence and the survivor's ability to cope, provide an opportunity for emotional support and dialogue, increase the caller's understanding of GBV, and provide referral information.

In addition to speaking directly to distant survivors, hotlines can be used to: 1) retain connection with survivors identified through mobile teams, 2) offer support and resources for community focal points and service providers working with survivors; and 3) facilitate community focal point capacity building.

**In Iraq,** IRC has established a hotline for the target beneficiaries covered by mobile programming. This hotline benefits the community and survivors while IRC mobile staff are not on site, providing consistent access.

In **Myanmar**, the IRC has established a hotline (a "Call Support Center") with the large target area in Northern Shan State. An information dissemination campaign is being conducted in IDP communities and in 10 targeted townships through community focal points. The IRC coordinates with the Department of Social Welfare to receive referrals in Northern Shan State through the hotline. The Call Support Center is also being advertised to government, NGO and civil society health organizations so that they can refer patients to the hotline if a survivor is identified through health services. Further training for health agencies and other referral pathway providers is planned.

The hotline in Iraq and the Myanmar "Call Support Center" provide survivors with crisis support, case management, and referrals as well as serve as information lines for family and community members. The lines are also being utilized for remote supervision of community focal points and IDP case workers to provide consistent coverage in mobile sites.

## What are the requirements for a remote technology-based response?

- Information Communication Technology (ICT) assessment of social and cultural acceptance
- Beneficiary population with reasonable access to devices and reliable network coverage
- Approval secured from government authorities, if required
- Reasonable expectation that calls will not be monitored and survivors will not be targeted
- Trained and dedicated staff time available during all hours of operation and in all languages offered
- Budget allocations for hardware, phone credit, and reimbursement of callers
- Reference guides and documented protocols and phone-based referral pathways and procedures

IRC Iraqi team members training on remote technology for GBV case-management

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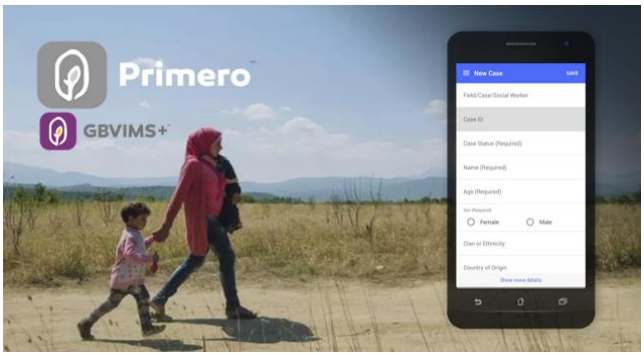
## What technology enhancements will be used for mobile and remote service delivery?

Three innovative technology enhancements will be created and/or utilized in this project to enable supervision of distant staff and safe documentation of data in mobile sites.




The **Primero mobile application** eliminates the need for the use of paper case files in mobile programming, thereby increasing safety and security. Primero allows for the maintenance of individual case records as well, and compiles GBVIMS data for safe analysis. The application is specifically developed to respond to mobile settings, providing caseworkers and other frontline staff a safer way to track incidents and document and monitor case management efforts. The Primero application is being piloted in Iraq with complementary funding from ECHO.

A second technology enhancement utilized in this project is **CommCare**, a mobile data collection platform for survey collection. Deploying this platform allows users to better evaluate the services provided through mobile and remote technology-based approaches and the level of client satisfaction. CommCare will be used for client satisfaction surveys and case management quality control checklists.

Lastly, **ROSA**, a remote supervision and skill-building application is also under development for this project. The application—which will be ready in November 2018—will facilitate skill assessment and capacity building for frontline workers and create a community space for peer learning and coaching. The app will improve caseworker and community focal point knowledge of GBV and strengthen case management, communication, and survivor-centered attitude skills. By having this content available on a mobile device (tablet, smartphone) via an application, users will be able to access it in settings with low or no connectivity.

Myanmar mobile and remote technology training participants, including IRC staff, IDP case workers, and focal points from the Northern Shan State Women's Organization Network (NSSWON).

**For more information on the IRC's mobile and technology-based approach to GBV service delivery, please contact Amy Neiman: Amy.Neiman@rescue.org.**

**Additional information about the IRC's GBV program models, research, and advocacy can be found at: www.GBVResponders.org**

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