Template: Plan for adapting GBV response services during Covid 19

1. **Context Analysis:** (2-3 sentences)

How would the national response strategy in the context be characterised? (See Annex A for more details on each phase):

- Containment
- Delay
- Mitigation

Further details: Types of restrictions on services and service users, types of authorisations/exceptions available etc. Geographical or local restrictions, IDP or refugee camp specific restrictions.

In quick summary:

● Containment strategies enable public life to be minimally affected and as such, static face-to-face GBV case management services can largely continue, incorporating rigorous infection control measures.

● Delay and Mitigation/suppression strategies see tougher restriction on movement and assembly, making face-to-face case management challenging without high-level official permissions and adequate resources for, and stocks of, personal protective equipment for caseworkers to protect staff, service users and communities.

2. **Priorities for Protection of women and girls (PWG) response programming:** The priority is maintaining life-saving services, which are health and psychosocial, including emergency case management and psychosocial support.

3. **Protection of women and girls programme context:** (2-3 sentences)

Are health services operational, including Clinical Management of Rape and IPV survivors?
Are PSS/GBV staff currently available to work, including working from home?
Have PSS/GBV staff been redeployed and if so to what aspects of the response?
Are WGSS, WGC or women's groups able to continue operating? If so, what infection prevention and control measures have been put in place and how does this impact service provision?

4. **Options for models of GBV case management service delivery:**

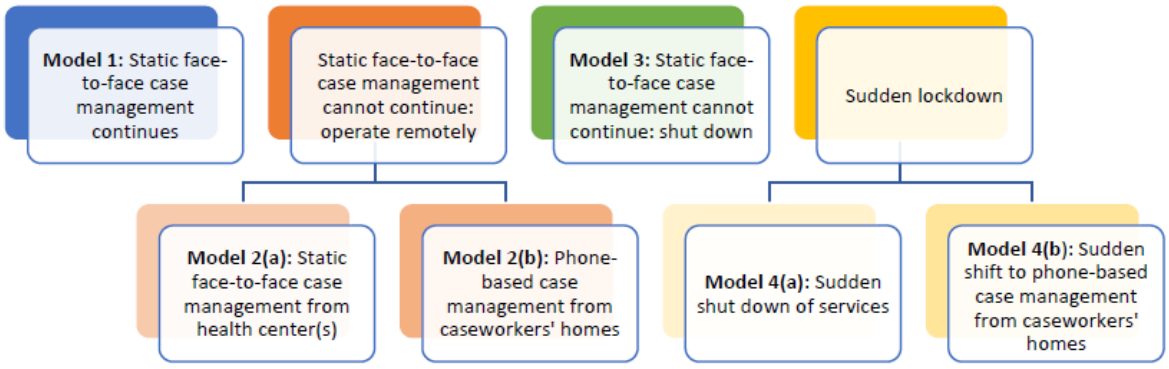

Figure 1 Suggested models of GBV case management according to national response strategies to Covid-19

5. **Checklist of key actions for PSS and Case Management** (sample actions – Fiona can support to plan for your context)

Actions	Check/Remark
Model 1: Maintain static face-to-face service provision (individual)	
Practice rigorous infection prevention and control measures in line with WHO guidance (2m distance between all people at all times, handwashing before and after sessions, frequent cleaning of surfaces, cough etiquette, no physical contact and symptomatic people or contacts to self-isolate at home)	
Ensure all staff and participants understand and practice these measures	
PSS/GBV staff discuss the changing climate and contingency plans with women and girl participants, including survivors.	
Review individual safety plans with current individual case management participants and update in preparation for further restrictions including lockdown or freedom of movement restrictions. Particularly relevant for those living with their abusers. Including agreed plans for safe contact if possible, risks of phone contact, plans to mitigate risks.	
Put in place practical support to facilitate safe contact (e.g. participant arranges with trusted person to use their phone if they don't have one, saves PSS staff/case managers' number in phone under a code/safe name, agreed time for contact, provide airtime/ phone card)	
Provide cash assistance to implement safety plans where available in your programme, using the cash assistance request form and tracking sheet.	
Discuss safe storage for existing paper files in the static women's center in case of lockdown and data storage protocols for remote GBV Case Management or remote individual PSS	
Discuss with participants options for potentially shifting to phone-based case management, if they wish to do so obtain informed consent. Collect phone numbers of participants and store them with the consent form, separately from the case files.	
Update referral pathway (GBV sub-cluster) with a focus on health facilities and medical service providers as these are most likely to remain open even during mitigation or lockdown. Include COVID-19 services and reflect changes to existing services as a result of COVID-19. Inform key communities and service providers about the updated pathways.	
Model 2a: Static face-to-face case management from health centres	
Discuss with health facilities whether GBV case management can be provided from the facilities: • Identify a confidential and safe space in the health center to provide GBV case management services • Identify case managers who can be deployed to work from health facilities (at least one female case manager per facility)	

• Ensure Social/physical distancing can be implemented in the health facility to ensure safety of staff and survivors. • Ensure IPC procedures can be implemented in the centre.	
If health facilities are not currently part of the GBV programme, train medical and non-medical staff on how to safely and competently receive GBV survivors at the facility (e.g. GBV basic concepts, confidentiality, a survivor-centred approach, and GBV guiding principles; referral to the case manager)	
Disseminate information on availability of service provision and referral pathways in health centres through SMS, WhatsApp or other communication means.	
Model 2b/4b: Phone based case management from case managers' homes	
Identify case managers who may be able to provide phone-based case management from their homes (feel comfortable doing so, have private and confidential space at home, living conditions safe and confidential)	
Obtain quotes from telecoms provider for free-phone hotline number linked to X phone lines, phones on bill pay and data bundles (3g/4g) to ensure internet access to send information from laptop and solar phone chargers for staff working in areas with frequent power shortages.	
Explore whether it is possible to continue providing emergency cash assistance within case management – can mobile money or other forms of remote cash assistance be used in your context to facilitate access to emergency health services?	
Provide online training to Case Management Supervisors, POs, PM and case managers if possible • Emergency case management = **crisis intervention** (psychosocial first aid, immediate safety and facilitating accessing to urgent health care and services, not the same case manager every time the survivor calls) • GBV Information management while working from home (review data protection protocols, review practices for safe GBVIMS data sharing with Case Management supervisor) if using digital system in line with data protection protocols. **Alternatively, no information related to a survivor's case should be documented in writing to ensure data confidentiality. Do not store case files information in caseworkers' homes.**	
Support Case Management Officers to roll out training to case managers. This may have to be delivered as short phone sessions if staff already working from home or temporarily re-deployed.	
Document assessment of risks, mitigation measures and decisions related to information management and sharing while phone based case management is being provided from case managers' homes	
Develop helpline roster (sample provided Annex B) for 12 hours per day (8am – 8pm) in 4-hour shifts, with one staff member on-call overnight in case of emergency if possible.	
Share very simple info with women and girl participants and wider communities: For example *"Women and girls may be experiencing violence in their homes at this time. This Helpline offers confidential information, support and understanding for those*	

experiencing abuse or violence. Call for free on xxxxx. If you don't have a phone ask someone you trust if you can use their phone."	
All: Ensure staff care and support	
POs will convene a staff wellbeing group whatsapp call with partner PM, POs and Case Management Supervisor	
Case Management Supervisors keep in contact with case managers on a daily basis and at least once a week have a 30 minute phone conversation individually with all remote case management staff to check on their wellbeing, share accurate information updates and assess any support needs.	
Ensure all pre-existing staff support and supervision measures (including external Clinical Supervision) are continued remotely and that any disruptions are minimised.	
Ensure accurate, clear information is regularly communicated to staff regarding the crisis, organisational responses, security and wider staff safety and care measures (link to wider Trócaire and partner staff care actions)	
All: Monitor and adapt to evolving situation	
Fiona and GBV/PWG team to check in weekly, to adapt strategies as needed	

6. **Checklist of key actions for Health Responses to GBV, including Clinical Management of Rape and Intimate Partner Violence Survivors** (sample actions – Fiona can support to plan for your context)

Model 5: Health Responses to GBV provided through health centres	
Ensure health responses to GBV are classified as essential services, whether provided by government or NGO run health facilities or one-stop-shops. This might include • Advocacy with National level Covid 19 response task force, WHO, MoH and other relevant line ministries. • Advocacy at local level including with camp management agencies and committees, local authorities and local law enforcement, and any other actor who may restrict the movement of women and girls seeking services or service providers going to work. • Clear messages "Seeking health and psychosocial services is an exception to the lockdown. People have the right to travel to access health services/ NGO/ Centre" should be delivered by local government, local law enforcement agencies and NGOs.	
Put in place a plan to maintain Clinical management of rape and IPV survivors services during the response, maintaining or increasing staffing, dedicated private spaces within health facilities, ensuring rigorous IPC protocols, adequate medical supplies (factoring in potential supply chain delays) and practical supports for referral (e.g. cash assistance provided through mobile money, MoU with transport providers, radio messages about service availability and how to access them)	
Coordinate with health technical specialists and management, to implement strict infection prevention and control (IPC) protocols throughout health facilities. This includes; • Train all staff including medical and non-medical staff on IPC protocols • Procure sufficient, appropriate materials to facilitate IPC • Provide IEC materials for patients and staff throughout the facility to ensure IPC protocols and practices are understood	
Coordinate with health technical specialists, to ensure all staff who are required to wear Personal Protective Equipment are adequately trained on the importance and value of PPE, its role in protecting staff from infection, and its correct use, including correct donning, doffing/removal and disposal of PPE. Monitoring and refresher training will be required.	
Develop staff care protocol to ensure safe work practices during the pandemic, this may include; • Ensure all staff are trained and equipped to implement strict infection, prevention and control protocols • Ensure all staff who are required to wear PPE have adequate supplies, training and supervision to do so. • Ensure all staff know and understand how to get to work and have the correct passes, letters or authorisation to travel to work. • Ensure staff are supported to access childcare arrangements (as schools are closed and regular childcare might be interrupted by lockdowns etc.)	

• Ensure staff are supported to safely travel to work (as public transport or other travel arrangements might be interrupted by restrictions, this may include financial supports or providing transport) • Ensure staff have clear working hours, including breaks for meals, rest, to check on childcare arrangements etc. • Explore options for providing accommodation for staff who cannot stay in their homes, either for health-related reasons such as to avoid infecting a vulnerable family member or for reasons related to restrictions including closed borders. • Offer confidential psychosocial support to all staff.	
Provide emergency GBV case management from health facilities: • Identify a confidential and safe space in the health center to provide GBV case management services • Identify case managers who can be deployed to work from health facilities (at least one female case manager per facility) • Ensure Social/physical distancing can be implemented in the health facility to ensure safety of staff and survivors. • Ensure IPC procedures can be implemented in the case management space.	
Assess current practice for facilitating referrals and decide how to adapt it to the current context, for example; • Contact: Provide information about how to contact the facility (helpline, staff work phone number, on call midwife out of hours), airtime and solar chargers to existing community focal points (health extension workers, protection focal points, women leaders, women community volunteers, female camp management committee members). Provide airtime directly to participants who will need to return for follow up appointments. • Cash: Provide cash assistance directly to women and girls through mobile money for participants who have not yet reached the facility or through cash in hand for participants to facilitate return for follow up appointments, or indirectly through camp-based or community-based focal points (women leaders, women community volunteers, female camp management committee members). Disbursement can be authorised over the phone in line with the revised cash assistance request form. This cash can be used to meet basic needs to help women access services (transport, fees, childcare, food, clothing). • Transport: Use private hire cars or private taxis to enable service users to reach the health facility. Hire cars/ private taxis can be contracted by the facility and paid on arrival, or alternatively hired locally with cash provided by the programme.	
Disseminate information on availability of service provision and referral pathways in health centres through radio messages, SMS, WhatsApp, posters, community volunteers who are still in phone contact with their communities, helplines and hotlines.	

Annex A: Understanding National Response Strategies

Current national responses to COVID-19 can be roughly classified into three strategies: containment, delay, and mitigation[4]. It is important to note that all three strategies can run concurrently in any one territory, and that changes from one to the other might change in as little as 24-48 hours. Therefore, a **high- level of preparedness is necessary in all countries, even those with zero or few confirmed cases**. Given how rapidly responses are changing, service providers should put contingency plans in place immediately for each of the strategies.

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

• **Containment**: Normal public life is minimally affected as governments focus on early detection, isolation and care of people already infected with careful tracing and screening of their contacts. Static, face-to-face case management, with strict adherence to IPC protocols, is possible under this strategy. However, plans must be in place for a rapid escalation in number of virus cases which may prompt governments to quickly change strategy and take more aggressive action to reduce the spread of infection. This includes identifying alternative models and beginning to train staff and actively communicating with clients about possible changes to come.

• **Delay:** the aim is to slow the spread of the virus and push the impact away until a time when a country's health service can cope with the spread. Social distancing strategies, closure of education institutions, prohibitions on large gatherings, and reduction in the use of public transport are common and are implemented with varying degrees of enforcement. Static, face-to-face case management may be possible depending on the location of the service, the ability to resource and provide effective protection of case workers, and the severity of national policies on freedom of movement and assembly. Action should be taken at this stage to include other modalities of delivering case management, and to train staff and clients alike for continued changes.

• **Mitigation planning for widely established infection**: This strategy is deployed by governments seeking to stem widespread infection during a prolonged pandemic in which high levels of the population are infected. This may involve more directive "lockdowns" or "sheltering in place", where movement is more tightly restricted and monitored, transport arteries may be blocked, and possibly permissions required. Maintaining static, face-to-face case management services outside health care facilities will be extremely challenging, or even impossible.

Annex B: Sample Roster for helpline operation

GBV Helpline Roster Week starting _____				Programme Manager Signature_____			
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8am-12 noon	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.
12 noon- 4pm	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.
4pm – 8pm	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.	1. 2.
On call (Case Management Supervisor/ PO keeps phone on overnight in case of emergency)	1.	1.	1.	1.	1.	1.	1.