

Myanmar

Gender-Based Violence (GBV)

Hotline Minimum Standards





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1. Introduction

1.1 Addressing Gender-Based Violence in The Context of Myanmar

Gender-based violence (GBV) is a life-threatening health and human rights issue worldwide. It violates not only the principles and core values of gender equality but also international human rights laws and norms.

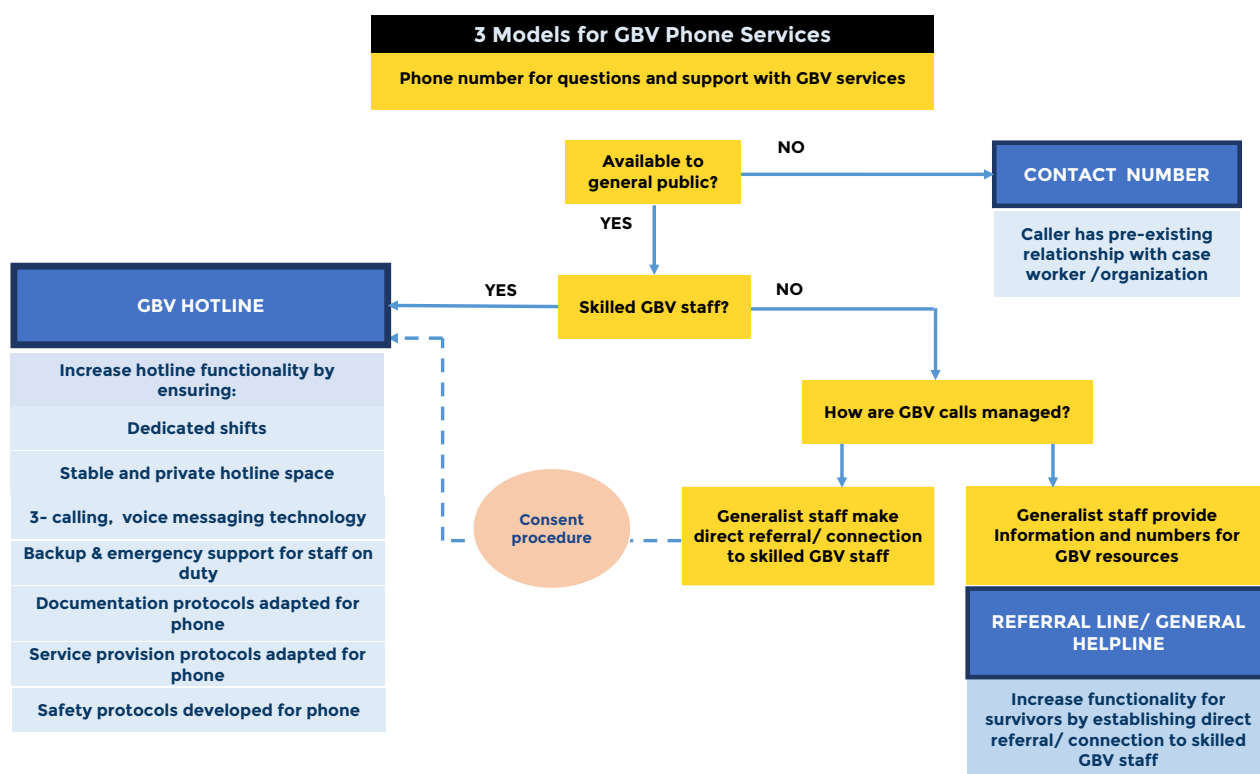
“Gender-based violence is a violation of universal human rights protected by international human rights conventions, including the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman or degrading treatment; and the right to life (IASC)”.

In Myanmar, high levels of gender inequality and a weak legal framework contribute to GBV across the country. Moreover, insecurity and other factors commonly associated with armed conflict and forced displacement exacerbate vulnerability to GBV among certain populations. The outbreak of COVID-19 further exposes many women and individuals from vulnerable minority groups (e.g. people with disabilities, adolescent girls and boys, lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other (LGBTIQ+)) to increased isolation and risk factors due to movement restrictions and lockdowns. Too often in Myanmar, individuals experiencing GBV are unable to access appropriate case management and multisectoral services due either to limited availability; financial, geographical or security-related barriers to reach them; and fear or stigma.

There has been long-standing recognition among practitioners of GBV helplines as an initial point of support and entry into accessing GBV response services. However, the COVID-19 pandemic has brought increased awareness among GBV actors globally of the importance of enhancing remote support for GBV survivors and expanding the scope of support provided through remote programming. Many GBV and mental health and psychosocial support (MHPSS) service delivery organizations started adopting remote services to reach communities in geographically complex and remote areas including internally displaced population (IDP) camps. As the context in Myanmar has become more complex in 2021 with a compound political crisis on top of a public health crisis and ongoing conflicts, United Nations Population Fund (UNFPA) has seen increased requests for technical and financial support for hotlines intended to expand access to GBV support services.

1.2 GBV Hotlines

There are different modalities of GBV-related phone services, which are categorized and summarized in the graphic below as “hotlines”, “referral lines/general helplines” and “contact numbers”. Further descriptions of each modality can be referred to in the GBV Hotline Guide developed by the UNFPA Asia-Pacific Regional Office. All modalities of these GBV-related phone services are offered in Myanmar. While this set of Minimum Standards can be applied to all models, the focus will be on hotlines given that this is the recommended model (albeit the most resource intensive), providing assistance to callers by skilled staff and available 24/7.



Despite the many advantages offered by hotlines, there are some common/global challenges with this remote modality itself, as well as challenges related to the specific context in Myanmar which were documented in specific research funded by Foreign, Commonwealth & Development Office (FCDO) of the UK in 2020,¹ and corroborated through consultations conducted by UNFPA in late 2020 and 2021 on the Minimum Standards for Myanmar. Some of the key challenges related to hotline operation in Myanmar include the following:

- Varying levels of phone ownership and access for women and girls
- Internet accessibility, which has deteriorated considerably in 2021
- Language barriers can limit access to assistance, particularly for non-Burmese speakers
- Difficulties in obtaining informed consent of GBV survivors remotely (via phone)
- Challenges to securing sustainable and predictable funding for hotlines, which can limit capacity to adequately staff them, and to ensure adequate infrastructure and technology

1. Cate Buchanan and Mi Mi Thin Aung, Gender-Based Violence Helplines and Referral Systems in Myanmar: Reflections on Knowledge and Skills Gaps, Report for UK Government, Athena Consortium, public version, August 2020.



- Most “hotlines” are actually “helplines” or “referral lines” because there are challenges to operating them 24/7
- Remote services are not always exclusive for the purposes of assistance to GBV survivors and may be multipurpose in terms of responding to various complaints or issues, which may then limit the technical knowledge of the staff members receiving calls
- At times the numbers provided are actually for individual staff members, who are then called directly as opposed to a separate hotline number
- Gaps in technical knowledge and skills of individuals answering calls because this function is usually an “add-on” to the tasks of staff, given that most staff do not have a clear job description or terms of reference
- Lack of safe documentation of personal information (e.g. storage systems and tools used by hotline operators are not necessarily optimal/reliable)
- Hotlines often lack links to associated formal referral systems due to funding limitations, absence of institutionalized referral pathways and at times limited familiarity and technical expertise of service providers with GBV case management and multisectoral response.

1.3 Why Have Minimum Standards for GBV Hotlines in Myanmar?

The objective of the Minimum Standards is to establish a common understanding of what constitutes minimum phone-based support to GBV survivors in Myanmar. The 12 standards define what organizations delivering these services should prioritize to improve the quality of GBV hotline services and mitigate practices that may cause unintended harm to survivors and service providers.

They are designed to support practitioners, organizations and donors to improve accessibility for underserved populations (e.g. IDPs, LGBTQIA+ and male survivors) compared to traditional service delivery points, to ensure accountability of GBV actors, to build trust between survivors and hotline staff and to ensure ownership and support of local communities.

The Minimum Standards are rooted in global good practices and the universally-applicable GBV Guiding Principles, and have been contextualized through a participatory process in Myanmar to ensure their local relevance. Training resources to accompany the Minimum Standards have been developed to guide dissemination and facilitation application of the Minimum Standards in Myanmar.

Designing comprehensive and realistic services for GBV survivors requires in-depth contextualized and realistic minimum standards based on the survivors’ needs, service providers’ wellbeing and all stakeholders’ commitment and willingness to deliver high quality services.

To further contextualize this document, UNFPA conducted an initial central level consultation in December 2020 followed by six subnational consultations during April-May 2021. The subnational consultations, facilitated in the Burmese language, were organized by state (Kachin, Kayin, Northern Shan, Southern Shan, Rakhine and “others”) and involved 59 participants from 35 organizations. Please note that the names of organizations and partners references in good practices in the document have been removed to ensure safety for service providers and their clients. Some of the key findings and recommendations that were addressed in this document follow:

- Awareness of GBV at the community level is important as a basis to promote trust between service providers and the community and to promote referral and service seeking behaviours. The impact of the current political context in Myanmar and COVID-19 have complicated community outreach strategies, yet it is essential that innovative means are utilized to engage communities and to build trust. Various ways to reach support should be provided and information on service hours, days and languages spoken should be clearly communicated to set clear expectations among communities.
- Establishing and maintaining survivor trust is critical; however, this can be extremely difficult particularly when working remotely. Specific tips on how to communicate with survivors to establish trust are required. Staff also need to be trained to manage calls and expectations for a call, e.g. by clearly indicating how long the call can last and reminding them when the session will be ending 10 minutes before.
- Concerns around the security of telecommunications are increasingly a concern as they have been blocked in various contexts (parts of Rakhine State in 2019–2020 and nationwide in 2021) and there are increased concerns about monitoring. Providing alternatives to seek assistance, and promoting and supporting digital security measures is critical in Myanmar to uphold survivor and service provider safety.
- Some organizations have been requested in the past to provide data on GBV cases supported. Clear data sharing and reporting standards must be developed.
- According to some organizations, peak hours are night-time around 9 p.m. and during weekends. Before a service is rolled out, or during service implementation, organizations should consult with different target populations such as women, girls, LGBTQIA+ and the disabled concerning what time would best suit them to call a hotline service. Organizations should also review the call log book for information on what time has the most calls from survivors, then adjust service hours accordingly. If adjustment is needed, it is essential to consult with hotline staff first on how they can manage their time and what support they need from supervisor and organization.
- Some survivors call personal numbers of staff even during non-work hours. To the greatest extent possible this should be avoided and calls should only be received through the official hotline number.
- It is difficult to manage missed calls and follow-up with some survivors who borrow phones to make calls. Staff should be trained to ask for a contact number and available date and time for follow-up if needed.
- Staff are not well-trained to work with disabled persons. At times they require support/assistance from family members, which adds another dimension to their support, safety planning, etc. Additional resources and guidance are required.
- Currently staff from all organizations are almost all female. There should be a plan and strategy for male survivors if all staff are female. Otherwise, male staff should be recruited and trained.



- GBV coordination including referral is more effective where the GBV subsector is active. Most organizations join the coordination body and use referral pathway and service mapping developed by a working group. Service providers should be advised how often referral pathway and service mapping should be updated as a standardized practice.
- A few organizations specifically hire hotline staff, but others assign existing staff such as case workers, project officers or coordinators to run the hotline service. There should be clear standardized practice for case allocation and workload management to avoid work-related stress and burnout and to manage for quality service provision and staff well-being.
- Supervision is conducted in different ways: one-on-one or group, peer-to-peer support, mentoring and coaching, case management meeting or team meeting. Some organizations set up their supervision structure systematically and formally. Quality supervision and standard practice, which can provide capacity building and well-being for staff, are important. Supervision should not only be for technical support, but also for staff well-being. Well-being of staff should be taken into consideration through supervision structure. Supervisors should take care of staff well-being and deal with burnout issues through regular supervision sessions or providing training or sharing tools.
- Performance appraisals and quality checklists are used by a few organizations to determine which training or technical support is needed for each staff member; however, most have no specific strategies for staff development. Consideration must be given to capacities related to case management, mental health and psychosocial support, first aid system, legal knowledge and awareness of referral system. Other supports such as computer, technology knowledge, supervision and financial are also required for staff to provide quality services in a timely manner.

1.4 Who is this Document Intended for?

The Minimum Standards are intended for GBV practitioners, staff, programme managers and organizations involved in operating hotlines or planning to establish GBV hotlines. Organizations included on local referral pathways who are involved in delivering multisectoral support to survivors referred by hotline staff (e.g. those providing medical, legal and livelihood support) may also benefit from familiarity with the Minimum Standards.

Agencies and donors supporting remote GBV services in Myanmar should also be familiar with the Minimum Standards. This is to ensure that their financial and technical support is consistent with the Standards to contribute towards adoption and adherence to this set of priorities, and so strengthen the quality of services and ultimately the well-being of individual survivors and the staff and organizations assisting them.

1.5 How to Use this Document

The Minimum Standards provide practical guidance and can be used as a reference in the daily operations of a hotline, as well as a guide to scale up and support establishment of new services. It is a living document to be updated and improved on the basis of lessons learned and experiences, and can serve as a realistic road map to improve hotline services based on the survivor-centred approach. The annexes provide more details and guidance on the application of the standards. Additional technical support on applying the Minimum Standards can be provided through the GBV subsector, led by UNFPA in Myanmar, as well as its working groups (Please refer to the contact list provided in Annex 1).

2. THE MINIMUM STANDARDS

PART I: GBV Response Guiding Principles

STANDARD 1: Safety of Survivors and Service Providers

Hotlines should ensure that safety and security of survivors are prioritized through the following:

- Regular safety assessment and risk mitigation
- Adequate tools and resources for safety planning based on the survivor's unique context and personal choices.²

A – Digital Tools Safety and Security

Guaranteed by the following:

- Reliable and safe telecommunication provider that removes or limits cost barriers, guarantees reliable network coverage and provides confidentiality features for the survivor
- Functioning telephones/mobile phones as well as SIM cards, chargers and top-ups regularly provided to staff³
- Provision of multiple options for contact and accessing support (e.g. direct contact by survivor, as well as support from local community volunteers who may help to link survivors to services through shared phones or phone booths available in safe spaces)
- Regular scanning and review of recommendations related to the safety and security and use of digital tools (e.g. cell phone providers, Signal, Telegram, Facebook and Whatsapp) due to the fluid operational environment linked to public health and political factors, as well as the changing regulation of telecommunication providers
- Digital and physical safety tips for information gathering, storage and sharing (e.g. passwords, codes, antivirus and tracking software for cases where devices are stolen or confiscated).

For more information, please see Annex 2: Key digital safety tips

B – GBV Survivors' Safety

There are many factors related to ensuring a survivors' safety – both their actual safety as well as a sense of safety – this is fundamental towards establishing trust between the survivor, communities and the service provider.

Hotline staff need to be culturally sensitive and use appropriate attitude and language (respect social norms and beliefs, and awareness of traditions and customs in a way not to harm survivors). They must have technical knowledge of how to conduct interviews and provide counselling, ensuring that communication is safe, be able to identify safe communication tools and safe spaces for survivors free from third persons who could influence or exert pressure on them and to be ready to identify interlocutors and partners to work with grass-roots non-governmental/civil society organizations and international humanitarian organizations.

2. https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sc_sops_2018_english_final.pdf

3. https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_ENG_.pdf



C – Safety Planning for GBV Survivors

Safety planning is a fundamental process of case management in which survivors analyse their situation and take vital decisions to reduce risks. Caseworkers assist survivors to recognize their potentials and strengths and to identify available options, to guide decisions taken by the survivor intended to mitigate risks to additional safety concerns. Safety planning is neither a linear nor a static process. It is mostly reliant on risk factors that determine the approach and the process to be adapted for each individual's safety planning situation such as follow:

- The context where violence is taking/has taken place (e.g. family home, school, camp, conflict zone, during displacement and during detention)
- The relationship between the abusers and the survivors (e.g. parental abuse, intimate partner, community member and armed actor)
- The socioeconomic and mental health status of the abuser and the survivor
- The presence of drugs, alcohol, weapons or any other life-threatening situation.⁴

With this information established, the case manager/hotline staff can support the survivor to identify ways to mitigate risks to prevent violence.

For more information, please refer to Annex 3: Immediate safety planning steps

How to comfort a GBV survivor on the call before starting a safety plan:

"It is important to know that what you are undergoing is not your fault"

"You cannot blame yourself or control your abuser's behaviour"

"I am here for you, let us explore together how you can amplify your safety and that of your children in case of an emergency"

"I will have to ask you some questions to help you figure out a plan. You do not have to answer them all"

"I am here to support your decisions"

"I cannot promise that the safety plan will work but it can certainly help us reinforce your safety"

"Let me reassure you that the perpetrator's (name it in the language of the survivor) violence is not your fault"

"I would like to confirm that everything you will say here is confidential and I will only share it with my supervisor and no one else unless you ask me to or if it is for mandatory reporting requirements as they apply to Myanmar. I want you to be aware of these constraints to your confidentiality in order to keep them in mind while deciding on what to share but also to maintain trust between us"

"Do you have any questions?"

For more information, please refer to Annex 4: Building a caller safety interview

4. <https://aifs.gov.au/cfca/publications/planning-safety-risk-families-resource-guide-workers-intensi>

1. Safety planning for high-risk situations

In high-risk situations when the survivor is in immediate danger, it is extremely important that hotline staff can contact the hotline supervisor to discuss any emergency concerns, and to agree on solutions. Survivors are backed up to explore all possibilities for safety options by providing psychological support and increasing his/her resilience and coping strategies to control the situation and reduce risks.

The role of hotline staff is to focus on the survivor's self-potential and resilience by doing the following:

- Inviting them to think positively about their important role within their families and communities
- Increasing their self-esteem while helping them to stop blaming themselves
- Refraining from convincing them that leaving is the best option if their safety is not fully guaranteed.

2. Safety planning for children

The most important step in child safety planning is to identify the current risks facing children in Myanmar. It is also important for GBV hotline staff to know the relevant laws and policies (e.g. the Child Rights Law) and partners providing child protection services to be able to respond in a timely manner to assist the child according to her/his best interest (e.g. whether to contact the police, child care entity/entities or any other relevant institution).^{5 6}

For more information, please see Annex 5: Supporting children and minors: dos and don'ts

3. Safety planning for LGBTIQ+ survivors

LGBTIQ+ individuals in Myanmar are often isolated and in danger of physical harm and sexual assault. They have difficulties finding people they can trust or supportive networks and need rapid intervention to mitigate risks of harm or suicide and come up with sustainable safety plans.⁷

For LGBTIQ+ survivors, the hotline staff's main duty is to prioritize essential safety planning, take note of all the information about their situation and walk them through the development of an urgent solution. Most importantly, staff should be aware of Myanmar laws that criminalize LGBTIQ+ individuals, of potentially discriminatory attitudes by the authorities and security personnel, and sociocultural norms that can cause hostility or intolerance towards people with non-binary identities.⁸ To the greatest extent possible, hotlines should identify service providers on their referral pathways who are well-equipped to support LGBTIQ+ survivors or at least serve them without stigma.

5. <https://www.unicef.org/myanmar/child-protection/>
<https://ihl-databases.icrc.org/applic/ihl/ihl-nat.nsf/implementingLaws.xsp?documentId=BFBAB7AD3A65FEF6C12584AE007B3FDC&action=OpenDocument#:~:text=On%2023%20July%202019%2C%20the,children%20affected%20by%20armed%20conflict.>

6. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/gbv_pocket_guide.pdf

7. <https://outrightinternational.org/ongoing-myanmar-crisis-situation-lgbtq-people>

8. <https://www.unfpa.org/sites/default/files/pub-pdf/MHPSS-CountryCasesAndOverview.pdf>



4. Safety planning for survivors with suicidal thoughts/behaviours

Safety planning for suicidal cases requires additional efforts from hotline staff and supervisors, adequate wording (see preliminary life saving tips below, questions to measure the risk for safety planning and how caseworkers identify immediate danger in the Annex 6), solid crisis management skills and psychological strength to stay calm to control the situation and prevent suicide happening.⁹

Preliminary life saving tips for suicidal cases

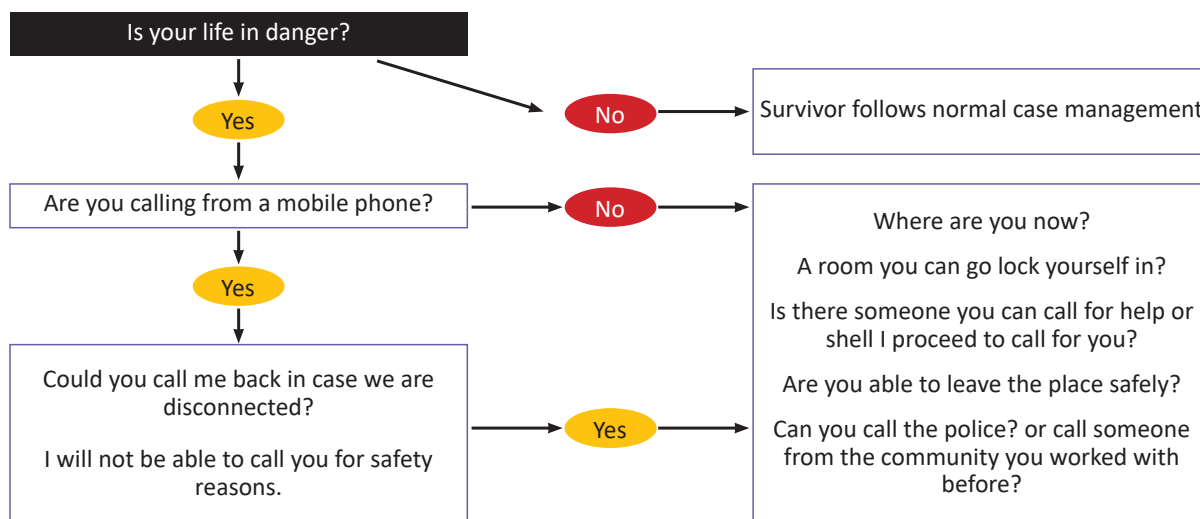
Assess the degree of the survivor's intention to act using very specific questions (How do you feel? Would you like to tell me what you are thinking about?) and avoiding naming the act (suicide) for whatever reason – like asking him or her why do you want to commit suicide?

Show compassion and empathy and praise him or her for their trust and courage if they disclose their thoughts and provide enough comfort to think collaboratively about a safety plan or in the best-case scenario share their location if possible or the name of a person to contact.

Offer multiple possible support options (sending someone to help, a friend to rely on, to contact a person on his or her behalf) and explore the survivor's coping strategies and mechanisms.

For more information, please see Annex 6: Questions to measure the risk for safety plan and Figure 1 on identifying the caller's immediate danger, adapted from COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines¹⁰.

Figure 1. Identifying the Caller's Immediate Danger¹¹



9. <https://drive.google.com/drive/u/0/folders/1CZVMBnGCC-vRS98zLdeGokze8n7hOM6e>

10. <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services->

11. <https://reliefweb.int/report/world/guidelines-mobile-and-remote-gender-based-violence-gbv-service-delivery-enmy>

D – Ensuring the Safety of Hotline Service Providers

The GBV service providers, particularly those located in conflict-affected areas, may be more prone to intimidation, stigmatization, armed attacks and other conflict-related violence. To protect service providers from such situations, it is extremely important that response service facilities are placed in a secure environment offering opportunities for hotline actors and remote service providers to ensure safety exits in cases of emergency. Service providers' safety should be linked with the organization's risk mitigation mechanisms and security warden system, if one exists.

How can hotline operating organization ensure safety?

- By undertaking regular assessment of the safety and security conditions on the ground
- By building a network of reliable local community members to leverage the safety of staff and local partners and friends and to share and receive regular situational updates
- By providing safe means of transportation and points of access for hotline staff
- By coordinating with actors of international humanitarian partners operating on the ground and ensuring regular communication and information-sharing of security risks and mitigating measures
- By training staff on safety planning in different circumstances.¹²

Staff safety measures

- Do not share your name with the survivor.
- Use a hotline name so that call documentation can be tracked through the staff members involved.
- Do not take hotline calls in locations with weak privacy. Anyone around you who overhears could compromise safety by revealing your involvement in a survivor's case.
- Follow documentation protocols to ensure that all written material connecting yourself and your organization to a survivor is adequately protected.

Applying COVID-19 oriented staff safety measures entail the following:

- Total compliance with the pandemic restrictions and health measures, including increased focus on the safety of personal spaces and equipment
- Appropriate safety policies and processes to conduct calls
- Management of staff safety planning in cases of extended confinement or escalation of the pandemic
- Assessment of the well-being of the hotline staff through available communication tools like WhatsApp, Skype, Messenger or Zoom¹³, remote sessions on staff self-care and stress management conducted by supervisors or professionals and most importantly, team mates' support through peer learning and coaching.¹⁴

12. <https://reliefweb.int/report/world/guidelines-mobile-and-remote-gender-based-violence-gbv-service-delivery-enmy>

13. For safety and security concern on using different digital platforms, please refer to the above section on "Digital tools safety and security".

14. <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>



Key Actions

- **Conduct scenario based GBV safety plans** that will be relevant to the context of the survivor including type of GBV violence and perpetrator, ethnic group and right to access health and legal resources.
- **Ensure safety plans are up to date** to factor in changes in the referral ecosystem that may promote or hinder the survivor's health and safety such as a COVID-19 surge or major political, legal or conflict triggers directly impacting access to resources and movement restrictions.
- **Establish and communicate safety protocols** to survivors at the beginning of the calls to promote a safe use of the hotline technology and prevent potential harm from perpetrators who can track communications.
- **Encourage survivors to maintain written safety plans** to facilitate execution particularly in situation of crisis and emotional shock.

STANDARD 2: Respect

Hotlines should ensure that all staff interventions are guided by respect for the survivor's best interest and choices.

A – Survivor-Centred Approach

"The survivor-centred approach seeks to empower the survivor. It focuses on delivering services in a way that puts the survivor in control; helping her analyse the available choices and supporting her in making decisions."¹⁵

In practice, the survivor-centred approach entails hotline staff being mindful of the survivor's choices, to ensure a non-judgmental attitude regarding their experience of types of GBV incidents, their cultural, ethnic and religious backgrounds, social status and sexual orientation throughout the process, to consult them about their preferred language as well as the gender of the hotline staff, the pace and what to disclose of their stories and the places to be referred to for services. The survivor should be in the lead in that the role of the service provider is to provide information on services available and the advantages and disadvantages of seeking services or taking actions, however, decision-making power is in the hands of the survivor.

B – Characteristics of Service Provision from A Human Rights Perspective

Hotline actors are required to do the following:

- Promote human rights and condemn all forms of discrimination that impact populations.
- Provide survivor-centred services to protect minorities and populations exposed to increased vulnerabilities.
- Guarantee sufficient human resources to avoid work overload and qualified GBV staff to handle emergency cases in different situations and provide timely, accurate and appropriate responses.
- Be alert during recruitment to avoid candidates driven by stigma and personal cultural or ethnic and racial bias.
- Ensure that staff have an appropriate private setting to conduct interviews and that the working hours are not excessive.

C – Building A Culture of Respect Among GBV Actors

A step forwards in building a culture of respect is to be reflective over one's personal feelings and perceptions that may trigger negative responses and be mindful in addressing interactions involving the following:

Mental health issues/substance abuse

- Ethnic, religious, social and/or political background
- Frustration over language barriers
- Survivor's statements that might appear as "wrongful" in the service provider's eyes.

15. UNFPA Guidelines on the Provision of Remote Psychological Support



STANDARD 3: Confidentiality

Hotline operators should recognize that information shared by GBV survivors is extremely sensitive and observe confidentiality rules and reporting protocols and modalities.

GBV hotline staff must adopt confidentiality rules for all information shared by survivors. Failure to do so can have serious and potentially life-threatening consequences for survivors, their families and relatives. Staff providing remote hotline services should receive calls in private spaces undisturbed by colleagues, friends and family members.

A – Adult Survivors' Informed Consent

The process of seeking survivors' informed consent is an important aspect of providing GBV response services in a meaningful and dignified manner. It ensures that the survivor is fully aware of the steps involved in the provision of care they are being offered, as well as the implications and consequences of their choices and decisions.

Hotline staff are required to obtain informed consent from the survivor (written for on-site services and verbal for services via the phone) prior to any service provision or referral and upon which only pertinent and relevant information is shared for case management purposes, such as referring to services indicated by the survivor, on a strict "need to know" basis.

B – Child Informed Consent/Assent

To obtain informed consent/assent from children, hotline staff should be extremely vigilant and aware of the child's best interest. It is very important that hotline staff use friendly and comforting language to consult child survivors and provide them with all the needed information to obtain their consent/assent for services and decisions concerning them (depending on their age and maturity). If the child is under 15 years old, caregivers or authorized adults can give their informed consent on behalf of the child who provides his or her oral informed assent as well. If the child is mature enough, he or she shall provide informed consent by themselves or shall be requested for permission in cases where caregivers are asked for their informed consent as well.

"Informed consent and informed assent are similar, but not exactly the same.

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide "informed consent" the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.

Informed assent is the child expressed willingness to participate in services."

For more information, please see Annex 7: Informed consent forms for adults and child, and Annex 8: Key steps to remote informed consent

STANDARD 4: Non-Discrimination and Intersectionality

Diversity among populations in Myanmar including by ethnicity, age and/or being part of a specific vulnerable group may result in different experiences of violence and requires service providers to proactively apply intersectional approach to establish trust with survivors, and to ensure that appropriate support is prioritized. A hotline should guarantee impartial support to survivors, without discrimination of any kind, in any of its activities and operations.

A – Discrimination in Conflict Situations and its Implications

Discrimination means treating a person unfairly because they possess certain characteristics. This includes but is not limited to gender, age, social status, ethnic origin, sexual orientation, religion, political views, disability or any other characteristic. Conflicts can aggravate pre-existing inequalities, exposing minorities and vulnerable communities to increased risks of violations. Survivors of GBV who belong to certain ethnic groups in Myanmar are often subjected to institutionalized discrimination and denied access to basic rights, health services including sexual and reproductive health, employment, education and legal rights. Looking into their cases compels hotline staff to be aware of the multiplicity of factors impacting their lives and conditions and consider the intersectionality of these factors in addressing the case. Bias against some ethnic and religious groups is a common form of discrimination and results in systematic and systemic exclusion from equal opportunities and fair treatment.

B – The Intersectional Approach

Hotline operators should apply an “intersectional approach” to multiple grounds of the discrimination experienced by the survivors, acknowledge the unique character of the case and take into account, among other factors, the socio-cultural-political context of the survivor.

Adopting an intersectional approach enables hotline staff to gain a better understanding of a survivor’s specific needs through acknowledging the various grounds of violence as well as the unique way they may intersect with each other. Hotline actors are encouraged to take into account the survivor’s cultural, historical, social and political context, treat them equitably and deal with each case as a unique experience.

In addressing a domestic violence-related call for instance, it is essential to consider the survivor’s characteristics including gender, age, social status, ethnic origin, sexual orientation, religion and disability when planning for support. For a GBV survivor living in an IDP camp experiencing domestic violence, additional circumstances create a unique experience of violence and additional barriers, such as the following:

- Traditional and cultural oppressive norms that prevail within the survivor’s own community
- Exposure to armed forces and armed ethnic groups, as well as potential exploitation from camp authorities
- Hostility from host community
- Volatile environment and potential frequent displacement
- Limited freedom of movement and access to services
- Living conditions and limited livelihood opportunities.



Good Practice

An international NGO operates a hotline covering IDP camps in Rakhine State, however, women and girls in some camps have limited access to mobile phones. To meet this challenge, the NGO provides mobile phones to camp-based volunteers, so that women and girls can have access through volunteers' phones. This strategy at least partially expands access to support and must be complemented by other strategies, including developing the capacity of camp-based volunteers and support to directly assist survivors. During COVID-19, the NGO opened up the Women and Girls' Centers in the IDP camps so that women and girls can use phones to call the NGO's office-based staff to seek support.

STANDARD 5: Survivor's Trust

Hotlines Should Build Foundations to Enhance Survivors' Trust

Establishing trust with GBV survivors is of utmost importance to increase the probability that advice will be considered and that survivors feel comfortable and empowered. On the contrary, demonstrating behaviours that may compromise trust could leave survivors in a more precarious situation, reluctant to seek support and hesitant to recommend the hotline to other people, which may limit the hotline's acceptance at the community level.

Steps to promote trust follow:

- Communicate with respect and empathy, "I feel your suffering and concerns"
- Respect the survivor's confidentiality and privacy, as well as their decisions and choices, "I respect your decisions and choices"
- Refrain from over-reassuring or over-promising on what the hotline can do to support the survivor, "I cannot promise that the safety plan will work"
- Establish strong relationship with trusted community representatives, including with women, adolescent women and at-risk groups
- Partner with trusted community institutions and GBV response services
- Seek client feedback on hotline services and establish mechanisms to receive complaints
- Build operating efficiency to avoid long waiting times and unanswered calls.

PART II: Increasing Capacity of Hotline Workers/Organizational Standards

STANDARD 6: Remote Service Provision – Case Management and Referral Pathways

The GBV hotline services should serve to inform survivors of appropriate and available GBV services and to support them to determine means to access those services, according to the survivor's needs and priorities. In order for hotline operators to provide this information, the organization operating the hotline must ensure that the operators have access to comprehensive up-to-date and localized referral pathways.

A – Case Management

Case management is a process by which social/case workers and GBV survivors collaborate to explore available resources and options to draw up multisectoral safety processes/plans and monitor and evaluate the effectiveness of the quality of services. Organizations should have a case management system in line with the national GBV and child protection case management Standard Operating Procedures (SOPs) and/or global guidelines. Social workers assigned for hotline services are first-hand call responders and service providers for case management and psychosocial support and should be fully aware of their organization's case management systems.

For more information, please see Annex 9: Standard case management pathway/Crisis case management pathway

B – Remote Case Management: Key Elements

- Regular surveys/analysis to determine the proportion of women and girls who own phones and how they communicate remotely if they do not have phones
- Remote case management procedures and protocols in place and known to staff
- Available and operational contact means, including emergency contact modality
- Staff ability to identify urgent cases referred from others
- Well established and functional security storing measures
- In parallel, organizations and hotline actors should benefit from training based on the Inter Agency GBV Case Management Guidelines to ensure that service is survivor centred and in compliance with GBV response guiding principles relevant to confidentiality, safety, non-discrimination and respect.



Remote assessment of the survivors' psychological and mental health is the first step to ensure their safety as well as that of their family and community. Hotline actors in Myanmar should prioritize training staff on survivor-centred guidelines, basics of emotional support and/or psychotherapy (e.g. handling survivors with depressions, post-traumatic stress and/or anxiety) to enable them at least to mitigate risk, to identify individuals who need more specialized and urgent support and connect them with MHPSS specialists.¹⁶ Organizations providing hotline services should be members of the GBV Coordination Working Group/Sub-Cluster and MHPSS working group¹⁷ in order to benefit from training and resources available in Myanmar, as well as to request for technical support and assistance on related capacity building as needed.

For more information, please see Annex 10: Case management in the context of COVID-19

C – Mapping of Services and Infrastructure for Referrals

Before beginning to develop a referral pathway, hotline service providers should consult with local GBV working groups (there are currently active working groups for Rakhine, Kachin, Northern and Southern Shan, and for Kayin States and it is anticipated that a new group will be formed for Kayah State) or with the **GBV Coordination Working Group** (Sub-Cluster) for Myanmar to determine if local referral pathways have already been developed. If they are available, the service provider should carefully review them to analyse whether the referral pathway (1) is adequately localized for the target population to ensure accessibility of services, (2) is comprehensive and provides appropriate/functional referral points for multisectoral assistance (health, MHPSS, legal, shelter and safety/security services) and (3) includes appropriate referral points for specific groups such as children, LGBTQIA+ and disabled persons. Hotline service providers should also review barriers and gaps hindering survivor access to services and recent referral experience to determine if further adaptation of the referral pathway is required.

Myanmar's GBV Coordination Working Group Referral Directory provides referral pathways for the national and subnational levels. They are password protected to ensure security of service providers; however, organizations can use the links provided on the website to request access.

If a referral pathway is not available, hotline service providers should undertake a mapping exercise to identify services available to GBV survivors. It is recommended that the organization operating the GBV hotline be familiar with the service providers and quality of services included on their referral pathway so that survivors can be accurately informed about the types of support available once referred. Contact information for referral points, operating hours and any related service fees should be regularly updated. If there is not a local/relevant GBV working group in the area, it is advised that service providers on the local mapping and referral pathway meet and coordinate together regularly to better facilitate referrals, share information (always with consideration for the confidentiality of individual cases) and discuss and address local challenges to providing appropriate survivor-centred care.

For more information, please see Annex 11: Mapping process

16. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/covid-19_gbv_guidance_-_apr_2020_-_final.pdf

17. Myanmar MHPSS Working Group website: <https://www.mhpssmyanmar.org/>

Managing Cases of Sexual Exploitation and Abuse

Case managers and organizations should be prepared to receive reports of GBV cases perpetrated by aid workers, staff of an NGO or the United Nations, which are classified as cases of sexual exploitation and abuse (SEA). Is it important that case managers receive training and preparation to assist survivors accordingly. Additional resources and information are available through the PSEA Network and through the GBV Sub-Cluster.

What to say/do:

If a survivor reports that the perpetrator of the violence is an aid worker or staff of an NGO or UN, there is an obligation to report this. The case manager should inform the survivor of this obligation, by saying: 'If you tell me that the person doing the harm is an aid worker, I have to tell my supervisor so that he/she won't harm others.'

Survivors reporting SEA should be referred to a GBV service provider according to GBV referral procedures.

How to report:

All allegations of SEA, even if unconfirmed, must be reported confidentially to your supervisor or directly to the organisation that the perpetrator is affiliated with. Alternatively, you can report to the Inter-Agency PSEA helpline: 09405149616

D – REMOTE REFERRAL

In all settings and circumstances, remote GBV service provision requires the following:

- Safe means of communication generally used and accepted by the local communities
- Sufficient qualified backup personnel, strong policies and procedures to ensure delivery of services
- Operational referral pathways to support case management
- Multisectoral response appropriate to each survivor.

In cases of remote referral, hotline actors face structural barriers pertaining to human and financial resources. Remote service referrals may be more demanding in terms of training staff on how to operate in unstable contexts, how to address survivors' accessibility (e.g. in areas with weak Internet accessibility or when survivors do not possess mobile phones as is the case for women and children in remote/displacement areas), how to provide accurate information and how to connect with reliable local community members and outreach agents who can facilitate accessibility and communication between referral services and survivors. It is preferred that those providing remote case management services have previous experience with in-person case management processes, which should also include experience managing child survivors as well as emergency and life-threatening cases.

Operational requirements follow:

- Awareness of the context where services are delivered including the geographical location, local dynamics related to conflict, adequacy of facilities and availability of staff
- Adjustment of referral response planning to changes in the context, including in places that are unstable or insecure
- Remote coordination with partners regarding survivors' access to services



- Regular follow-ups with survivors, communities, civil society organizations and humanitarian actors.

Benefits of remote case management

Remote referrals offer greater confidentiality to survivors of rape and LGBTIQ+ survivors, the latter of whom tend to be stigmatized and persecuted for their sexual orientation. For example, LGBTIQ+ survivors generally feel safer and less likely to be assaulted or stigmatized when they speak to caseworkers via phone. Remote referrals, in times of lockdowns or conflicts, also enable case managers with opportunities to broaden their scope of connections and networks within the local community members, supporters and volunteers who play a critical role in reaching out to survivors, reporting on cases, maintaining coordination between all stakeholders and ensuring survivors safe access to available services on the ground.

Good Practice

One organization in Myanmar runs a helpline service for the LGBTIQ+ community. Their helpline service is doing outreach on their Facebook page in various modalities to allow easy access for more clients. Clients can chat through Facebook Messenger for psychosocial support. Phonenumber counselling is running with different telecommunication providers, such as, MPT, Ooredoo and Telenor. If the clients are calling the helpline from the phone number with the same telecommunication provider, they have the chance to talk free of charge at certain times. The helpline also has a missed-call service for those who may not have money to pay for the phone call. Clients can leave a missed call or Viber message, so that staff can contact the client during their service hours. The helpline's Facebook page is also active, sharing useful and relevant information for the LGBTIQ+ community.

E – Referrals in the Context of Covid-19

The COVID-19 pandemic has required GBV actors worldwide to shift towards remote service delivery, which requires adaptation of case management and referral processes to address new challenges. Response modalities and service availability are often subject to continuous update and revision according to the evolution of the scale of the COVID-19 pandemic and the level of restrictions imposed by authorities (partial or full lockdown). Hotline actors should act proactively to ensure that all staff have reliable communication tools (e.g. phone and landlines) and financial aid to recharge them on a daily basis if necessary and if possible to maintain communication with survivors. Most importantly, they should be aware of their responsibility to develop and disseminate safety measures in line with the Inter-Agency Minimum Standards on referrals, compelling caseworkers and all service providers to uphold them and inform survivors, GBV service providers and community focal points about their obligation to respect the Minimum Standards and to mobilize resources to reach out to all survivors, in particular those heavily affected by lockdowns and curfews.¹⁸

For more information, please see Annex 12: Key Steps for Referrals in the Context of COVID-19

18. <https://reliefweb.int/report/lebanon/lebanon-inter-agency-inter-agency-minimum-standards-referrals>

To continue GBV case management services in the context of COVID-19 in Myanmar, the GBV subsector has developed a guidance document to guide partners, i.e. non-GBV specialized partners, on how to refer GBV cases to relevant service providers in a safe and timely manner.¹⁹

For more information, please also see Annex 13: Decision tree

F – Local Community-Based Partnership for Remote Referrals

In crisis situations, GBV actors often rely on local communities and their focal points to confirm their assessment findings, coordinate between service providers in the same or neighbouring locations and ensure safe transportation/accommodation for survivors. Community-based partners and focal points can play a critical role in informing survivors and focal points in other local communities via their local communication channels or via mobile applications and messaging about the changes and updates in the referral pathways as well as possible options for support mechanisms. However, at times, even these focal points cannot reach survivors, particularly those who are not cell phone users or who do not have Internet access.²⁰ Undertaking continuous review of strategies that are effective to engage and work with local communities with community leaders and focal points is advised to ensure strategic engagement and cooperation. It is also advised that community leaders and focal points are trained to understand GBV guiding principles and specifically to understand the importance of upholding confidentiality, and are also well informed about the services that are available locally, including the hotline information and operating hours.

Key Actions

- Participate in GBV working groups where they are active or in the GBV subsector
- Leverage existing local referral pathways to prevent duplication of service mapping
- Assess relevance of existing referral pathways and ensure they are reflective of the current context
- Regularly review and adapt GBV referral pathways

19. Guidance on GBV referrals during COVID-19 outbreak.

20. <https://reliefweb.int/report/lebanon/lebanon-inter-agency-inter-agency-minimum-standards-referrals>



PART III: Human Resources Standards

STANDARD 7: Staffing for GBV Hotlines

A - Basic Screening and Background Check Standards

One very basic aspect of protecting GBV survivors and maintaining the integrity of hotline operations is ensuring that applicants with previous safeguarding violations or pending cases are ineligible for recruitment.

However, it is acknowledged that there are no reliable systems in place to facilitate this process and candidates may not be forthcoming with relevant information. Myanmar's Protection from Sexual Exploitation and Abuse (PSEA) Network has developed a Safer Recruitment Checklist to guide organizations on key steps that can be undertaken during the recruitment and employment to mitigate the risks of employing individuals with a conflicted history. Self-declaration forms for staff should also be used to indicate that they have never been involved in any GBV cases or have never committed GBV.²¹

For more information, please see Myanmar PSEA Network's page on the Myanmar Information Management Unit (MIMU) at <http://themimu.info/sector/protection-sexual-exploitation-abuse-psea> (PSEA Toolkit section), and Annex 14: Sample Interview Questions on PSEA.

Good Practice

One international NGO in Myanmar is currently handling the hotline (a dedicated phone line) of Country Taskforce on Monitoring and Reporting on Grave Violations against Children (CTFMR), PSEA and safeguarding. In regard to risk mitigation, there is the Child and Adult Safeguarding Policy and all staff including affiliates have to follow the policy. Under this safeguarding policy, there is also a written behavioural protocol that covers in-person engagement, digital/phone engagement, social media communication and communication through any digital technology. Capacity building of the operators differs based on the requirements of the sectors or phonelines while project staff monitor the operators through regular meeting, report submission and training.

B - Staff Competences, Role Definitions and Attitude

To ensure relevance and to ensure trust, organizations should make services available in the local language(s) in addition to Burmese. Recruitment strategies should ensure that staff are able to support survivors in their own language; it is recognized that this may then require that candidates with less previous GBV experience receive more intensive training and close support supervision to rapidly enhance their skills and ensure they are prepared to directly assist survivors. Twinning arrangements could be put into place so that staff directly engaging with survivors can consult with more technical specialists as they develop their own confidence as case managers. This then brings another consideration into recruitment. Some applicants may belong to at-risk communities that suffer institutionalized discrimination, or who are stateless and do not have legal documentation. Given the need to ensure that service providers speak local languages and have a strong understanding of the context, barriers to recruitment of such individuals should be removed, as possible, to promote more diverse staffing and inclusive services.

21. <https://www.themimu.info/sector/protection-sexual-exploitation-abuse-psea>

1. Competences

Generally, hotline staff are recruited on the basis of their knowledge of GBV. Staff must have at least basic knowledge of GBV, because they will be in situations where they will have to identify the types of violence and their implications on survivors. They need a predisposition to show empathy to survivors, and treat them with respect and dignity, and basic skills relevant to counselling, case management and ethical and professional commitment which are also acquired through regular capacity-building sessions, supervision feedback and practice.

Increasing accessibility to GBV hotline services in Myanmar, including for at-risk population groups, will require hotline internal hiring policies to ensure that several requirements are met during recruitment:

- Hire staff that can communicate in the main language spoken by the local community in addition the official national language of Burmese
- Minimize barriers for candidates from at-risk/vulnerable populations like children or people with disabilities to increase representation, e.g. staff with specialized skills who can speak to persons with disabilities or to children
- Train staff on how to appropriately support vulnerable populations and/or refer them if more specialized services/support are available and accessible

2. Role Definitions

Organizations should clearly define the objectives of hotline services as well as what kind of immediate support would be provided by hotline staff. Based on objectives and the support identified, role and responsibilities should be assigned to hotline staff or assigned staff, GBV case workers and their supervisors. Hotline staff play a major role in saving lives and accompanying survivors in their safety planning journey.

Defining the roles of hotline staff is clearly necessary to avoid unclear and conflicting job roles which trigger ambiguity in a team structure and result in a wide range of issues such as staff feeling devalued, increase in stress and tension between staff, as well as lack of accountability and a risk of augmented finger-pointing particularly in a set-up where survivor safety is at stake.

The agreement between organizations operating GBV hotlines and hotline staff should be a written statement/contract with clear terms of references describing roles including main duties and responsibilities as well as the consequences in cases where hotline staff breach the contract. For more details on roles, definitions and requirements, please see the IRC's Guidelines for Mobile and Remote Gender-Based Violence Service Delivery.



As front-line workers, hotline staff tasks and functions can be summarized:

- Assessing services availability and operationalization in the targeted area
- Answering calls and inquiries
- Assessing the level of danger/risk facing the survivor and sharing appropriate information with the survivor pertaining to their safety and security
- Providing crisis support in cases of emergency (health, mental/psychological and physical preliminary support)
- Providing information to survivors on other available services
- Coordinating case management service delivery
- Updating referral pathways according to circumstances (e.g. COVID-19, conflict and displacement)
- Designing safety planning with survivors
- Ensuring follow-up of case management
- Checking on survivors' safety by maintaining regular calls and advising on safety measures
- Documenting and storing data
- Contributing to the supervision of services delivery. (For remote services from homes or private rooms by sending photos of the spaces, equipment and reports, by attending briefs with staff and by maintaining follow-up questions with survivors for feedback).

Like GBV hotline staff, the role of their **supervisor** is also essential to provide quality service and to enhance staff capacity accordingly. Supervisor tasks are described below:

- Oversee operation of the hotline service
- Review call loads to determine staff requirements, training needs and technical support as well as to make appropriate adjustments of workloads
- Provide regular supervision and be ready for ad hoc supervision if needed
- Ensure well-being of supervisees
- Ensure service is provided in a timely manner and quality assurance with confidentiality
- Standby to support staff regarding technical problems with equipment and operation company
- Provide immediate guidance to hotline staff when they face complicated calls/cases
- Lead coordination and networking within the organization as well as with partner agencies and other stakeholders accordingly.

3. Attitude

The GBV hotline staff have the duty to create a safe, supportive and empathetic environment for survivors to receive support. Failure to do so is likely to exacerbate existing anguish and to delay healing and recovery. That means that hotline staff must have the right abilities, knowledge and skills including, but not limited to, advocacy and commitment to GBV issues, strong ethics and adherence to the GBV guiding principles at all times, as well as emotional intelligence.

STANDARD 8: Workload Management

To meet the needs and expectations of GBV survivors, organizations operating hotlines should ensure efficient case allocation and establish plans for addressing increased staff workload. Good capacity management is an important aspect of operating GBV hotlines, particularly when the risk of being under-staffed is raised. Staff members' heavy workloads can have negative consequences on survivors, whose safety may be undermined if their calls remain unanswered or if they incur long waiting times. Organizations operating hotlines should refrain from assigning individual staff members, who have additional functions not related to hotline operations and/or at the same time own multiple functions within the hotline structure, to be in charge of hotline operation.

Inadequate staffing can also have a major impact on staff well-being, motivation and performance. Organizations operating hotlines must not only ensure that all essential functions to operate a hotline are sufficiently staffed, but also look out for signs such as staff working overtime and demonstrating fatigue or survivors' complaints of long waiting lists, to prevent staff burnout and find sustainable and well-designed solutions.

Key Actions

- Plan resourcing ahead of time based on staff capacity and available data on call traffic
- The maximum workload should be agreed upon and respected
- Establish mechanisms to scale up during peak time/periods, conflict resurgence or in aggravating contexts such as with the COVID-19 pandemic
- Be prepared to re-allocate cases across the hotline team based on capacity in a flexible setting
- Communicate with operators to understand their capacity and gather relevant data to support additional funding requests



PART IV: Training and Protocols

STANDARD 9: Induction Training Areas and Protocols

Organizations operating hotlines should provide comprehensive training to staff to ensure their readiness for hotline operation. All hotline operators should receive basic training on core principles of GBV case management and child protection. Although it is the responsibility of organizations operating hotline services and those funding them to ensure that staff have the required background and training, training resources and opportunities are available through the GBV subsector and the local working groups. Organizations operating hotlines should be engaged in these networks to benefit from these resources as well as to bring attention to any related gaps where additional resources and opportunities can be requested and considered.

A – Induction Training Key Areas

Hotline staff should be provided with a minimum level of training as part of the onboarding process to ensure they have the capacity to interact with survivors in appropriate and meaningful ways. Induction and training of hotline operators should include the following as a minimum:

- Staff induction sessions to explain the hotline functions and mission, working conditions including safety and security of staff and equipment, tasks and roles of each staff member involved in the hotline operation including administrative and logistics matters, and ethical guidelines
- Training sessions on active listening, remote counselling skills, GBV guiding principles, case management and referrals, staff self-care, supervision and reporting
- Practical training: case and role-playing exercises where participants and supervisors are in different scenarios (with different levels of risks) playing the roles of anxious, angry or suicidal survivors as well as perpetrators or family members.

In addition to induction training, it is equally important to organize regular refresher training.

B – Training Scope

Hotline staff should receive training on protocols and policies concerning how to meet the needs of survivors and ensure consistency in service delivery. At a minimum, clear protocols and training should cover the following:

- Preliminary protocols specific to the operation of relevant tools like mobile phones, computers and technology used to provide remote services, e.g. mobile and messaging applications
- Basic confidentiality protocols and tools (e.g. clearly define in which situations the survivor's contact details such as names and addresses shall be obtained and when codes, numbers or nicknames should be used instead of personal names; and survivor's verbal informed consent form).

- Standard call answering process:
 1. Phone listening skills (active listening)
 2. Introductory statements (building trust)
 3. GBV identification and assessment
 4. Basic case management process (introduction and engagement to case closure)
 5. Child case management
 6. Case management of life-threatening cases (suicidal cases, cases in distress and high risk)
 7. Obtaining verbal consent/assent via the phone
 8. Development of a safety plan over the phone
 9. Reporting and assessment protocols
 10. Referral process over the phone
 11. Closing.

Important

All hotline staff, irrespective of their role, should be trained on the case management and protection of child survivors, survivors with disabilities, LBGTIQA+ survivors and male survivors. This includes treating survivors with dignity and respect, respecting their right to take their own decisions, maintaining privacy and confidentiality, honouring the principle of non-discrimination and providing full and accurate information to survivors. When supporting child survivors, all decisions made by hotline staff should promote the best interest of the child. It is also crucial that hotline staff are aware of reporting protocols and mechanisms on sexual exploitation and abuse committed by humanitarian actors^{22 23}.

Myanmar national consultations recommendation for training and capacity building:

Communication tips (dos & don'ts for hotline staff)

Self-care and stress management tools

Gender mainstreaming

GBV case management

Legal framework for GBV survivors

MHPSS for survivors and staff

Professional ethical boundaries and breaches

Human trafficking

22. <http://themimu.info/sector/protection-sexual-exploitation-abuse-psea>

23. https://psea.interagencystandingcommittee.org/sites/default/files/1%20Myanmar%20Data%20Protection%20Policy%20Example_final.pdf



PART V: Establishing Safe GBV Information Management Process

STANDARD 10: Data Documentation, Storage and Management Protocols

Staff must collect and store data in a safe manner in accordance with confidentiality rules and survivors' consent.

Safe data documentation and storage is an important step in GBV hotline interventions. Data stored includes information collected from the survivor to support her/his needs as well as the next steps in management of a case. While keeping track of new IT security advice, hotline operators should establish and train staff on clear data documentation and storage procedures specific to the available tools.

In all funding proposals, organizations' operating hotlines should request funds for computers, phones, equipment and technology and related maintenance required to ensure data safety and security. As a matter of due diligence, donors should ensure that these considerations are supported and if not included in a proposal, must confirm that related equipment and technology is funded through other sources.

Protocols for Documentation and Storage

1. Tips for electronic devices documentation protocol

- Do not use personal information about survivors when filing data digitally. Instead, use a coding system to safely stored information.
- Information stored electronically should be password protected and stored in tools that are not prone to hacking such as folders on the computer hard drive, folders with survivors' ID numbers/codes or initial telephone numbers instead of names, or phone memory cards which can be easily removed from devices and destroyed.
- Computers where hotline data are kept should be accessible by only relevant staff such as case workers or hotline staff if the organization is unable to provide a separate computer to each staff member.
- Send emails only when necessary and use encryption tools to protect files and data. Further information is available on the different types of encryption.²⁴
- Make secure backup copies and ensure they are stored in a locked storage space.
- Change passwords regularly, especially when there is a staff change.

Prior to all the above recommendations, organizations providing remote services should ensure their Wi-Fi passwords are strong and not prone to hacking and check on the level of security of the communication devices used by staff, e.g. computers, tablets and mobile phones. They should not only check, before handing mobile phones to the new staff, that all previously stored data are eliminated but also ensure that staff provide a backup of work computers in cases of contract termination.

24. <https://digitalguardian.com/blog/what-data-encryption>

How to guarantee phone security

Use strong and complex passwords (e.g. capital and small letters and numbers, avoiding personal names or dates of birth) and regularly update them

Update security questions and set antivirus programs

Disable all applications that may compromise information safety (location tracking Bluetooth and deleting calls and sensitive information)

Avoid storing very confidential and sensitive information about survivors (contact information and address)

2. Tips for paper documentation protocol

- Register each survivor's file using a unique individual file registered with the incident number. Names of survivors should not be written on the outside of the paper file.
- Store printed materials in locked file storage.
- Control access to files through encrypted folders and password (including for informed consent forms) known only to the caseworker, hotline respondent and the supervisor in charge of the case.
- Do not discard case files in a normal bin. Instead, shred them.
- Ensure that there is an emergency plan and protocol in place for the deliberate destruction of all case-related information materials in the case of an evacuation.

Good Practice

One international organization in Myanmar provided technical assistance and support on human resources and data management to an agency operating hotline services for trafficking survivors. Service continuity with adequate consideration for the security of case files was maintained even when the impact of the pandemic began to limit staff attendance at the office. A highly experienced supervisor closely oversaw management and storage of case files and guided the staff responding to calls who attended the office on a rotational basis. This ensured that calls could be taken in a private and appropriate setting and that case files were maintained securely at the premises while the health of staff was protected during a critical period.



GBV Information Management System (GBVIMS):

The development of the protection information management system and its relevant modules, GBIMS/GBVIMS+, supports the needs of GBV humanitarian actors for safer data collection, storing, management and sharing for case management and incidents. The system provides staff with a mobile application of GBVIMS+ to document data on a tablet, to enter case management data at the mobile site without relying on personal memories and a highly secure server to submit files. In Myanmar, the GBVIMS was rolled out in 2016 and launched in 2017. UNFPA manages the GBVIMS and organizations interested to learn more, including potential to use the system as data-gathering organizations can contact UNFPA. There is a designated Information Sharing Protocol for the data-gathering organizations of the GBVIMS, and standard incident recorder and data tools designed to uphold confidentiality are available.

Further guidance on considerations for shifting case management services from safe spaces to remote service delivery by phone is also available in video and podcast form (in English): a short video is found here [English with Myanmar subtitles] and the podcast can be found here [English].²⁵

Good Practice:

One donor embassy introduced a Legal Aid Data Management System to partner organization, which can be accessed with a password. Before starting to use the online data system, the data focal person from the partner organization twice attended 1-day training organized by the donor embassy. Partner organizations can share their data in the cloud with technical safety measures. The donor embassy provides not only technical support but also other necessary support such as computer and data package fees to remove barriers to enhanced data security for its partner.

25. For more information: <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf> and www.primero.org and www.gbvims.com

STANDARD 11: Data Sharing and Reporting Protocol

A – Data sharing

It is important that hotline actors adopt and abide by the protocols regulating information sharing in line with the GBV guiding principles. Spaces and devices containing paper and electronic information should not be accessible to staff without the supervisor's permission and should be locked when the staff leave the room or office. Staff should be alert to any illicit disclosure or sharing of data and immediately inform supervisors when encountering any such cases. To avoid such incidents, organizations running hotlines should always consider raising the following interrogations: (1) who requested the information? (2) Is the information seeker reliable and trustworthy? (3) Is the information really necessary for the advancement of the case? (4) How will the information be used and reported?

B – Data reporting

GBV hotline actors need to ensure that their reporting system and mechanisms are in compliance with national policies (if applicable) and in line with GBV guidelines and principles including ethical and moral principles prioritizing survivors' confidentiality and safety and the need to obtain informed consent from survivors before disclosing or sharing information concerning them. Hotline staff are required to maintain survivors' confidentiality and are not allowed to disclose any information against their will. Even in cases of rape or sexual assault, it is imperative that survivors are made aware of the reporting rules and regulations before any disclosure, sharing or reporting is done. Exceptions of information disclosure occur in cases where survivors are psychologically unstable and become a threat to their safety or in cases where it is mandatory by the force of law as it is in cases of grievous harm or in the case of minors in Myanmar.²⁶

C – Possible situations of mandatory reporting

There are situations where hotline staff have a moral duty to report incidents to prevent, for example, child abuse, sexual exploitation/trafficking and/or serious threats compromising the survivors' and/or others' safety and security or in areas where reporting is legally mandatory.

Other situations that may require reporting are related to the collection and sharing of non-identifiable data for case management and monitoring purposes (such decisions should be included in the informed consent form to be validated and approved by the survivor).

1. Medico Legal Reporting

Given the complexity of reporting and all the ethical and moral boundaries framing it, the medico legal recording is qualified as the only material evidence besides the survivor's own story.

Generally, medico legal reporting is requested for legal or medical case management purposes in cases of rape, sexual violence or any grievous physical or psychological harm and injuries. Medical officers and forensic doctors are legally assigned to conduct survivors' clinical examinations and fill in the medico legal records. They are not allowed to share the reports with the police for instance without the approval of the survivor (unless it is binding by the country's law). In all cases, survivors have total control over their medical records and no caseworker has the authority to file the case or report the incident to the police.

26. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/5._gbv_reporting_for_non_gbv_actors.pdf



In Myanmar, the medico legal report is called Medical Form Crime 38/Police 75²⁷. This is a process that requires every detail of the incident to be reported and requires accuracy in collecting and reporting evidence (including clinical examination by specialists, questioning and interviewing survivors in their language, with simple wording and in a convenient environment).

Survivors of assaults willing to report to the police shall be informed that they must undergo a forensic clinical examination for evidence collection by a qualified health care worker. They should also be informed of the full physical medical exam they have to take regardless of their decision to collect evidence or not. Generally, forensic evidence can only be collected up to 7 days after the assault.

In Myanmar, for cases where survivors of assaults choose not to report to the police, caseworkers are compelled to do the following:

- Respect the survivor's choices
- Inform them of their right to change their mind within less than 7 days after the assault happened
- Invite them to speak to a person they trust and offer them help in drafting the medical report
- Inform them about the current legal reporting obligations that require grievous harm and child rape and abuse only to be reported to the police and not to anyone else.

Caseworkers may also be apprehensive about reporting GBV incidents in legal courts if survivors need to appear in courts as factual witnesses for fear of them being targeted by their alleged perpetrators or when survivors are not prepared to provide accurate evidence. It is important to be aware that hotline staff working in conflict zones or facing Internet or connectivity limitations may not always be able to collect enough accurate evidence for cases in courts. They can rely on trustworthy community focal points and humanitarian actors on the ground as an alternative with the survivor's consent.

2. Mandatory Reporting for Child Survivors

Parents or any legal guardian of children who have experienced GBV, including sexual violence, should be informed of any existing mandatory laws and legal procedures concerning children and should be aware of their legal capacity to provide their informed consent in cases where they are not involved in the child abuse or ill treatment. Hotline staff handling child survivors' cases should be well trained and qualified on children's specific needs and guidelines on working with children²⁸.

In Myanmar, there are special mandatory procedures that health workers have to follow in cases of child reporting, which include the following:

- The child should be assisted during the clinical examination process by a person known to him/her, trustworthy and not involved in the child abuse/incident
- The medical staff should motivate the child to speak freely about his/her concerns throughout the examination process
- The child is informed in simple and child-friendly language of all steps of the examination process
- Prior to that, the medical staff undertaking the examination and the support person prepare the child to contribute actively in the examination process.

27. <https://mohs.gov.mm/page/174>

28. <https://myanmar.unfpa.org/en/publications/guidelines-healthcare-response-gbv>

STANDARDS 12: Monitoring Protocols and Tools

A – Monitoring the Implementation of the Minimum Standards

A helpful tool to track progress and implementation of the Minimum Standards is to use a comprehensive checklist covering key areas of the Minimum Standards, identifying its current status and flagging major gaps and areas of improvement.

The monitoring checklist follows the framework of this Minimum Standards document for ease of use and can be divided into the following sections: (1) organizational standards, (2) physical infrastructure, (3) human resources, (4) data documentation and storage, (5) training and protocols, (6) data access and sharing and (7) monitoring and evaluation.

For more information, please see Annex 15: Minimum Standards monitoring checklist

B – Monitoring Hotline Locations

Monitoring hotline spaces occurs through supervisors' regular visits to check if the working conditions are suitable, safe, decent and appropriate to ensure confidentiality and privacy of women and girls and to conduct private case management activities.

In the case of a crisis where hotline activities are conducted from home and remote locations, monitoring private spaces (homes and private rooms) is generally reliant on the following:

- Local friendly community members who conduct visits to staff and report to the hotline supervisor (based on previous training on GBV guiding principles and trustworthy relationship)
- Staff collaboration (sending photos of location, describing every detail of the space and reporting existing deficits in confidentiality and privacy norms)
- Sustainable relationship between staff and supervisors to improve conditions and amplify confidentiality and safety of survivors and staff.

C – Monitoring Services and Staff

Measurement of the functionality and quality of services is reliant on the following:

1. Feedback collected from survivors depending on the working conditions and available communication tools
2. Audits conducted regularly by supervisors through specific documentation and assessment forms and tools to evaluate confidentiality of information, communication devices and support implementation (psychological, social, mental health care, medical examination and legal)
3. Regular supervision of hotline staff through phone checking, community-based focal points or staff training sessions and briefings, which are necessary to ensure a sustainable relationship between staff and supervisors, mutual respect and an enabling environment to detect and manage staff stress.



Key Actions:

- Conduct regular audits, spot checks and observations
- Capture survivors' feedback and build action plans to address service quality issues
- Ensure operators receive supervision to provide opportunity of development
- Regularly assess and monitor protection and security risks

Key Findings and Recommendation from Subnational Consultation

Clients' feedback or satisfactory form or quarterly case-worker skills assessment are used to monitor the quality of services and staff capacity and attitude. Some organizations have specific monitoring mechanisms and tools as well as a regular plan. But monitoring systems and plans of some organizations are not strong. Regular interval and a timeline for monitoring are important. It is better if a monitoring plan is recommended or suggested with time bounds.

D – SUPERVISOR PROFILE AND COMMUNICATION PRACTICE

To ensure an effective tracking and assessment of services and staff, it is crucial that hotline supervisors have adequate interpersonal, motivational, facilitation and crisis management skills. Ideally, hotline supervisors are able to navigate group dynamics, coordinate between different stakeholders, reassess the needs and update case management plans.

When communicating with caseworkers, supervisors should:

- Be patient and demonstrate empathy regarding the caseworkers' concerns and needs using expressions to comfort them
- Avoid criticism and blame, show compassion and try to inquire about the rationale behind decisions taken and always seek to empower by providing constructive input and further capacity building sessions if needed
- Listen carefully to the caseworker and validate what he or she say
- Pay attention to caseworkers' verbal and non-verbal communication and respect their pace of speech especially in situations where the challenges are high
- Ensure that supervision is collaborative, an opportunity for learning and exchange and remember that attitude and practice are always a model for staff
- Ensure safe environment and means for staff during supervision meetings or calls

Glossary

Hotline: an established phone service that provides crisis support and information to any survivor who calls. It 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.²⁹

Hotline staff: persons with GBV and case management background, directly involved in service provision to survivors. They should be capacitated on survivor-centred approach and case management, supervised and supported to offer psychosocial support if needed, inform survivors and help them come up with their safety plan in line with GBV guiding principles.

Remote services: services provided over hotlines, chat or SMS or other available technology platform.

Static services: services provided at a static service provision point, have a set location and do not move.

GBV service delivery via the phone: implies that service providers reach out through mobile phones to people who are displaced, in transit or cannot be accessed by static in-person services.

Survivor: a person who has experienced GBV. The terms “victim” and “survivor” are often used interchangeably. Victim is a term more often used in the legal and medical sectors. Victim is also used by human rights activists to flag due diligence issues. Survivor is the term generally preferred in the psychological and social support sectors because it implies resilience.

Perpetrator: a person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against their will.

GBV actor(s): individuals, groups, organizations and institutions involved in preventing and responding to GBV.

Child: Any person aged 10–19 years. Early adolescents are 10–14 years. Later adolescents are 15–19 years.

Adult: Any person aged 18 years and older.

Gender: “Gender refers to the characteristics of women, men, girls and boys that are socially constructed. This includes norms, behaviours and roles associated with being a woman, man, girl or boy, as well as relationships with each other. As a social construct, gender varies from society to society and can change over time. Gender is hierarchical and produces inequalities that intersect with other social and economic inequalities. Gender-based discrimination intersects with other factors of discrimination, such as ethnicity, socioeconomic status, disability, age, geographic location, gender identity and sexual orientation, among others. This is referred to as intersectionality” (World Health Organization, WHO).

Gender-based violence: “Gender-based violence refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms” (UNHCR). It affects both men and women and used by some actors to describe violence against non-gender conforming persons and non-dominant sexual orientations.

29. <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>



Domestic violence: describes violence that takes place within the home or family between family members, including intimate partners.

Mental health and psychosocial support: include any support that GBV survivors receive to protect and improve their mental health and psychological well-being. They also include support for survivors' general psychosocial well-being. Helping them connect with other family and community members, or helping them deal more effectively with personal challenges or practical problems, can have great benefits in reducing their distress and suffering.

GBV guiding principles: internationally accepted principles meant to guide the work of all helpers – no matter what their role is – in taking a survivor-centred approach in all their interactions with people who have experienced GBV. This includes a survivor's right to safety, confidentiality, dignity and self-determination, and non-discrimination. **GBV focal point:** the part- or full-time role of designated staff who represent their organization, community structures and/or their sector and participate in meeting and coordination activities related to GBV; it also refers to individuals within services and associations who have been appointed as staff of contacts for GBV cases (Guidelines for gender-based violence interventions in humanitarian settings, IASC, 2005).

Informed consent for GBV survivors: approval or assent expressed verbally or in written according to specific circumstances and after thoughtful consideration. Informed consent is voluntarily and freely given based upon a clear appreciation and understanding of the facts, implications and future consequences of an action (GBVIMS user guide, 2011; and WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies, 2007).

GBV referrals pathways: guidelines (local or national and can be adapted depending on context and circumstances) that provide service providers with information on how to respond to GBV cases and refer survivors on where to seek support, what services are available and operational for case management and help to ensure survivors' protection and safety.

Inter-Agency Standing Committee: an inter-agency forum of United Nations and non-United Nations humanitarian partners, founded in 1992 for coordination, policy development and decision-making. The overall objective of the IASC is to improve the delivery of humanitarian assistance to affected populations.

Acronyms

GBV	: Gender-based violence
GBVIMS	: Gender-based Violence Information Management System
IASC	: Inter-Agency Standing Committee
IDP	: Internally displaced population
IRC	: International Rescue Committee
LGBTQIA+	: Lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and many other terms
MHPSS	: Mental health and psychosocial support service
PSEA	: Protection from sexual exploitation and abuse
UNFPA	: United Nations Population Fund

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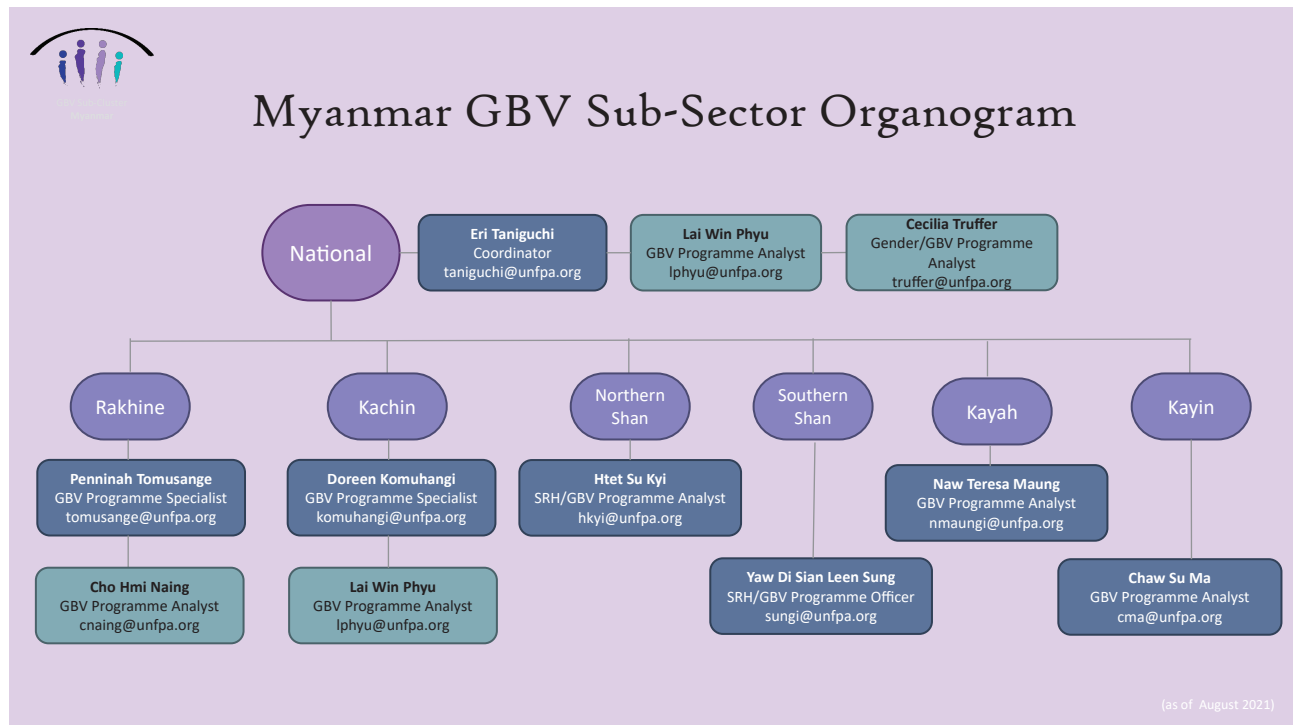
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Annexes

Annex 1: Contact Information of GBV sub-sector in Myanmar



Annex 2: Key digital safety tips

Some useful digital safety tips for hotline staff:

1. Use strong passwords to protect your digital devices to protect survivors' information
2. Back-up files in the cloud, e.g. to recover files in cases where devices are stolen or damaged; an example of online backup (<http://bit.ly/TI8YzU>)
3. Use tracking software to localize device if stolen or a remote control via SMS or other methods
4. Keep digital devices (e.g. mobiles) away from thieves while in public places, transportation or cars
5. Store sensitive data in encrypted files in case a device is stolen
6. Remove sensitive personal data from your device



Annex 3: Immediate safety planning steps

In cases of immediate safety planning, hotline staff should:

1. Check the safety of the environment during the call with the survivor
2. Determine the current emotional condition of the survivor
3. Identify warning signs such as screams, shouts and the presence of guns
4. Measure the level of risks by asking the survivor to rate this with a number 1 to 5 and plan for immediate evacuation if the level of risk is high (e.g. by calling the police)
5. Refrain from recording the conversation
6. Inform the survivor of their rights:
 - To choose not to answer all questions
 - To stop the conversation if they are exhausted or tired
 - To decide on the safest digital tool to ensure follow-up calls
 - To consult on how to arrange follow-up calls

Annex 4: Building a caller safety

Hotline Caseworker: This is Mia speaking. How can I help you?

Survivor: Shall I tell you my name?

Hotline Caseworker: No, you do not have to. What would you like me to call you?

Survivor: Lina

Hotline Caseworker: Hi, Lina. Is there anything you want to talk about?

Survivor: Yes, I think so. My husband is beating me, I am afraid of him. I don't know where to go or what do to.

Hotline Caseworker: I understand you are worried. You did well to call and I will do my best to comfort you. First, let us make sure you are safe to speak. Where are you calling from?

Survivor: home

Hotline Caseworker: Fine, are you by yourself at home or with someone else?

Survivor: My oldest daughter is in another room. She cannot hear me.

Hotline Caseworker: Is your husband at home?

Survivor: No, he is outside. I do not think he will come back now.

Hotline Caseworker: Great. Is it safe for us to agree on a code word in case you want to let me know that you cannot talk anymore? For example, we could choose "weather." If you want to tell me that someone is listening to what you are saying, you can talk about the weather in your town. I also want you to know that in case we are interrupted, we will never call you back but you can call us back when it is safe and you have privacy.

Survivor: OK, I understand. I will use "weather"

Hotline Caseworker: If anyone asks who you are talking to, you can say that I am from a women's catering project. Are you calling from a mobile phone?

Survivor: Yes, it is mine.

Hotline Caseworker: Will you be able to delete this call from the call record after we speak?

Survivor: Yes, I will.

Hotline Caseworker: Thank you for being patient to set up this plan. Now can you tell me more about your worries? What is your husband doing that is causing you fear?

Annex 5: Supporting children and minors: dos and don'ts

- DO** listen attentively and pay attention to moments of silence, tone and voice
- DO** be patient, tolerant and non-judgemental
- DO** allow the child to speak freely and use their own words
- DO** comfort the child and let them know it is ok to disclose their story
- DO** show respect to the child's opinions, beliefs and thoughts
- DO** use comforting statements relevant to the social and cultural context of the child and work to gain their trust using words like, "I believe you", "I agree with you"
- DO NOT** ask for personal details if not necessary or if the child is reluctant to share
- DO NOT** disagree with the child's beliefs, show anger, raise your voice or show any other reactions that may create make the child uncomfortable or to mistrust you
- DO NOT** use complex words or speak in a language that the child cannot understand
- DO NOT** promise anything you cannot fulfil or raise the child's expectations to what you can help with
- DO NOT** pressure the child for more information against their will

Annex 6: Questions to measure the risk for safety plan

Hotline caseworkers have the responsibility to determine any risk facing the survivor, evaluate the level of danger and react accordingly in a timely manner to support her/him planning a safe way out.

1. How often have you been subjected to violence and how frequent are the life-threatening physical injuries?
2. How often do you (and your children) feel threatened?
3. Has your abuser ever tried to kill you? How many times has he threatened to kill you (and your children)?
4. Does he possess a gun or weapon? Has he ever tried to use it?
5. Does he use drugs or alcohol?
6. Do you live in the same place or room?
7. Is there anything which has happened or may happen that will expose you to more violence?
8. Are there any signs that your abuser may become more violent?



Annex 7: Informed consent forms for adults and child

It is essential that hotline staff and survivors understand that informed consent occurs only when GBV survivors are adequately informed about possible options, their implications and the potential risks they may face when they consent to share personal information. In this context, it is important that the hotline staff are aware of the power dynamics between themselves and survivors so that survivors can make informed consent without pressure.

Adults:

Before obtaining the survivor's consent, hotline caseworkers should make sure carefully read the form in the language of the survivor, check the survivor's comprehension and explain to them in simple and clear language that they have the right to choose any or more options listed in the form or decline them all.

I _____, give my permission to (name of the organization running the hotline) to disclose and share information about the incident that I have reported as explained below:

I understand that in giving my authorization below, I give (name of organization running the hotline) permission to share the specific case information from my incident report with the service provider(s) I have indicated so that I can receive support with for my safety, health, psychosocial, and/or legal needs. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance that I request.

I understand that releasing this information means that a person from the organization may call me or come to talk to me. At any point, I have the right to change my mind about sharing information with the hotline organization/focal point listed below. I would like information released to the following (tick all that apply and specify name, facility, and agencies/organizations as applicable):

YES

NO

Shelter

Police

Counselor/Psychosocial support

Health Facility/medical professionals

Legal Assistance

Community or family member

(other as relevant to the survivor)

Name of the caseworker/focal point

Signature:

Date:

Code or initials of the survivor:

Signature:

Date:

Children:**Authorization to be provided by the survivor (or parent/guardian if survivor is under 18)**

I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared I understand that shared information will be treated with confidentiality and response Authorization to be marked by survivor (or parent/guardian if client is under 18). Signature/thumbprint of client:

_____ (or parent/guardian if survivor is under 18)

INFORMATION FOR CASE MANAGEMENT (OPTIONAL- DELETE IF NOT NECESSARY)

Survivor's name/code: _____

Name of Caregiver, parent (if survivor is a minor): _____

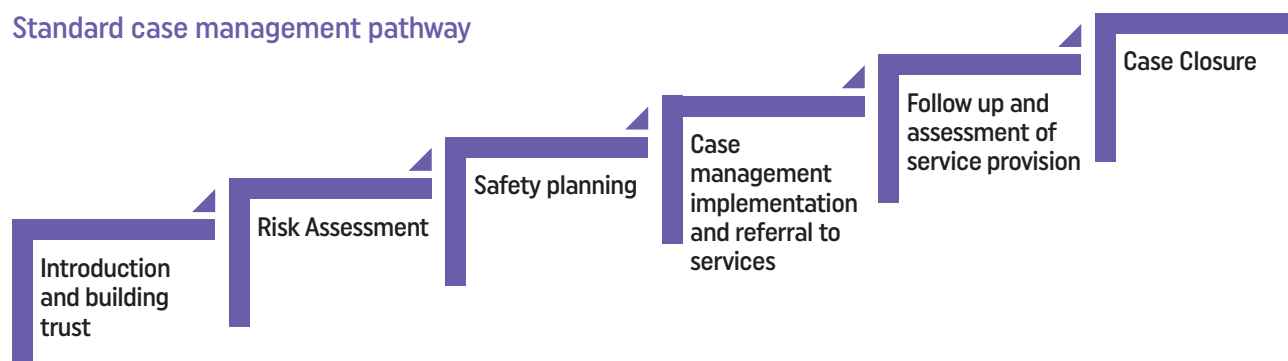
Annex 8: Key steps to remote informed consent**To obtain obtained consent by phone, hotline staff should:**

- **Be aware and mindful of the survivors' complex and unstable circumstances** while seeking their informed consent and explore with them the safest support options.
- **Explain the constraints related to remote service provision** and options before obtaining informed consent from the survivor verbally.
- **Ensure that a written informed consent form is available** and validated by the organization operating the hotline.
- **Read all the details of the consent form**, check the survivor's understanding, their approval for disclosure, referral terms and implication before obtaining remote verbal consent from the survivor.
- **Inform the survivor that personal information** (such as name, age, date of birth) and hotline name will be documented in writing, and will be kept in a safe place for the survivor's signature as soon as in person services are possible.
- **Collect, store and share information** on individual cases in a safe way and according to agreed upon data protection policies.
- **Keep written non-identifying information** about survivors in password-protected and locked files (use of a coding system is best practice)

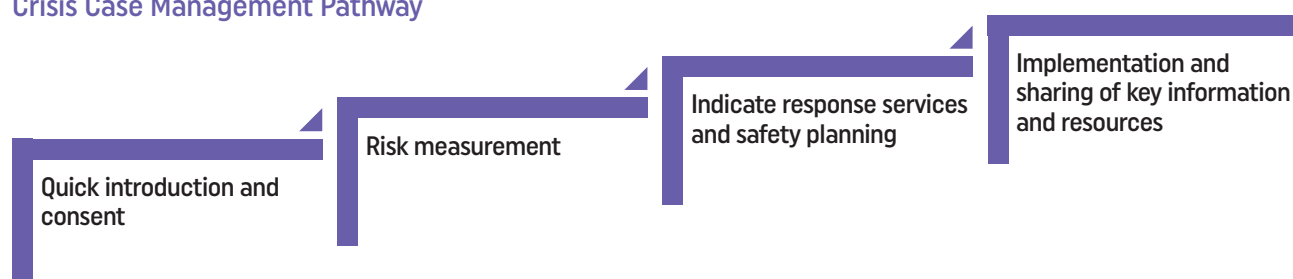


Annex 9: Standard case management pathway/crisis case management pathway

Standard case management pathway



Crisis Case Management Pathway



(Adapted from <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>)

Annex 10: Case management in the context of COVID-19

Providing GBV case management through the hotline while maintaining the security of survivors and caseworkers has been the top concern of hotline and service delivery actors since the outbreak of COVID-19. It was clear to all service providers that lockdowns and movement restrictions have affected service delivery and accessibility heavily, bringing to surface considerable changes and tremendous challenges, exacerbated by the rise of domestic violence incidents mostly in situations of full and long lockdowns. To ensure survivors' and staff safety and privacy for case management in the context of COVID-19, hotline actors should consider:

- Building effective partnership, collaboration and coordination among service providers during the pandemic and beyond to ensure the availability of services and the promotion of safety and security of all stakeholders and survivors.
- Mobilizing resources such as volunteers, staff and tools like mobile phones, SIM cards and chargers not only to meet the needs of survivors.
- Amplifying privacy of information by adapting the privacy norms and by providing financial support to staff to afford privacy of space and information and by training them on data documentation and storage.
- Assessing risks and developing alternative COVID-19 safety-oriented plans.
- Protecting home-based caseworkers from isolation and burnout by programming flexible shifts, reduced working hours and by designing self-care programmes (e.g. peer or team activities, regular chats, inquiries and supervision and team support for tough cases and emergencies).
- Exploring access options to services for women who do not possess phones and encouraging community phone spaces where women and children can feel comfortable and secure to make calls.
- Adapting case management and supervision modalities and procedure in line with COVID-19 measures (e.g. increased remote supervision via phone or local community focal points).
- Strictly following the COVID-19 prevention measures such as wearing masks, physical distancing, washing hands, covering mouth if coughing and sneezing, as well as adhering to the lockdown rules for emergencies. Survivors and family should also be educated concerning COVID-19 prevention and awareness.

Annex 11: Mapping process of GBV services, stakeholders, opportunities and gaps

Mapping GBV services is a preliminary process to collect information that will assist in drawing priorities to be pursued through the coordinated response. It allows hotline actors to have a clear vision of the needs of survivors, the available services to respond to GBV, the populations who benefit from those services as well as those not being reached and why and the forms of violence addressed and the areas covered.

To conduct a mapping exercise, hotline actors are suggested to collect information for the following key areas:



- The locations of existing GBV services and respective target areas (urban, rural, camp, living conditions and structures, such as, tents, building, safe, unsafe, who controls/manages the location)
- The populations benefiting from available services (what groups /subgroups, which languages they speak, what is their status and circumstances, e.g. displaced, undocumented?)
- The most common means of communication used by women, girls and minorities (including LGBTQIA+ and persons with disabilities) that ensure safety and security of survivors and staff
- The times when services are provided (opening and closing times)
- The types of transportation, their availability, accessibility and safety
- The types of services provided and the type of existing infrastructure and leadership (women's organizations, CSOs, NGOs, UN agencies, humanitarian actors...)
- The protocols in place for GBV services, reporting and referrals
- The staff who delivers services, their numbers, skills, professional competencies and availability
- The services which entail referrals and the channels available for coordination
- The contact persons and the forms of coordination established with local communities
- The costs of service delivery and the allocated funding

Based on the findings and outcomes of the mapping exercise, hotline actors are able to understand clearly the existing opportunities and barriers and set priorities and resources to address GBV cases in all situations and circumstances to fill the gaps.

Adapted from: https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

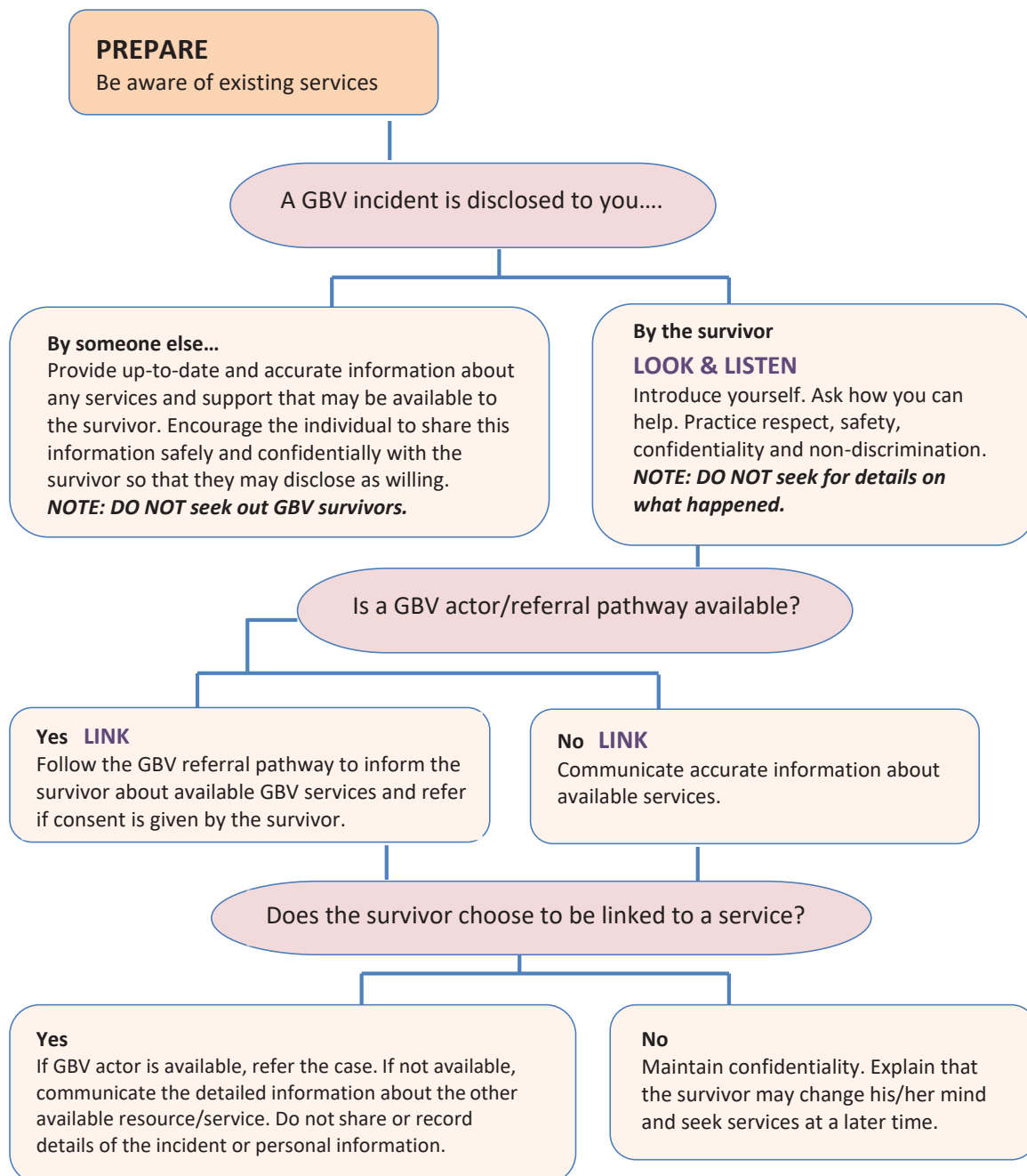
Annex 12: Key steps for referrals in the context of COVID-19

Updating referral pathways in the context of COVID-19 takes other dimensions and considerations generally dictated by the health and safety measures and their complex implications such as:

- Which organizations are still operating on the ground?
- What kind of response/services are they providing and are they on-site or remote?
- How can survivors reach out to them without compromising their safety and can they be granted safe transportation by the organization offering services?
- Are staff working to their full/partial capacity?
- What COVID-19 health safety measures are available for survivors and staff?
- What kind of reporting is available/mandatory, if there is any, in cases of child abuse, for undocumented or from LGBTQIA+ communities?
- What adopted mechanism of assessment is in place in the context of COVID-19?
- How can hotline caseworkers conduct remote assessment in situations of lockdown?

In cases where help-seekers have COVID-19 symptoms, hotline caseworkers must inform them of their health status concerns and danger, of the control measures to follow and their obligation to abide by the national COVID-19 procedures and measures.

Annex 13: Decision tree



From: Guidance on GBV referrals during COVID-19 outbreak¹ (as of 6 April 2020) https://themimu.info/sites/themimu.info/files/documents/Guidance_GBV_Referrals_during_COVID-19_Outbreak_Apr2020.pdf



Annex 14: Sample interview questions on PSEA

Below are sample questions. Not all questions need to be asked.

- Have you ever been investigated for a breach of your organization's code of conduct, safeguarding or PSEA policy?
- The organization's code of conduct applies to all staff, both on and off duty. Do you have any issues with that?
- Tell us about a time when you witnessed a case of abuse of power in the workplace. What action, if any, did you take? What did you learn?
- Some individuals may be more vulnerable to sexual exploitation and abuse than others. What groups or individuals do you think would be more at risk in terms of (organization's name) related to the position you have applied for?

Annex 15: Minimum Standards monitoring checklist

	Standards	Category	Key Actions	Met	Working Towards	Not met
GBV Response Guiding Principles	Standard 1: Survivors and Service Providers Safety	Knowledge	Action 1: Are there any safety assessment or risk mitigation matrix in organization?			
		Aptitude	Action 2: Are you using reliable and safe telecommunication providers?			
			Action 3: Are you using the functioning telephones?			
			Action 4 : Do you have multiple options for contact?			
			Action 5: Can your employees identify safe communication tools and space for survivors in considering the influence of third person?			
			Action 6: Can your employees develop a safety plan according to the context of survivor, the relationship between survivor and perpetrator, the socioeconomic and mental health status of survivor and perpetrator, the presence of drugs, alcohol, weapons and any other life threatening situation?			
			Action 7: Can your employees develop safety plan in special situations like at high risk situations, child survivors, LGBTQIA+ survivors and survivors with suicidal thoughts and behaviours?			
			Action 8: Do you have practices and support to ensure staff safety measures?			
			Action 9: Do you have practices and support to ensure staff safety measures for COVID-19?			
		Attitude	Action 10: Are your employees culturally sensitive to ensure that they are conducting interviews in an appropriate attitude and language?			
	Standard 2: Respect	Knowledge	Action 1: Do your employees understand survivor centered approach?			
		Aptitude	Action 2: Can your employees provide services in respect to survivor's choices?			
		Attitude	Action 3: Do your employees have non-judgmental attitude?			
	Standard 3: Confidentiality	Knowledge	Action 1: Does your organization have practices to maintain the confidentiality of the survivors?			
		Aptitude	Action 2: Can your employees take informed consent including informed asset for the children?			
		Attitude	Action 3: Do your employees maintain confidentiality for the best interest of survivors?			
	Standard 4: Non-discrimination and Intersectionality	Knowledge	Action 1: Do your employees understand intersectionality?			
		Aptitude	Action 2: Do your employees provide services in intersectional and non-discriminative approach?			
		Attitude	Action 3: Do your employees acknowledge the unique character of the cases?			



	Standards	Category	Key Actions	Met	Working Towards	Not met
GBV Response Guiding Principles	Standard 5: Survivor's Trust	Aptitude	Action 1: Does your organization have efficient workforce which can avoid long waiting calls and unanswered calls?			
			Action 2: Did your organization build a strong relationship with trusted community representatives?			
			Action 3: Did your organization partner with trusted community institutions and GBV response services?			
		Attitude	Action 4: Do your employees respect the survivor's confidentiality and privacy including their decisions and choices?			
Increasing Capacity of hotline workers/ Organizational Standards	Standard 6: Remote service provision _ Case Management and Referral Pathways	Knowledge	Action 1: Do your employees has knowledge on case management?			
			Action 2: Does your organization have case management SOP and guidelines?			
		Aptitude	Action 3: Did your organization already identify the existing local referral pathways?			
			Action 4: Does your organization periodically adapt the GBV referral pathways in regard to the changing situations?			
		Attitude	Action 5: Can your employees work harmoniously with partners?			
Human Resources	Standard 7: Staffing for GBV hotlines	Knowledge	Action 1: Do your employees have basic knowledge of GBV?			
			Action 2: Do you have a written job description which is clearly informed to the employee?			
		Aptitude	Action 3 : Does your organization has a procedure to follow in selecting hotline staff which includes assessing the attitude and knowledge of the staff on GBV issues, the background check and other assessment to ensure the fitness of the candidate?			
			Action 4:Do you consider the language proficiency of the candidate ?			
		Attitude	Action 5: Do your employees have the commitment to GBV issues, strong ethics and adherence to GBV guiding principles?			
	Standard 8: Workload Management	Knowledge	Action 1 : Did your organization make an agreement on maximum workload with employee?			
		Aptitude	Action 2: Does your organization plan resourcing ahead of time based on staff capacity and call traffic?			
			Action 3: Did your organization establish mechanisms to scale up during peak time/ periods, conflict resurgence or in aggravating context like COVID 19?			
			Action 4: Did your organization prepare to reallocate cases across the hotline team based on capacity in a flexible setting?			
			Action 5: Does your organization regularly communicate with employees to understand their capacity?			
		Attitude	Action 6: Do you have a supportive working environment?			

	Standards	Category	Key Actions	Met	Working Towards	Not met
Training and Protocols	Standard 9: Induction Training Areas and Protocols	Knowledge	Action 1: Do you have written policies or protocols for the induction of new employees?			
		Aptitude	Action 2: Does your organization have sessions to explain new staff the hotline functions and mission, working conditions including safety and security of staff and equipment, tasks and roles of each staff member involved in the hotline operation, including administrative and logistics matters, and ethical guidelines?			
			Action 3: Does your organization have an induction training plan which covers active listening, remote counselling skills, GBV guiding principles, case management and referrals, staff self-care, supervision and reporting?			
			Action 4: Does your organization have practical trainings like role playing exercises?			
			Action 5: Does your organization's training plan cover to manage the child survivors, LGBTQIA+ survivors and male survivors?			
Establishing Safe GBV information Management Process	Standard 10 : Data Documentation, Storage and Management Protocols	Knowledge	Action 1: Does your organization have protocols for data documentation and storage which covers not only digital documentation but also paper documentation ?			
		Aptitude	Action 2: Does your organization practice GBVIMS+?			
			Action 3: Does your organization have enough physical infrastructures which ensure safe paper documentation eg: cupboard, drawers which can be locked?			
			Action 4: Does your organization have enough physical infrastructures which ensure safe digital documentation eg: computers which have enough space to keep password protected folders?			
	Standard 11: Data Sharing and Reporting Protocols	Knowledge	Action 1: Does your organization have data sharing protocols which are in line with GBV guiding principles?			
			Action 2: Does your organization have data reporting protocols which are in compliance with national policies and in line with GBV guiding principles?			
			Action 3: Do your employees understand when mandatory reporting and medico-legal reporting will be required? How to report without breaking the confidentiality against the survivor's will?			
		Aptitude	Action 4: Does your organization practice safe data sharing and reporting among the staff and among GBV service partners as well?			
		Attitude	Action 5: Do your employees pay respect to the survivor's will in data sharing and reporting process?			



	Standards	Category	Key Actions	Met	Working Towards	Not met
Monitoring and Evaluation	Standard 12: Monitoring Protocols and tools	Knowledge	Action 1: Does your organization have monitoring checklist , protocols and guidelines for M&E process?			
		Aptitude	Action 2: Does your organization conduct regular audits, spot checks and observations?			
			Action 3: Does your organization capture survivor's feedback and build action plans to address service quality issues?			
			Action 4: Does your organization ensure operators receive supervision to provide opportunity of development?			
			Action 5: Does your organization regularly assess and monitor protection and security risks?			
			Action 6: Do hotline supervisors have abilities such as navigating group dynamics, coordinating between different stakeholders, reassessing the needs and update case management plans?			
		Attitude	Action 7: Do hotline supervisors have adequate interpersonal, motivational, facilitation and crisis management skills ?			



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