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Gender-Based Violence AoR

Gender-Based Violence Case Management and the COVID-19 Pandemic

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Overview

This note aims to provide practical support to gender-based violence (GBV) practitioners to **adapt GBV case management service delivery models quickly and ethically during the current COVID-19 pandemic**. It does not address all aspects of a gendered analysis that are necessary to create a robust response, nor is it a definitive set of guidelines. Rather, it is designed to be a *"living"* document, that will continue to draw upon the experience and expertise of the global community in this new and evolving situation. It assumes that users of this note are already implementing or supporting GBV case management.

While the pathology of COVID-19 presents some unique challenges, GBV programming from other contexts of severely restricted access, such as conflicts and natural disasters, offers important insights into how the provision of remote GBV case management support may be adapted in order to continue to provide critical support to women and girls in need.

GBV and COVID-19

There are growing concerns and reports of increases in GBV incidents globally as a result of pandemic control measures to stem the spread of COVID-19—particularly intimate partner violence (IPV). In addition to gendered power imbalances that drive IPV, many households are now facing high levels of stress related to economic and health shocks, as well as forced coexistence in narrow living spaces. Hubei province in China, a city at the epicenter of the outbreak, reported a more than three-fold increase in police reports of domestic violence from 2019, while in Spain, during the first two weeks of the lockdown in March 2020, calls to the domestic violence emergency number increased by 18 percent.[1] Even where reports have not increased, there are concerns that women may be locked down with their partners and unable to safely seek assistance. While IPV is the most common form of GBV, risks of other types of GBV increase in relation to COVID-19.

Ensuring that women and girls can access GBV support services remains critical, and lifesaving. Maintaining the health and wellbeing of GBV case workers, as well as aligning with service delivery standards and guidelines necessary to reduce transmission of the pandemic, are also issues of critical concern. A flexible and adaptive approach is required to ensure that life-saving GBV services continue to be made available without compromising the safety of GBV case managers or the women they serve.

[1] See Taub, A. (6 April 2020, updated 14 April 2020). *A New Covid-19 Crisis: Domestic Abuse Rises Worldwide* New York Times. https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html; and Wanging, Z. (2 March 2020). *Domestic Violence Cases Surge During COVID-19 Epidemic*. The Sixth Tone. https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic

Introduction to Case Management Services During COVID-19: A Layered Approach to Risk Management

While some past infectious disease outbreaks provide valuable insights into how to maintain GBV case management, such models are not always directly transferable, given the unique pathology of COVID-19. Unlike Ebola, COVID-19 is transmitted by droplets, appears to be more contagious, harder to detect and many carriers of the virus are asymptomatic (Zhanewi et al, 2020).[2] The way in which the virus is transmitted, its level of potency in a country/region at a particular time, and the stark differences and exponential changes in national government responses all demand a different level of flexibility, and a more layered approach to GBV case management service delivery, than other epidemics.

During the Ebola crises in West Africa and the Democratic Republic of Congo (DRC) for example, static case management services[3] were largely maintained - moreso when they were integrated within healthcare services. Humanitarian agencies and local women's groups were also able to provide limited outreach and case management through static safe space programmes by adhering to strict infection, prevention and control (IPC) measures.[4] Providing similar static case management services during all stages of the COVID-19 outbreak may be significantly more challenging, and at certain stages impossible. The need to change approaches to service delivery also may come faster in the context of COVID-19, and require more significant adjustments.

This is not to suggest that case management is not possible within all stages of the COVID-19 outbreak; on the contrary, **GBV case management remains a critical service that is possible to continue in most settings** as long as sufficient modification and adaptations are made to uphold public health guidelines. A number of factors will impact decisions about whether to continue static, face-to-face case management services, scale down services, or dramatically change service delivery in favour of other modalities such as remote case management. Some of these factors include:

- **The national response strategies, guidance and policies related to the coronavirus**. These may include restrictions affecting movement and service delivery according to different stages of the pandemic, making some modes of service delivery more possible than others.
- **Organizational policies.** Organizations may have their own policies related to provision of care during epidemics or disease outbreak. In addition, different service providers may be affected by or interpret government guidance and

[2] Also see https://www.infectioncontroltoday.com/covid-19/asymptomatic-carriers-covid-19-make-it-tough-target

[3] Static refers to services provided in a given location, face-to-face, e.g at women's centers, health centers or offices.

[4] Discussions with GBV practitioners

policies in different ways, which in turn will affect GBV case management service delivery.

- **Resources (including flexibility in reallocation of resources).** Flexible funding from donors, as well as flexibility in managing funds by the service provider, are both necessary in order for the service provider to maintain stringent IPC standards at all stages of the pandemic, but particularly during periods of accelerated risk, and to adapt case management service delivery approaches as needed.
- **Existing capacity and infrastructure of the service provider.** Not every remote service modality will be right for every organization or context. Service providers will need to critically assess their existing infrastructure, technical and logistical capacity, and consider their capacity to transition to and carry out remote case management safely.
- **Risks for staff, clients and others**. Considerations of the health and safety risks to staff, volunteers, clients and others who may be exposed in the delivery of services, whether static or remote, must be of highest priority at all times, and must be continually assessed. This includes assessing perceived risks and how they may impact service delivery (e.g. fears of going into health centers or other spaces based on worries about COVID-19 transmission).
- **Location of static services.** Continuity of case management services will also be affected by where services are provided. In high-risk areas, some centers may be forced to close, or some clinic-based services may be overstretched. Conducting a mapping of essential services that are continuing to operate can not only improve coordination with other actors on referrals, it can also help to identify new potential sites where GBV services can be introduced in the short-term safely.

Understanding the Impact of National Response Strategies on GBV Case Management

Current national responses to COVID-19 are constantly evolving and for the purposes of this paper and at the time of writing, can be roughly classified into three strategies: containment, delay, and mitigation/suppression.[5] All three strategies can run concurrently in any one territory, and changes from one to the other might change in as little as 24-48 hours. Therefore, a **high- level of preparedness is necessary in all countries, even those with zero or few confirmed cases**. Given how rapidly responses are changing, service providers must have contingency plans for each strategy.

Below is a brief description of each strategy and the type of impact that can be expected on GBV case management services:

[5] It is important to note that these are not official classifications and the terminology surrounding responses by governments is constantly evolving. For further description of these three strategies, see https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30128-4/fulltext

- **Containment**: Normal public life is minimally affected as governments focus on early detection, isolation and care of people already infected, as well as careful tracing and screening of their contacts. Static, face-to-face case management, with strict adherence to IPC protocols, may be possible under this strategy. However, if there is a rapid escalation in number of confirmed COVID-19 cases, governments may quickly change strategy and take more aggressive action to reduce the spread of infection. This means that even when containment is the strategy in place, it is critical for GBV programs to put plans in place for identifying and choosing alternative models of service delivery, and training staff on these new models and associated skills (e.g. community-based alert systems, hotlines, remote check ins, digital data management, etc.). It is also essential to communicate regularly with clients about possible changes to come.
- **Delay:** The aim of this strategy is to slow the spread of the virus and delay its impact until a country's health service can provide appropriate clinical care to any and all who are infected. Social distancing strategies, closure of education institutions, prohibitions on large gatherings, and reduction in the use of public transport are common features of this strategy, and are implemented with varying degrees of enforcement. When this strategy is in force, static, face-to-face GBV case management may be possible depending on the location of the service, the ability to resource and provide effective protective equipment to case workers and clients, and the level to which national policies restrict freedom of movement and assembly. Action will also be required at this stage to include other modalities for delivering case management services. Staff will need continued training and support to adjust service delivery approaches, and measures put in place to regularly update clients about changes in access to care.
- **Mitigation planning for widely established infection**: As seen in China, Italy and Iran, this strategy is deployed by governments seeking to stem widespread infection during a prolonged pandemic in which high levels of the population are infected. This may involve more directive "lockdowns" or "sheltering in place", where movement is more restricted and monitored, transport arteries may be blocked, and permissions are required for citizens to move in public. When this strategy is in place, maintaining static, face-to-face case management services outside health care facilities will be extremely challenging, or even impossible. Therefore, case management will need to be transitioned to alternative modes of support, either through integration into other essential service locations or remotely through phone support, and other means (described further below).

Table 1 below summarises the common national strategies that are emerging, the features of each, their impact on GBV case management and possible modalities for delivering case management services. These will not be applicable to every context. Rather, GBV teams must weigh their specific circumstances and current public health guidance in order to contexualize their approaches.

National Strategy	Features of Strategy	Impact on GBV Case Management	Possible Case Management Modalities
Containment	Relatively low numbers of infected cases Tracking and isolation policies in place for infected individuals and their contacts Limited impact on freedom of movement and assembly	Introduction of IPC protocols , contingency planning and community dialogues about the novel coronavirus. Services may generally continue, with slight modification based on IPC protocols.	Static face-to-face may be able to continue; Immediately implementation of stringent IPC protocols at all service points; Widespread communication on COVID-19, IPC measures, hygiene shared with survivors, case workers and wider community, including dialogue about their thoughts and concerns; Preparedness and contingency planning for adapted/ remote case management (including identifying new modalities and discussing safety considerations, referral pathway review, budget forecasting and re-alignment for unanticipated needs, revision of staff health and wellbeing policies, new case management protocols, etc.) Possibility of offering remote case management to a few survivors if they are interested and beginning to test the system; Ensuring that survivors have all information needed to access remote support and brainstorming safe ways to do this (e.g. storing phone numbers under code names in their phone, printing tiny information cards that can easily be hidden). Comprehensive review of safety plans undertaken urgently with survivors in case of rapid change in national strategy; Coordination with other actors and sectors— especially local women's organizations— on their plans. Updating contact lists, referral pathways and communication trees to include newly relevant information, e.g. neighborhood focal points Building connections with case workers. Putting systems in place for care and wellbeing of staff
Mitigation	"Social distancing" is put in place. This may include some or all, of the following: prohibitions or restrictions on large gatherings, closure of schools and other institutions, restrictions or closure on restaurants and bars, and closure of non-essential enterprises. Reduction in the use of public transport encouraged. Possible border closures Individuals advised not to be closer than 2 meters to others	Stringent restrictions on movement of staff and survivors highly likely. Movement could create risk of exposure. Very high levels of IPC practice expected and enforcement and monitoring by national agencies possible High level permission and clearance may be needed to operate case management services based in and outside of official health care settings. Survivors likely to begin being more confined at home. Resources needed to create a protective environment for staff, if face-to-face services continue	Shifts in case management are necessary. Case management within health centers (if not overwhelmed) or other locations designated as "essential" may be feasible in some contexts; Transitions to remote, adapted case management services- via phone, technology or low-tech alert systems- with limited or no face-to-face case management services as usual Training of frontline workers in first line support for disclosures of violence; Highly stringent IPC protocols and monitoring in place; Referral linkages and partnerships in place with health care providers, existing GBV hotline services, law enforcement, women's organizations and other actors still providing services; Supporting women's organizations and community-based systems of support Training other service providers using the GBV pocket guide. Regular monitoring of staff safety in use of mobile technology and new modalities of case management; Continual review of survivor safety plans Use of GBVIMS for remote supervision where safe and feasible; Possible inclusion of GBV caseworker into rapid response teams; Regular wellbeing check-ins, self and collective care support for staff; possible changes in schedules and work hours Reaching out to survivors known to be at high-risk; Continual contingency planning
Strict suppression/mitigation	Extremely high levels of social distancing in place including closure of schools, institutions and non-essential enterprises. Prohibitions on all gatherings, reduction in the use of public transport. Possible border closures	High level permission and clearance may be needed to operate case management services both in and outside of healthcare settings. Stringent restrictions on movement of staff and survivors. Home confinement for survivors highly likely. Very high levels of IPC practice expected and enforcement and monitoring by national agencies possible If static, face to face case management is permitted, resources will be needed to create a protective environment for staff.	Highly stringent IPC protocols and monitoring in place; Remote case management services with limited or no face-to-face case management services; Possible shutdown or temporary shutdown of services in cases where remote options cannot be delivered safely; Integration of GBV services into other service locations deemed "essential" may be possible Use of low-tech alert systems where safe to do so. Possible integration of Referral linkages and partnerships in place with health care providers, existing GBV hotline services, women's organizations and other actors still providing services; Regular monitoring of staff safety in use of remote service modalities; Continual review of survivor safety plans and trying to maintain contact with survivors known to be at high risk; Use of GBVIMS or other tools for remote supervision Possible inclusion of GBV caseworker in rapid response teams Regular wellbeing check-ins, self and collective care support for staff; changes in working conditions as needed Enacting of new aspects of remote service provision that were not feasible in earlier stages

Key Principles and Considerations When Adjusting GBV Case Management to the COVID-19 Pandemic

1. **Prioritise the safety and wellbeing of all staff and clients.** This is true in any GBV programme and remains true during the COVID-19 response.
2. **Ensure solidarity with the most vulnerable.** Some GBV clients will be more vulnerable than others, and some community members more vulnerable. 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, prioritise 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 that stress for staff, their families, clients and communities. As GBV service providers make changes to programming, it is important *not* to over-emphasise 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 be supported to manage the transitions and the changes that follow. It will be necessary to change expectations and operations in the work. Strengthening a culture of care that starts from the top of the organisation and various teams is essential.
4. **Be prepared, not panicked.** This paper highlights the importance of preparing for all scenarios urgently, and anticipating 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 panicked 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 COVID-19.

Recommended Actions for All Organizations Offering GBV Case Management

These key actions related to COVID-19 are recommended for all organizations or programs offering GBV case management services.[6]

1. **Put in place infection, prevention and control (IPC) measures in accordance with standards at all service delivery points.[7] This may**

[6] If case management services are provided in a shelter for women, it is particularly important to follow all IPC protocols and emerging guidance. Specific guidance for managing shelters during the outbreak is available at: https://vawnet.org/news/preventing-managing-spread-covid-19-within-domestic-violence-programs

[7] See, in particular, WHO's guidance on workplaces: *Getting your workplace ready for COVID-19* https://www.who.int/docs/default-source/coronaviruse/advice-for-workplace-clean-19-03-2020.pdf

require coordinating with Health, Water, Sanitation and Hygiene (WASH) actors and other relevant sectoral teams.

a. In places where case managers meet clients face-to-face, set up hand-washing stations and/or make hand sanitiser available immediately upon entrance.
b. Ensure all case managers have access to hand-washing stations, hand sanitiser, and all the tools they need to continue to provide support safely, for example mobile phones and mobile phone credit.
c. Train staff and clients in respiratory hygiene (e.g. cough/sneeze into elbow or disposable tissue) and reinforce with regular reminders.
d. Consult with health programs/actors about where and when protocols are needed to triage, detect and isolate potential COVID-19 cases. If "thermoflash" thermometers are accessible, it may be appropriate to use them to check temperatures of those accessing services. Check with health programmes about whether this protocol is suggested in your context. Note that the use of thermoflash thermometers can be scary to those who have never seen them before, particularly children. It might be necessary, therefore, to conduct some awareness-raising and communication about thermoflash so that people know what to expect.
e. Ensure adequate distancing so that women and girls accessing services can keep at least 1 meter apart, and address any risks of bottlenecks that may cause crowds of clients to form. Put in place measures to ensure that women and girls' centers or safe spaces, or any other sites where case managers operate, are able to adhere to distancing guidance. This may include putting a cap on the number of women and girls accessing the service at one particular time, and/or marking spaces for mats on the floor/ chairs on the ground, etc. Follow the guidance in your area for limiting numbers of people in the same area at the same time.
f. Maintain a clean workplace by ensuring regular and safe waste management, environmental cleaning and disinfection of items or equipment used by clients.
g. Do not send case managers into crowded areas or situations where they cannot maintain the suggested IPC protocols or suggested distancing.

2. **Case managers and staff communicate openly with women and girls about COVID-19 and any changes or potential changes in service delivery.**
    a. Develop brief facilitator discussion guides and communication materials for case managers and staff to discuss COVID-19 with clients and other women and girls in your programmes:
        i. Emphasise to case managers and staff the importance of *listening to clients* alongside giving out messages. Be sure that

they *ask questions* to better understand what clients know about COVID-19, as well as what their concerns and fears are and their suggestions for how GBV services can be adapted to address their concerns and fears.

    ii. Make sure that messages around COVID-19 and IPC measures evolve over time according to changing needs of women and girls.
    iii. Share any relevant information such as anticipated adjustments in services, hotline numbers, other critical services, and ways to reach service providers with any questions about changes.

b. Where there is the option of adjusting services and a plan is in place for implementing those adjustments, reassure clients that support services will still be available in some capacity, even if the modality changes, and that they will not be alone. Be careful to listen to their fears, questions, suggestions, as well as what will work best for them. Begin safety planning immediately (see details below).
c. If you are forced to shut-down or temporarily shut-down GBV case management services, communicate this openly with clients and case managers and engage as much as possible in safety planning with clients prior to the shut down (see details below).

3. **Meet as a GBV case management team to review different modalities of remote case management and support for survivors and decide together what would work best in the context.** Potential modalities of continued support for survivors, even under extremely restricted circumstances, include phone support, tele-health, low-tech alert systems and coordinating with other essential service providers to serve as entry or referral points (see details on modalities of remote support in sections below). It is important that staff are engaged actively in decision-making about how best to adapt services since they are in direct contact with clients and likely have a strong understanding of the context. Involving them will also help to ensure a sense of ownership and control over changes being made to case management.

   When reviewing different modalities, consider these questions:
   a. Do you have the infrastructure and technical capacity already in place to implement this new modality of care?
   b. If not, what else would be needed?
   c. Would you be able to transition to this type of support quickly, or would it take time?
   d. Are there other groups you could coordinate with to facilitate adjustments in service delivery?
   e. Would you be able to safely and effectively meet the needs of survivors through this modality?

        i. What are the potential safety risks for survivors and staff in this approach?
        ii. Are there ways to mitigate these risks and if so, can they put in place before the new modality is rolled out?
    f. Are there changes that can be phased in or do they have to be made all at once (e.g. starting with phone support and moving to another form as the situation evolves)?

4. **Supervisors discuss with case management teams how best to offer them ongoing support personally, as well as professionally**. Remember, this is about more than supervision; it is about support. Staff are also going through this crisis and will need support, just as clients do. There are many ways to support staff, both in terms of general wellbeing (e.g. what's app wellness check-in groups, scheduled phone check-ins, sharing stress relief ideas, etc.), and logistical and technical support (e.g. additional training to help them feel prepared for new types of work, providing airtime, internet modems or other hardware, brainstorming ideas to solve other anticipated issues, etc.). It is important to give people space to talk about their support needs, and also important that supervisors and their organizations invest the time and resources to meet identified needs wherever possible. Because needs may change over time (and sometimes rapidly), supervisors should check in regularly.

5. **Keep up-to-date on the latest guidance in the settings where the services are delivered.** It is essential to keep up-to-date with the latest guidance being given in your specific context and also to recognise that this will change on a day-to-day basis. Planning ahead is important, as is making sure that the actions of the program are aligned with what is happening in the affected communities. If the program is ready to take certain steps based on public health guidance, it is important that management and supervisors support what the program team believes is best for the safety of clients and staff.

Recommended Actions for GBV Case Management Programs when Preparing for Sudden Changes, Including "Lockdown" or "Quarantine"

Government responses to COVID-19 are changing rapidly and dramatically, perhaps moreso than in any other outbreak. Therefore, it is recommended that GBV supervisors and case managers working in countries that do not currently have confirmed cases also begin preparing for sudden changes in government strategy, particularly mitigation for high levels of infection, including the following actions:

1. **Case managers begin safety planning with current clients for situations of quarantine, lockdown, or "shelter-in-place."** Help clients to prepare for

the possibilities ahead and to feel a sense of control in a chaotic moment. Be sure to reach out to clients who are known to be at high-risk. Key issues and measures to explore include:

   a. Do clients have someplace safe to stay other than with the abuser now or in case of lockdown?
   b. If not, are there any steps clients can take to help minimise harm at home? Are there any weapons at home that can be removed?
   c. Do they have trusted friends or relatives they can keep in touch with?
   d. 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?
   e. Do clients have a place where they can safely keep the numbers of case managers, hotline, or other support providers? Suggest that if they have phones, they may store the number under a code name, or the case manager may print tiny cards that can easily be hidden.
   f. What are the different ways clients can safely call for help and access support?

2. **Put measures in place to ensure continued safe storage of sensitive documentation**. In the event that the office is or will be shut, consider the safest ways to store documentation without putting anyone at risk. As a team, discuss any changes required to current data protection protocols, and develop and implement new data protection protocols as needed with paper and electronic file provisions.[8] Key issues and measures to explore include:
   a. If shutting down the office, will documentation be locked and safely stored? Is it possible that someone might gain unauthorized access?
   b. If moving to remote support, how will cases be documented? Is it safe to store information on phones, tablets, or paper?

3. **As a GBV case management team, develop new case management protocols quickly and clearly to align with the new modalities of support adopted in response to COVID-19.** Some important issues to consider include:
   a. How often will staff contact current clients? How will staff be reachable to clients?
   b. Will the agency or organization be accepting new calls/clients in addition to following up with current clients?
   c. Which, if any, phones and phone numbers will be used for case management?
   d. How will calls and/or alerts be documented and followed up?

[8] Note that Primero/GBVIMS+ for case management offer options for digital storage, including on mobile phones. Also see template of the GBVIMS Data Protection Protocol: http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-PROTOCOL.pdf

e. Will there be a staff rotation to ensure coverage?
f. How will referral pathways work?
g. Will this be safe for staff?

4. **As a GBV case management team, identify modalities for remote supervision**. This refers to supervision of case managers. This may include remote individual supervision and peer-to-peer or group supervision through online platforms and/or phones. Case file review can be enabled for remote supervision through rollout of digital case management tool, such as Primero/GBVIMS+ which includes functionality such as flags, case plan/closure approval, remote case file review and automated production of key performance indicators (KPIs). supervision is not the same as support. Supporting the overall wellbeing, health, and stress management of staff is the first priority. This must be in place before supervisors can introduce new forms of staff supervision.

5. **Supervisors work with case managers to strengthen capacity and confidence to provide remote support.**
   a. As a team, review and discuss guidelines on supporting survivors through digital and remote support to determine the most relevant approaches to the setting. There are various types of guidance around using technology to communicate with survivors during a public health crisis, including text messaging, calls, online support, to ensure safe and ethical connections (see Resources below).
   b. Provide additional training for staff as needed on any new technology or approaches to be used for support. Teams may need to get acquainted with systems used for hotlines, online service provision, apps (e.g. Primero/GBVIMS+), referral systems with other services providers, etc. Training may be done in small doses, remotely, or in other ways that are adapted to the demands of the evolving situation. Supervisors can reach out for support to relevant actors who are managing or have experience with the platforms being used e.g. GBVIMS global team, etc.[9]

6. **Prepare for possible closure (temporary or long-term) of physical locations for case management.** It may be necessary to close women and girls' centers or other physical spaces where case management services are provided. If the shut-down is for an indefinite period, it may be necessary to take steps similar to programme exit in order to ensure a responsible closure (guidance on exit strategies can be found in the Resources section below). Even temporary closures require action to mitigate additional harm caused by the closure. Consider questions such as:
   a. Are there any outstanding payments that need to be made for the space?

[9] GBVIMS global team can be contacted by emailing gbvims@gmail.com

b. Can items be left there safely, or is it necessary to remove them?
c. Will anyone access the space for any reason during closure?
d. Are there any risks involved with closing the space? How can you mitigate these?

7. **Supervisors, case managers and GBV staff coordinate with other services providers.** Solidarity is critical in adapting to the new situation. It is also important for all staff to be aware of services that will remain available to survivors and how to ensure coordinated and safe access to healthcare, shelters, law enforcement, and other service providers.

8. **Inform communities of possible changes ahead.** Be sure to communicate possible changes with clients as well as communities, in order to maintain trust. Maintain two-way dialogue as much as possible to hear community feedback.

9. **Management communicate with donors about changing needs.** Begin communicating with donors immediately about changes in case management programming and funding needs, including preparations for worst-case scenarios. Organizations and/or projects may request greater flexibility of resources and rapid mechanisms for ensuring funds can be adapted to shifting demands.

Modalities of Adapted and Remote Case Management

In situations of containment, when limited movement and contact is a viable option, service providers may be able to continue face-to-face support, while observing IPC protocols. They may also consider switching to one or more of the models described below. As noted previously, it is critical to introduce preparedness plans at this stage so that if more severe restrictions are put in place, teams will be equipped to handle the transition. In situations of delay, mitigation, or any severe restriction of movement and access it will be necessary to shift to alternative systems of case management and support.[10]

There is not a 'one-size-fits all' approach for all service providers and contexts. It is essential that programs assess different options to determine their feasiblity. Safety for service providers and clients is the utmost concern, and changes can come in stages rather than all at once. Service delivery approaches may evolve as the needs on the ground change. In every setting, however, it is critical that GBV services be

[10] Note: If you are running case management services out of a shelter for women, it is important to follow IPC protocols and emerging guidance to the best of your abilities. Specific guidance for managing shelters during the outbreak is available at: https://vawnet.org/news/preventing-managing-spread-covid-19-within-domestic-violence-programs

designated as essential and life-saving by government and the humanitarian and health services systems.

The options provided below for continuing case management support remotely are not exhaustive; programs are encouraged to think critically and creatively about how to adjust strategies based on needs and resources in their own settings.

1. **Health center-based case management.** When movement of people is limited, and most efforts are focused on supporting healthcare systems, basing a GBV case manager at a health center might be an option. This model was used during the Ebola response in DRC by some GBV actors and may be applicable in others. However, healthcare centers servicing COVID-19 patients are likely to be overwhelmed, IPC requirements may be difficult to meet for additional staff, risk and fear of contagion may also keep survivors from seeking services at healthcare facilities. Therefore, this will not work in all contexts. There is a need to work closely with health teams to determine whether this is a safe and viable option. Good communication will help to ensure GBV services are not seen as an exra burden to staff. In either case, it is critical to advocate that GBV services be designated as essential, and life-saving by authorities.

2. **Case management at other essential service providers.** It may be possible to base a GBV case manager in other locations designated as an essential service that women can safely access, in a location other than a health facility, but one still designated as an essential service, e.g. a pharmacy or food market. This model requires close coordination and planning with the facility to ensure survivors' access can be safe, confidential, respectful and non-discriminatory .

3. **Mobile phone case management.** Case managers may be able to provide support to clients by mobile phone if it is safe to do so. It is critical for supervisors to facilitate discussions with case managers about any safety concerns of making and receiving calls and how to maintain confidentiality within the new context, and for case managers to raise these issues with clients. Some of the considerations for this approach include:
    a. Making sim cards and/or mobile phones available to case managers solely for the purpose of providing support.
    b. Assessing electricity sources for both case managers and clients: What kind of access to electricity do they have? Is maintaining charged phones a challenge? Can programs provide battery packs or solar chargers for case managers and clients and would that be safe or put them at greater risk?
    c. Determining how is data collected: How can risks associated with case managers storing paper forms at home or in locations that are unsafe be avoided? Can digital case management tools such as Primero/GBVIMS+ be rolled out?

d. Assessing what challenges will case managers have providing services from home: Will they be able to speak with a client confidentially? What responsibilities do they have at home that may affect their availability?
e. Identifying the best mobile application to receive calls: If WhatsApp is the preferred option for communication both by survivors and case workers, do all clients have this installed on their phones? Is it possible to delete records of communication on the phone? What other safety considerations need to be addressed for the application?
f. Where challenges exist for the survivor to privately use a phone, consider other ways in which mobile phones may be used safely, such as phone booths in permitted service locations or apps that are specially designed to detect off-line alerts from the survivor without her having to make a call (Erskine, 2020).

4. **Hotlines.** If a hotline exists already, GBV programs can discuss with the hotline provider the feasibility of incorporating GBV support into the hotline and what that would take—such as training hotline staff in psychological first aid (PFA), creating a referral list and system for making referrals, spreading the word about hotline services, etc. It is important to note that even in cases where it is possible to incorporate GBV service provision into a hotline system, this does not mean that women will want or feel to safe to access that system. Therefore transitioning to hotline support requires work to communicate with women about whether this is a safe option for them and how to access it. In some instances, GBV service providers may consider buying additional mobile phones for case managers and creating a shift schedule for them to operate a modified "hotline." However, as with any remote care, it is important to discuss with case managers what is feasible and safe for them and their clients, particularly if case managers are receiving calls in their homes, and given other responsibilities they may have as a result of the lockdown.

5. **Low or no-tech alert and response systems.** Not all surivors will have access to a mobile phone, and in many cases, this may not be a safe option. Women may be closely monitored by their partners at home—including monitoring of their mobile phone— particularly under situations of lockdown. In these situations, alternative alert systems are needed to know when survivors need help, including those in imminent danger of injury and harm, and how to get support to survivors. A number of strategies are emerging on setting up low tech systems- with many drawn from local women's organisations including leaving rocks, coloured cloths, leaving a window half open outside homes, using code words, etc. (Erskine, 2020). However, such systems only work when there are services available for the survivor who makes the alert. It is essential to ensure that services can be provided safely before setting up an alert system and encouraging women to use it.

Low-tech alert systems may seem simple, but to be safe and effective they must be linked to well designed chains of **support and security** involving a number of stakeholders. Without these chains of support and security in place, such a system can indeed increase harm to surivivors and those who seek to help them. Some of the considerations for setting up this kind of system are outlined below[11]:

a. Mapping out locations around homes, neighborhoods and communities that women and girls can safely and legally access, even where there is restriction on movement.
b. Assessing whether any of these locations could be used as entry points for survivors to signal a need for support and receive a referral to support. In some high-income countries, survivors are accessing a facilty permitted to remain open, such as a pharmacy or grocery shop, and communicate an alert by using a code word or phrase such as "mask 19." The alert is then referred to a GBV service provider. Adaptations of this are being considered in humanitarian contexts.
c. Providing rapid training/awareness to non-GBV frontline workers who are still permitted to operate on the provision of psychological first aid and referrals,[12] and identifying safe and confidential referral pathways to GBV services through such services.
d. Developing safe ways to promote the alert system that weigh the need to inform the largest number of women possible about the system against the risk that perpetrators will also find out about the system and use it against survivors.

6. **Limited rapid or mobile response team.** Some humanitarian organisations may maintain a rapid response team during the outbreak with limited staff involved in providing essential services, in accordance with national strategies and IPC protocols. If this is the case, GBV programs may advocate for a GBV case manager to be added to that team, if the benefits outweigh the actual and perceived risks.

Prioritising Duty of Care to Staff

Caring for staff and prioritising their wellbeing is the foundation of all of the recommendations and actions described above. It is essential that managers and supervisors at all levels put in place systems to support staff and that this is continually prioritized and monitorizes as the outbreak. This includes:

1. Creating space to ask staff about their concerns, their needs, and their ideas for moving forward. Give staff time to talk freely, whether about work, or the

[11] For greater detail on such solutions and how to safely design such chains of support see, Erskine, D, "Not just hotlines and mobile phones- GBV service provision during COVID-19."
[12] See, for example, the GBV Pocket Guide.

situation more generally. Ensure that this continues through every stage of the outbreak, whether in-person or remotely.

2. Observing IPC protocols and working to reduce risk as well as address perception of risk (see Key Principles section above).
3. Management communicating actively about the priority of staff wellbeing and shifting expectations around “productivity” and setting an example to others in practice. It is especially important that a culture of care starts with organizational and team leadership. Consider adjustments that can be made to help staff face the current situation such as changes in the number of days per week expected to work, avoiding too many meetings, etc.
4. Sharing resources for managing stress and maintaining emotional wellbeing. Managers and supervisors can share documents with links to tips and resources, self-care reminders such as one simple self-care exercise per day via text/WhatsApp group, collective care practices, phone numbers for accessing psychological support; etc.
5. Ensuring that staff have phone numbers and information about support services that are available to them and the resources they need to maintain work and access support (e.g. wifi, phones, phone chargers).
6. Checking in regularly with individual staff by phone or WhatsApp as a form of emotional support (different from supervision). Team leaders and supervisors are also encouraged to find new ways to show solidarity and encouragement to staff (e.g. weekly or bi-weekly audio messages).
7. Creating care circles, chat groups, calls/video calls or other fora for staff to connect and support each other.
8. Sharing resources online that staff can use to continue to build their skills. e.g. the Rosa App by International Rescue Committee (IRC), GBVIMS podcasts and videos, etc.[13]

[13] The Rosa App can be downloaded from app stores for Apple, Android and Google. The GBVIMS podcasts can be accessed on soundcloud or through iTunes , Google Play Music or Stitcher

Resources

Resources on GBV Remote Support:

How to Support Survivors of Gender-Based Violence When a GBV Actor Is Not Available in Your Area: A Step-by-Step Pocket Guide for Humanitarian Practitioners
https://bit.ly/2WqrT9f

Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery
https://bit.ly/2xKsFUe

GBVIMS Remote GBV Case Management series in the COVID-19 response – available in 4 languages, easy to use guides and podcasts on setting up hotlines
http://www.gbvims.com/covid-19/

Using Technology to Communicate with Survivors During a Public Health Crisis
https://bit.ly/3b6LMX5

Chat with Survivors: Best Practices
https://bit.ly/3deRXu8

Texting and Messaging with Survivors: Best Practices
https://bit.ly/33vOK4G

Communicating with Survivors using Video: Best Practices
https://bit.ly/3a553rl

Guidance Note on Ethical Closure of GBV Programmes
https://bit.ly/2Wye4pz

Low tech solutions
https://www.unicef.org/documents/gender-based-violence-service-provision-during-covid-19

Resources on GBV and Infectious Disease Outbreaks:

Overcoming the 'Tyranny of the Urgent': Integrating Gender into Disease Outbreak Preparedness and Response
https://doi.org/10.1080/13552074.2019.1615288

The Effect of the 2014 West Africa Ebola Virus Disease Epidemic on Multi-level Violence Against Women
https://www.researchgate.net/publication/306902936_The_effect_of_the_2014_West_Africa_Ebola_virus_disease_epidemic_on_multi-level_violence_against_women

Ebola Publications: Case management, Infection Prevention and Control
https://bit.ly/2vxEqN6

Resources Specific to COVID-19:

GBV Guidelines Resource Hub
https://gbvguidelines.org/en/knowledgehub/covid-19/

Technical Note on Protection of Children During the Coronavirus Pandemic
https://alliancecpha.org/en/system/tdf/library/attachments/the_alliance_covid_19_brief_version_1.pdf?file=1&type=node&id=37184

Staying Safe During COVID-19
https://www.thehotline.org/2020/03/13/staying-safe-during-covid-19/

The COVID-19 Outbreak and Gender: Key Advocacy Points from Asia and the Pacific
https://bit.ly/2WtyC2i

Coronavirus: Five Ways Upheaval is Hitting Women in Asia
https://bit.ly/2xc4JZz

COVID-19: The Gendered Impacts of the Outbreak
https://bit.ly/2xTfsJ1

The COVID-19 Pandemic & Digital Services
https://bit.ly/2xJG3rJ

Gender and the Coronavirus Outbreak
https://bit.ly/394ZDvD

Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings: Executive Summary
https://bit.ly/2QtFfxP

Gender Implications of COVID-19 Outbreaks in Development and Humanitarian Settings
https://bit.ly/2U1UbVV

COVID-19: Coalition Guidance for Programmes
https://bit.ly/3a6iWWH

COVID-19: The Gendered Impacts of the Outbreak
https://bit.ly/2IXNduT

Impact of COVID-19 Pandemic on Violence Against Women and Girls
https://bit.ly/2xbcM92

WHO country and technical guidance – COVID-19:
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

WHO. Getting your workplace ready for COVID-19: https://www.who.int/docs/default-source/coronaviruse/advice-for-workplace-clean-19-03-2020.pdf

WHO. COVID-19 and violence against women: What the health sector/system can do: https://www.who.int/reproductivehealth/publications/vaw-covid-19/en/

Bibliography

Diamond, F. (17 March 2020). Asymptomatic carriers of COVID-19 Make it Tough to Target. Infection Control Today. https://www.infectioncontroltoday.com/covid-19/asymptomatic-carriers-covid-19-make-it-tough-target

Ferri, P, Silvestri, M, Artoni, C and Di Lorenzo, R (2016) 'Workplace violence in different settings and among various health professionals in an Italian general hospital: a cross-sectional study', *Psychology Research and Behavior Managemen*t, Vol. 9 263–275; and Dr. Fraser, E. (16 March 2020). *Impact of COVID-19 Pandemic on Violence against Women and Girl*s. VAWG Helpdesk Report No. 284. UKAid from the Department for International Development.

Infection Control Today, Asymptomatic carriers of COVID-19 Make it Tough to Target. Accessed 18/3/2020

Lancet. (March 2020). *COVID-19: Delay, Mitigate, and Communicate*. https://www.thelancet.com/action/showPdf?pii=S2213-2600%2820%2930128-4

Taub, A. (6 April 2020, updated 14 April 2020). *A New Covid-19 Crisis: Domestic Abuse Rises Worldwide*
New York Times. https://www.nytimes.com/2020/04/06/world/coronavirus-domestic-violence.html;

Wanging, Z. (2 March 2020). *Domestic Violence Cases Surge During COVID-19 Epidemic*. The Sixth Tone. https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19-epidemic

Zhanwei Du, Xiaoke Xu, Ye Wu, Lin Wang, Benjamin J. Cowling, Lauren Ancel Meyers. Serial Interval of COVID-19 from Publicly Reported Confirmed Cases. *Emerging Infectious Diseases*, April 2020

The GBV AoR Help Desk

The GBV AoR Helpdesk is a technical research, analysis, and advice service for humanitarian practitioners working on GBV prevention and response in emergencies at the global, regional and country level. GBV AoR Helpdesk services are provided by a roster of GBViE experts, with oversight from Social Development Direct. Efforts are made to ensure that Helpdesk queries are matched to individuals and networks with considerable experience in the query topic. However, views or opinions expressed in GBV AoR Helpdesk Products do not necessarily reflect those of all members of the GBV AoR, nor of all the experts of SDDirect's Helpdesk roster.

Contact the Helpdesk

You can contact the GBViE Helpdesk by emailing us: enquiries@gbviehelpdesk.org.uk, and we will respond to you within 24 hours during weekdays.

The GBViE Helpdesk is available 09.30- 17.30 GMT, Monday to Friday.