Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic

Purpose

This guidance note aims at providing practical support to case management service providers on how to adapt their response in the context of the COVID-19 pandemic. This guidance note includes two parts: The first focuses on guiding service providers through the process of adapting their case management programmes to the needs arising from the COVID-19 pandemic based on a number of scenarios. The second part focuses on the use of GBVIMS and/or Primero/GBVIMS+ in relation to these different scenarios. This guidance note complements the GBV AoR Helpdesk note "GBV Case Management and the COVID-19 Pandemic"[1]. The present guidance note also complements the Remote case management series in the context of COVID-19 pandemic released by the GBVIMS Steering Committee.

Background

History has demonstrated that crises such as disease outbreaks affect women and girls differently to men and boys, and in ways that place women and girls at greater risk of GBV, particularly in contexts where gender inequality is already pronounced. This can include increased exposure to intimate partner violence due to tensions in the home in the face of dwindling family resources and under confinement conditions, while the economic impact can place women and girls at higher risk of sexual violence and exploitation[2]. Women's rights organizations, researchers, and service providers across the globe are already reporting increases in reported GBV incidents since the COVID-19 outbreak, including in countries most directly affected[3]. It is clear, however, that most cases of GBV will remain unreported due to the lack of available, safe, ethical and quality responses services as well as fears of stigmatization, reprisal, and lack of information on how to seek help. These existing barriers will be further compounded by the inundation of health services responding to the COVID-19 outbreak, and restrictions to movement and physical socialization resulting from government responses to contain and control the spread of COVID-19. Ensuring that women and girls can access GBV support services remains a critical and lifesaving activity. At the same time, maintaining the health and wellbeing of GBV caseworkers and contributing to efforts to stop the pandemic presents challenges for face-to-face GBV response services. A flexible and adaptive approach is

[1] http://www.sddirect.org.uk/media/1882/guidance-on-gbv-case-management-in-the-face-of-COVID-19-outbreak-final-draft.pdf
[2] https://asiapacific.unfpa.org/sites/default/files/pub-pdf/COVID-19_A_Gender_Lens_Guidance_Note_3.pdf
[3] Impact of COVID-19 Pandemic on Violence against Women and Girls, VAWG Helpdesk Research Report: https://gbvguidelines.org/wp/wp-content/uploads/2020/03/vawg-helpdesk-284-COVID-19-and-vawg.pdf

needed to ensure that life-saving services continue without compromising the safety of GBV caseworkers or survivors[4].

COVID-19 is a respiratory virus. The way in which the virus is transmitted, its level of potency in a country at a particular time, and differences in government responses, all demand flexibility and a more layered approach to GBV case management service delivery than in past epidemics.

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

- **Government response to the coronavirus.** Different government responses will result in different levels of risks and restrictions to GBV service delivery that make some modes of service delivery more possible than others.
- **Resources (including donor flexibility)** for the service provider to maintain stringent IPC[5] standards at all stages of the pandemic, and in preparation for more advanced stages.
- **Government guidance and policies** that affect freedom of movement, ease of obtaining official permissions, including formal exceptions which are required to operate static services in the event of mandated lockdown.
- **Risks and *perceived* risks for staff and others**: It is critical to weigh actual risks not only to the health of staff, but to the health of others whom may be exposed by the delivery of services, including movement to and from. In addition, *perceived* risks also affect staff and clients.
- **Location of static services:** While health clinics are likely to remain open during the pandemic, survivors may face challenges accessing case management services through health facilities due to fear of infection, stigma, or because clinics are overburdened with response to COVID-19. Where possible, separate service points for women and girls should be maintained that follow IPC protocols.
- **Organizational policies:** Each service provider interprets government guidance and policies in a more or less flexible manner, which can influence service provision.

Adapting GBV case management to the context of the COVID-19 pandemic[6]

This resource presents options for adapting GBV case management in the context of the COVID-19 pandemic so that survivors can continue to access and receive safe and confidential services. It focuses

[4] GBV AoR Helpdesk note "GBV Case Management and the COVID-19 pandemic".
[5] Infection, Prevention and Control.
[6] This brief complements the *GBV Area of responsibility (AoR) Research Query on GBV Case Management and the COVID-19 Pandemic.* The *Research Query* provides a more detailed layout of possible COVID-19 national strategies to respond to the spread of the virus, and their implications for GBV service providers and GBV case management service provision.

primarily on in-person case management adaptations, remote phone-based case management, and open-access hotlines (also known as helplines).

In this resource, **remote phone-based case management** is defined as case management that caseworkers provide to existing clients or in some cases new clients through direct referrals. It may be accessed through appointments agreed upon by the survivor and caseworker or through survivor-initiated calls when the caseworker is available (i.e., not open to the general public, or operating all hours).

A **hotline** – is 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.

The table below presents these different models for GBV case management service provision and considerations for those models during response to the COVID-19 pandemic. Actions outlined in the table below are directed to service providers and programme managers. Actions highlighted in red are directed towards both service providers and programme managers, as well as GBV Sub-Sector/Sub-Cluster coordinators for inter-agency response.

Please note that there are other adaptations to GBV service delivery that can be made that are not technology-based, which can be accessed here.

Model	Prerequisites	Recommended Actions
Model 1: In-person case management services continue with adaptations	• Social/physical distancing measures can be implemented in the center to ensure safety of staff and survivors. • IPC[7] procedures can be implemented in service locations. • Clients and service providers with any symptoms of illness are advised to avoid static service centers.	• Update referral pathways with functioning services and consider that listed services follow WHO recommendations in terms of IPC measures and social/physical distancing[8]. Inform key communities and service providers about the updated pathways. • Draft / update an internal organizational communication tree to ensure support for caseworkers in the interests of duty of care. • Caseworkers discuss the changing climate and contingency plans with survivors. • Review and update safety plans with survivors in case of a lockdown, especially those living with their abusers[9]. **Prepare for possible shift to remote service provision, which could include individual, phone-based case management or an open-access hotline.** [10] [11] • Assess with individual survivors whether receiving services remotely is feasible and safe. Depending on the assessment and interest of the survivor, obtain informed consent to potentially shift to remote case management. • Talk with survivors about phone safety—how to delete numbers, chats, etc.

[7] Infection, Prevention and Control.
[8] Watch video short or listen to the podcast on updating referral pathways from the Remote Case management series produced by the GBVIMS Steering Committee.
[9] Watch video short or listen to the podcast on safety planning from the Remote Case management series produced by the GBVIMS Steering Committee.
[10] Watch video short or listen to the podcast on prerequisites to shift to phone-based case management from the Remote Case management series produced by the GBVIMS Steering Committee.
[11] For alternatives to service provision during COVID-19 beyond mobile phones and hotlines, see UNICEF paper.

		• Collect phone numbers of consenting survivors and store them with the consent form, separately from the case files. • Procure mobile phones and credit (including data bundle) for GBV caseworkers / supervisors, and if needed also procure charging devices for use in settings with poor/unreliable power. • Identify existing open-access GBV hotlines[12], or explore opportunities for establishing a hotline, as another option for remote services. • Train staff on the transition to either phone-based case management or a hotline service.[13] • Plan for safe storage for existing paper files in case of lockdown. • Plan for data storage protocols for remote service provision.
Model 2: Transition of existing services to phone-based case management	• Caseworkers and survivors have access to telephones and reliable networks. • Caseworkers feel safe and comfortable offering case management services from their homes and over the phone. • Caseworkers have a private and confidential space available in their homes to speak to survivors over the phone. • Living conditions of caseworkers have been assessed by supervisors as being safe and confidential to conduct phone-based case management. • Caseworkers have obtained informed consent from survivors to conduct phone-based case management.	• Continue services via phone for consenting survivors of open case; if services may be extended to survivors of new cases, share caseworker's contacts with key service providers and focal points for direct referral. • Caseworkers store survivors' phone numbers using survivors' codes. Separate information on survivors' codes related to survivors' names & other identifying information should be stored in a paper file in a locked cabinet/drawer or in a password-protected electronic file. • Caseworkers can store survivors' case files in digital case management tool (e.g. Primero/GBVIMS+). Alternatively, no information related to a survivor's case should be documented in writing to ensure data

[12] GBV AoR, Guidance note on remote service mapping.
[13] Consult IRC's Guidelines for Mobile and Remote GBV Service Delivery: https://gbvresponders.org/response/mobile-and-remote-gbv-service-delivery/

	• Caseworkers have assessed with survivors that they feel safe being contacted by phone for case management services based on their living conditions (e.g. live with an abusive partner, space to isolate to speak confidentially, working hours, etc.) • Caseworkers have spoken with survivors about phone safety—how to delete numbers, chats, etc. • Mobile phones and phone credit (with plans for remote refills) are provided to Caseworkers so they do not use personal phones for casework.	confidentiality. Do not store case files information in caseworkers' homes.[14] [15] • Caseworkers shift to emergency case management[16] and focus on safety planning, especially for IPV[17] survivors. • Update referral pathways. • Review Case Management SOP to include regular remote supervision of caseworkers.[18] • Review Case Management SOP to include staff care considerations that can be implemented remotely. Supervisors are encouraged to establish daily contact with caseworkers to discuss experience and stressors, encourage them to actively reach out for support and connect them to psychosocial support and mental health professionals.[19]

[14] This recommendation is meant for immediate transition to home-based case management and based on best practices. Each organization should decide how to adapt this guidance should this situation last for longer period of time and adapt their services and data protection accordingly.

[15] Watch video short or listen to the podcast on documentation and confidentiality from the Remote Case management series produced by the GBVIMS Steering Committee.

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

[17] Intimate Partner Violence.

[18] Supervisors should plan for regular individual and/or group sessions. Group supervision could be organized through online platforms such as WhatsApp, Skype or Zoom. Supervision tools can be found in the Case Management Guidelines (2017), pp.161-162 and annexes here: http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf
In addition, if Primero/GBVIMS+ is rolled out, supervisors can conduct remote case files review by using functionality such as custom export, case plan/closure approval, and flags.

[19] Staff care tools can be discussed between caseworkers and supervisors – such as Self-Care inventory available in Module 19 of the Case Management Guidelines training material: https://gbvresponders.org/response/gbv-case-management/

Model 3: Open-access hotline services[20]	• Pre-existing hotline, or ability to quickly establish hotline service. Hotlines are open-access services, available to a wider net. • Ability to establish one telephone number that can be answered by multiple phones • Ability to connect callers to a recorded message if services are not available 24-7 • Ability to respond to calls from different populations in relevant languages • Hotline caseworkers have a safe and confidential space to speak to survivors over the phone • Hotline caseworkers and survivors have access to telephones and reliable networks. • To the extent possible, ensure the hotline is toll free. If not, organizations should have budgeted available credit for hotline caseworkers to call back survivors when needed.	• Establish call management and safety protocols[21]. • Prepare key messages that should be shared during calls[22]. • Establish protocols for responding to emergency cases. • Train hotline caseworkers, including service protocols, adapted case management steps and management of threatening and inappropriate calls. • Provide emotional support, help with safety planning, and referral to resources/services, as appropriate and possible, through hotline service. • Establish regular remote supervision methods, including real-time support for caseworkers for troubleshooting and crisis situations.[23] • Establish protocols for safe data management. • Inform catchment communities on the availability of hotline services through safe means of communication.

[20] Consult IRC's Guidelines for Mobile and Remote GBV Service Delivery: https://gbvresponders.org/response/mobile-and-remote-gbv-service-delivery/

[21] Consult IRC's Guidelines for Mobile and Remote GBV Service Delivery: https://gbvresponders.org/response/mobile-and-remote-gbv-service-delivery/

[22] GBV AoR Guidance, Developing Key messages for communities during COVID-19, 7 April 2020.

[23] Watch video short or listen to the podcast on supervision and staff care from the Remote Case management series produced by the GBVIMS Steering Committee.

In the context of COVID-19 the shift between service delivery models might be quite rapid. Organizations should be prepared to adapt services and should also be prepared to safely shutdown face-to-face services.

Preparing to shutdown face-to-face services:

- Ensure procedures are in place to refer survivors to services that may continue.
- Prepare/update data evacuation plans
- Determine what can be done remotely

If shutting down face-to-face services:

- Implement data evacuation plans.
- Caseworkers inform survivors about the service shutdown by phone if they obtained prior consent to contact them by phone and it is assessed safe. Information can also be shared face-to-face if safe and possible, and if IPC protocols/social distancing measures are in place.
- Caseworkers refer survivors, upon their informed consent, to services that are still operational. Alternatively, they inform survivors who to contact if they need help.
- Supervisors are encouraged to check in with caseworkers to monitor their wellbeing. They can establish a support network across caseworkers.
- Inform communities of the shutdown of services and provide information on how to access remote services.
- Plan for awareness raising-activity at the end of the pandemic to inform communities in which they work that services have reopened using a variety of communication means.

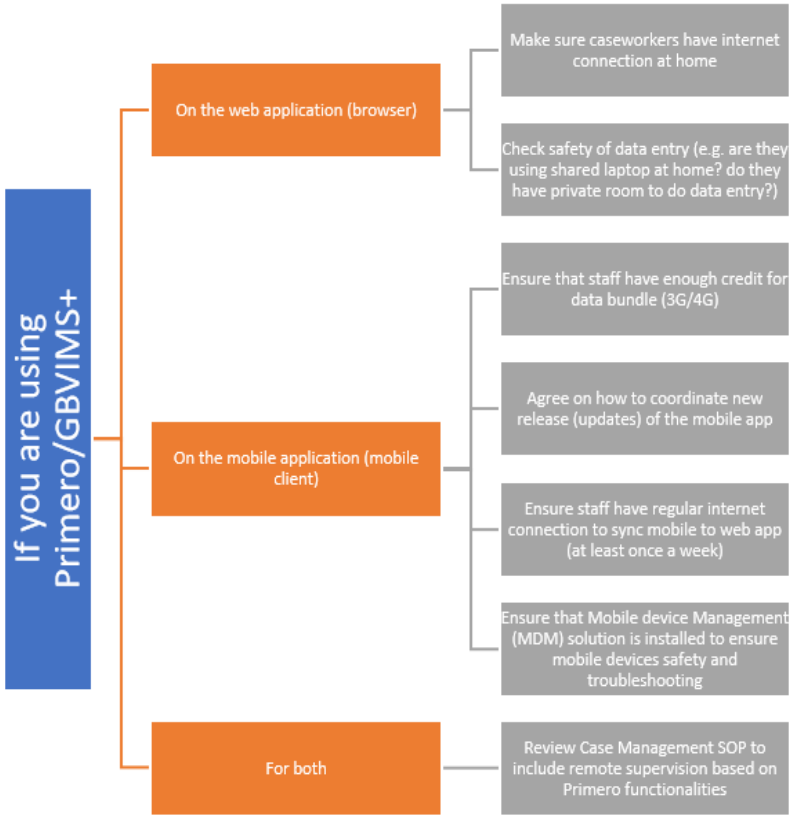

Figure 1 Adaptation to the GBVIMS and/or Primero/GBVIMS for remote service delivery

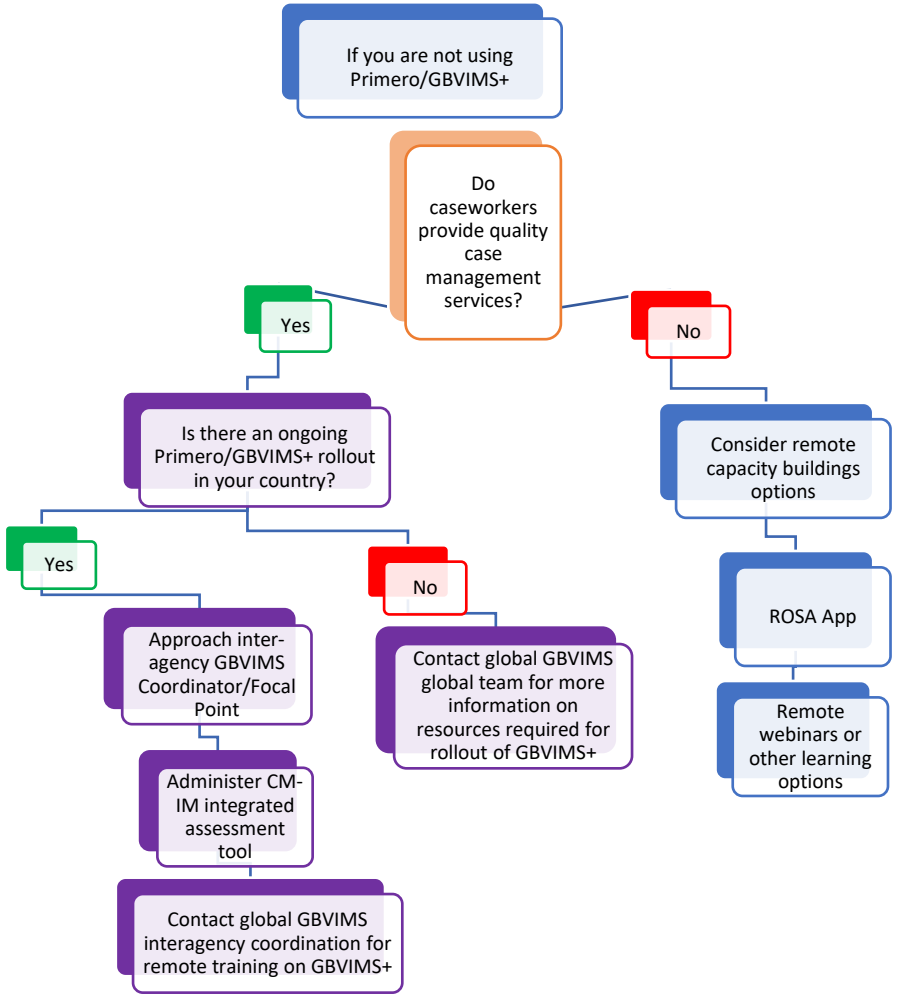

Figure 2 Adaptation recommended for non-Primero/GBVIMS+ Users

Recommendations for service providers using GBVIMS, Primero/GBVIMS+ during COVID-19

Collection

- Consider rolling out Primero/GBVIMS+ (see diagram above)
- Consider using the emergency intake form
- Record informed consent of survivors to receive phone-based case management in consent form
- Ensure confidentiality of service provision prior to pursuing data collection (e.g. safe space where phone-based case management can be conducted).

Storage

- Do not store any case file information at home
- Record phone numbers based on survivors' code and store document linking survivors' codes to names in locked cabinet

Compilation

- Determine which staff are entering data into the Incident Recorder (IR) – i.e. GBV caseworkers themselves, or data entry personnel. If not GBV caseworkers, how will data from the Intake Form be shared with data entry personnel for subsequent entry to the IR?
- If GBV caseworkers enter data directly into the IR, how will caseworkers send line data (individual survivors data) from their IR to the organization focal point for compilation? Do GBV caseworkers have internet access? If not, how will the data be communicated? If sending line data by email is impossible due to lack of connectivity, caseworkers and data entry focal point can agree on alternative and exceptional measures, such as sending data by WhatsApp or text messages. These should be deleted right after being recorded by the data entry staff.

•Analysis & Reporting

- GBVIMS organizations should build pivot tables on their Incident Recorder in order to better understand the impact of the COVID-19. Relevant data points includes, among others:
  - 1-Sex, age and disability disaggregation against GBV types, and referral pathway data points
  - 2-Displacement status disaggregation against GBV types and referral pathway data points.
  - 3-Intimate partners violence trends based on incident dates

•Protection

- For contingency purposes, service providers should ensure their data protection protocol is developed and updated and that roles & responsibilities in case of evacuation are clearly allocated.
- Consider having caseworkers sign a revised Data Protection Agreement linked to working from home.

Recommendations for GBVIMS, Primero/GBVIMS+ Interagency Coordinators/ Focal Points during COVID-19

Collection

- If Primero/GBVIMS+ is rolled out, consider expansion to new actors. If not, consider rolling out at interagency level by reaching out to the Global Team
- Consider rolling out the emergency intake form and adapt IR/compilation tool accordingly
- Modify consent forms to record informed consent of survivors to receive phone-based case management

Storage

- Based on in-country situation, adapt the Data protection checklist at interagency level to provide guidance ot DGOs

Compilation

- Does the focal point for compilation within each DGO have internet access to send compiled data to the GBVIMS Interagency Coordinator? If not, how can compiled data be shared for the purpose of interagency compilation, analysis and reporting?

Analysis & Reporting

- At interagency level, special attention should be given to the impact of COVID-19 on Intimate Partner Violence and access to services and adapt service provision accordingly. Upon approval of the ISP signatories, the Interagency Coordinator can draft, in collaboration with signatories of the Information Sharing Protocol (ISP) a survey to be completed by caseworkers in order to triangulate GBVIMS data with other sources of trends observed
- In addition to continuing the analysis of all GBVIMS data, thematic reports on the impact of COVID-19 on GBV situation can be drafted as a result of this analysis upon approval of all ISP signatories
- Hold data analysis coordination meeting online to enable remote service provision (e.g Skype, Zoom, or even a group WhatsApp call).

Sharing

- Review the ISP with all signatories to include special considerations for data sharing during COVID-19 in preparation for escalation of the restrictions on service provision.
- Request approval of all ISP signatories for developing and sharing a thematic report on GBV and COVID-19.
- If services are interrupted and thus data collection halted, DGOs should inform the GBVIMS interagency coordinator as per the ISP.
- Since GBVIMS focal points within DGOs might not have internet access, agree on quick decision tree to remotely obtain approval of ISP signatories for data sharing with non-approved external actors. This can be done through creating a WhatsApp group with all focal points or SMS system to obtain quick approval of all signatories.

Usage of Primero/GBVIMS+[24]

Primero/GBVIMS+ is the Protection-related information management system. It's an application developed to enable humanitarian actors to safely and securely collect, store, manage and share data for protection-related incident monitoring and case management. Primero/GBVIMS+ is a survivor-centered module within the system that utilizes technology enhancements to accompany the full GBV case management process, manage individual cases and referrals, as well as aggregate incident monitoring. Since 2015, under the leadership of UNICEF, the GBVIMS Steering Committee has developed and endorsed Primero/GBVIMS+ as an inter-agency GBV case management tool, used in conjunction with the 'legacy' GBVIMS. Currently, Primero/GBVIMS+ is being implemented in Bangladesh, Libya, Lebanon, Iraq and Nigeria, and is used by over 250 service provision personnel across seven organizations.

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

- It allows for use in low/infrequent internet connectivity contexts - which may be the case if GBV caseworkers are based at home with no regular internet connection - and it allows caseworkers to go 'paperless', which will provide a solution to paper file storage issues that GBV case workers may face when working from home. While the web version of Primero/GBVIMS+ can be used from an internet-connected computer and enjoys the highest level of functionality, Primero/GBVIMS+ can also be used offline for data entry on a **mobile device**, such as a smartphone or tablet. This version works entirely offline and can later sync data to the cloud once the user is able to access with a secure internet connection. This means no data is stored on paper or on the user's desktop. Furthermore, if mobile devices are used, a Mobile Device Management (MDM) solution can be used to ensure the safety and confidentiality of data stored.

- Where caseworkers and their supervisors may be confined to their homes, limiting in-person supervision, supervisors of caseworkers can use Primero/GBVIMS+ to conduct **remote supervision,** such as case file review for each caseworker they supervise. Findings from case file reviews can be discussed in individual or group supervision sessions. Supervisors can also use the 'approvals' feature, by which a caseworker can request supervisor approval, review and feedback for an action plan, or case closure. They can also benefit from the 'flagging' feature, whereby supervisors can add a 'flag' to a case to draw attention to a particular issue and insert a reason. In order to efficiently use the remote supervision functionality of Primero/GBVIMS+, Case Management SOPs would need to be revised accordingly.

- When caseworkers are working from home and mobility is limited, it may be challenging to consolidate data from each staff member. With Primero/GBVIMS+, data is hosted on an internet Cloud, meaning that it **eliminates the need to compile data internally** in an organization – data from

[24] http://www.gbvims.com/primero/ and https://www.primero.org/

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

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

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

Linkages with service provision in the context of the COVID-19 pandemic

The use of GBVIMS or Primero/GBVIMS+ in the context of the COVID-19 pandemic is interlinked with the changes in modalities of GBV service provision (e.g. from center-based to home-based) and should therefore be adapted correspondingly. Whenever possible, remote capacity-building opportunities for GBV caseworkers and supervisors should be considered. In this regard, International Rescue Committee's 'Rosa' mobile application[25] is recommended. The Remote-Offered Skill Building App (Rosa) was designed to utilize technology and keep the community and continual skill building ongoing for staff working remotely outside of traditional offices. Rosa provides key content on GBV, case management, communication and attitude skills; offers self- or supervisor-administered skills assessments; and a community space for users to expand their learning through facilitated remote discussions and distance supervision.

For further information on Primero/GBVIMS+ or GBVIMS, please contact the GBVIMS Global Team at gbvims@gmail.com

[25] https://gbvresponders.org/rosa-skill-building-application/