من الشعب الياباني
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UN WOMEN

Part A

Guidance Note

for Remote Service Delivery to Survivors of Violence in the Arab States Region

About this toolkit

Purpose and scope

This toolkit is designed to support women-led civil society organisations (CSOs) in the Arab States region to strengthen their capacity to deliver remote services to survivors of violence against women and girls (VAWG). It aims to increase CSOs' preparedness and high-quality response to the COVID-19 pandemic and future crises.

The toolkit focuses primarily on remote services for women survivors of intimate partner violence (IPV) and online violence.[1] However, it recognises that women in all their diversity are at risk of multiple and often overlapping forms of violence, experienced on a continuum throughout their lives. It is therefore hoped that the toolkit will also be a useful resource for CSOs to use and adapt when responding to other prevalent forms of VAWG in the region, some of which are highlighted in Part One.

The guidance is intended to be inclusive of all women in the region and examples are given throughout of women who experience multiple and intersecting discriminations who may be at particular risk of IPV or online violence and where additional considerations are needed to ensure safe and ethical support. Users of the toolkit are also signposted to further resources for specific groups of survivors, where these are available. The toolkit does not provide specific guidance on remote services for girls under the age of 18 and additional considerations need to be taken into account when supporting girl survivors of violence remotely (such as obtaining informed assent and appropriate ways of involving caregivers in the process). However, CSOs working with girl survivors of violence may find the guidance on essential elements and types of services useful for establishing or shifting to remote service provision.

The toolkit is designed to be a resource that focuses on the provision of remote services through technology. However, it also includes a section on 'low-tech' systems for delivering services in times of crisis - recognising the structural challenges present in many countries in the region, including unreliable electricity and digital exclusion where women and girls have limited access to mobile phone or internet connection.

Part A of the toolkit provides guidance and tips on how to establish remote case management, helplines and online support groups. It also focuses on how to coordinate with specialised services, including health services, mental health and psychosocial support (MHPSS), legal services, and livelihood support, in order to meet the immediate and longer-term needs of survivors. A separate **Training Manual** (**Part B** of the toolkit) has been developed to help CSOs apply the learning in Part A and use this to support community-based and grassroots women-led CSOs through participatory exercises and real-life scenarios.

Organisations that are planning to set up or shift to remote service provision also need to consider the impact this can have on staff well-being and safety. Part A of the toolkit offers guidance on how managers and supervisors can ensure that the transition is sustainable for staff, to ensure that lifesaving VAWG services can continue to reach survivors, even during challenging circumstances.

Background

Service delivery for survivors of violence is a critical component of humanitarian response and an essential service in any society. Before the COVID-19 pandemic, most VAWG services in humanitarian and development contexts relied on in-person service modalities to reach women and girls, or in some cases mobile teams have travelled to areas where static facilities are not available or easily accessible. While some organisations also used remote services, through which they connect with women and girls through technology, the global outbreak of the COVID-19 virus forced many service providers to establish remote services for the first time, or rapidly expand their existing remote services to respond to the increase in violence.

A study conducted by the UN Women Regional Office for the Arab States (ROAS) found that while frontline CSOs rapidly adapted to the pandemic, many also faced challenges in continuing services.[1]
The increase in demand, coupled with challenges such as resource constraints, stretched staff, disrupted communications with survivors, and delays in training staff to use remote modalities, resulted in many organisations operating at stretched capacity from the early stages of the crisis.

1 In this toolkit we use the term 'online' to be inclusive of all information and communication technologies, including those that do not make use of the internet (for example, mobile phones).

This Guidance Note is designed to respond to some of these challenges and gaps highlighted by CSOs in the region. It provides guidance to support CSOs to deliver remote VAWG services in the COVID-19 context as well as in other circumstances where remote service delivery is needed.

Intended audience

The intended users of the Guidance Note are caseworkers and staff who, among others, operate helplines and online support groups for VAWG survivors and those at risk, as well as supervisors and programme managers. The guidance builds on emerging global good practice in remote service provision as well as promising examples from CSOs in the Arab States region during the COVID-19 context. While the resource was developed to support CSOs in the Arab States region, the models and approaches outlined in this Guidance Note and in the accompanying Training Manual have been designed to be adaptable to various contexts, and be utilised by organisations and staff in the region and beyond.

Acknowledgements

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Acronyms

BCP	Business continuity planning
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organisation
FGM	Female Genital Mutilation
GBV	Gender-based violence
GBV AoR	Gender-based violence Area of Responsibility
IBSA	Image-based abuse and image-based sexual abuse
ICTs	Information and communications technologies
INGO	International non-governmental organisation
IPV	Intimate partner violence
LGBTQI+	Lesbian, gay, bisexual, transgender, queer and intersex +
MENA	The Middle East and North Africa
MHPSS	Mental health and psychosocial support
NGO	Non-governmental organisation
NNEDV	The National Network to End Domestic Violence
OPD	Organisations for people with disabilities
PEP	Post-exposure prophylaxis
PWWSD	The Palestinian Working Woman Society for Development
ROAS	UN Women Regional Office for the Arab States
SEAH	Sexual exploitation, abuse and harassment
SOGIESC	Sexual Orientation, Gender Identity and Expression, and Sex Characteristics
SOPs	Standard operating procedures
SWG	Sub Working Group
VAW	Violence against women
VAWG	Violence against women and girls

How to use this Guidance Note

The Guidance Note is split into four parts. The first part introduces the context – what remote services are and when they are needed as well as provides guidance on adapting GBV Guiding Principles to remote service provision, which run throughout the Guidance Note. The second part explores essential elements of remote service provision, which are key components that are relevant when shifting to any type of the remote services in this Guidance Note. The third part provides step-by-step guidance in establishing and operating the main types of remote services as well as linkages to specialised services. The fourth part provides further insights into the benefits and limitations of different modalities of delivery. Lastly, the 'In Focus' section zooms in on the issue of online violence against women.

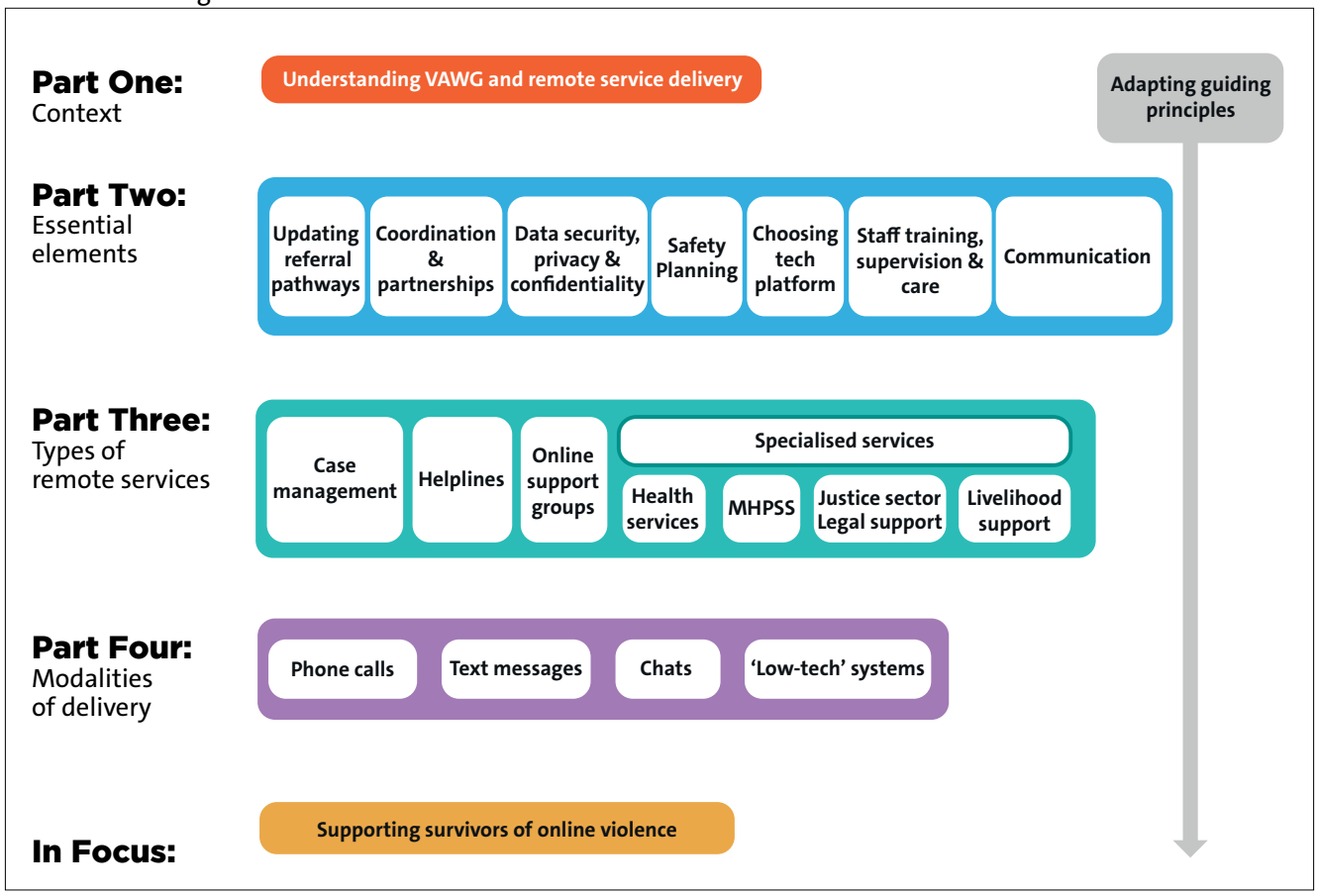


Figure 1: Overview of the guidance note/toolkit

Using the Icons

There is a number of icons throughout this Guidance Note to help users navigate through the document.

Indicates there are suggested exercises to support this part of remote service delivery. You can find these tools in the accompanying Training Manual (Part B of the toolkit).

Signposts resources for additional information and further reading.

The warning sign indicates that there are particular risks to consider in relation to the outlined step/ process.

The In Focus section specifically focuses on supporting survivors of online violence. However, it is important to consider the needs of survivors of online violence throughout design, planning and delivery of remote services. This icon is a reminder to do so.

PART ONE: Understanding VAWG and remote service delivery

Summary of chapter

Remote VAWG services are provided using a technology platform such as helplines,[2] chats, and text services where caseworkers and other staff communicate with survivors from a remote location rather than providing in-person services in a physical space. Many VAWG services that are usually provided in-person can also be delivered remotely, including case management, mental health and psychosocial support (MHPSS), and support groups.

Remote VAWG services can enable continuity of services during emergencies (as seen during COVID-19), in places where there are no in-person services available, or where in-person services are available but difficult to access. Remote service delivery also holds potential to increase access to VAWG services and information for women and girls, especially survivors who may face particular barriers to accessing in-person services.

Despite the many benefits and opportunities presented by remote service delivery, there are also challenges. Almost half of the female population in the Arab States region do not have access to a mobile phone or internet connection,[2] making access to remote services a challenge for many women and girls. Remote service provision also comes with unique confidentiality and safety concerns as it requires that both the survivor and services provider have a private space and secure device to safely make and receive calls/ texts. This can be particularly challenging for survivors who live with or are confined with their perpetrator.

Providers of remote VAWG services, including case management and helplines, need to be prepared to support survivors who have been targeted by diverse forms of offline and online violence, committed by a range of perpetrators. Women and girls in the Arab States region are exposed to high levels of VAWG, including intimate partner violence (IPV) – prior to COVID-19, 37% of ever-partnered women had experienced physical and/ or sexual IPV.[3] Online violence is a growing problem in the region with women and girls experiencing sexual, psychological, emotional and financial violence and abuse online, which is part of the continuum of violence that women and girls are exposed to during their lifetime.[4] CSOs have used innovative approaches to adapt and respond to the increasing levels of violence in the region during the COVID-19 pandemic, using more technology-based platforms to reach survivors. While most services provide support for women and girls who have experienced diverse forms of VAWG, there are less documented examples of how service providers respond to the growing issue of online violence.

The Inter-Agency Minimum Standards for gender-based violence (GBV) in Emergencies Programming apply to all forms of remote service provision, however, these need to be understood in the context of remote service provision and adapted accordingly. This chapter provides guidance on how the key principles of the survivor-centred approach, the intersectional approach (which should be considered throughout each essential element of remote service provision), and the do no harm principle can be adapted for remote services.

2 Helplines can also be referred to as 'hotlines'. This document uses helplines throughout for consistency.

1.1 VAWG in the Arab States region

Violence against women (VAW) is a form of discrimination and human rights violation, as set out in international and regional human rights frameworks and instruments, including the Convention on the Elimination of All Forms of Discrimination Against Women (1979) (CEDAW). It includes GBV against women, that is, violence directed against a woman because she is a woman and/or that affects women disproportionately.

> Violence against women is "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life
> **- Declaration on the Elimination of Violence Against Women, 1993**

The continuum of violence

Women and girls are exposed to violence on a continuum throughout their lives, manifested in multiple and often overlapping forms, and involving a wide range of perpetrators. Whilst this Guidance Note focuses primarily on remote services for women survivors of IPV and online violence, it recognises that women in all their diversity are at risk of other forms of violence in the Arab States region. It is also hoped that the guidance can be adapted by CSOs working with girls under the age of 18. Women and girls who experience multiple and intersecting discriminations are often at increased risk of violence and have specific support needs that should be taken into consideration.

While many CSOs providing VAWG services will focus on IPV, as this is a highly prevalent form of violence against women – providers of remote services should be prepared to encounter survivors who have experienced multiple and diverse forms of violence, including but not limited to offline and online violence, committed by various perpetrators including intimate partners, family members, colleagues, peers, community members and strangers, as well as by institutional actors such as law enforcement officers, health care professionals, teachers and members of armed groups.

Online violence against women is a growing problem and many CSOs and staff who provide direct support to survivors want to build their capacity on the issue with guidance and training on how to support survivors of online violence. To help ensure caseworkers and helpline operators are better equipped in this area, this guidance integrates emerging practice on online violence throughout (for example in case management and updating referral pathways). In addition, the 'In Focus' section sets out additional considerations and promising strategies, to support CSOs to strengthen their capacity.

Violence against women and girls in the Arab States region

Prior to the COVID-19 pandemic, 37% of ever-partnered women in the eastern Mediterranean region reported that they had experienced physical and/ or sexual IPV in their lifetime.[5] However, this figure is likely to be even higher due to underreporting of incidences, and most women and girls in the region who experience violence do not seek any form of support or protection.[6]

Online violence was already on the rise in the region prior to the global COVID-19 outbreak, with women and girls experiencing sexual, psychological, emotional and financial violence and abuse online.[7] Their exposure to and experiences of online violence can also result in physical harm, including suicide. While data on online violence against women and girls in the Arab States region has until recently been scarce, it is clear that women and girls in the region face multiple forms of violence online, perpetrated by individuals as well as governments.[8] For example, a 2019 study in Egypt found that 42% of participants reported having experienced online violence in the past year, of which 45% reported being targeted multiple times.[9]

Other forms of VAWG are prevalent in the region, including Female Genital Mutilation (FGM) and child marriage – 14% of girls marry before their 18th birthday.[10] Whilst not the focus of this toolkit, CSOs in the region providing support to survivors of other forms of violence should be able to use and adapt the guidance contained here.

Exercise 2 in the Training Manual is designed to ensure that participants understand key national and sub-national VAWG data and trends in their national and sub-national context, including during the COVID-19 pandemic and other emergencies.

1.2 What is remote service delivery and when is it needed?

Overview

Remote services are provided using a technology platform rather than being delivered in-person at a physical location, such as a health facility or women's centre. Common modalities for remote VAWG services are phones, helplines, chats, and text services where caseworkers and other staff communicate with survivors from a remote location, either from their homes or from an office. A range of VAWG services can be delivered remotely, including case management, mental health and psychosocial support (MHPSS), and online support groups. Remote services can be designed as a standalone intervention or be delivered in parallel with static or mobile VAWG services.

Opportunities and challenges with remote service delivery

While the COVID-19 pandemic saw an unprecedented expansion of remote VAWG services across the globe, some CSOs were already providing remote services as they offer benefits and opportunities to expand reach and ensure continuity of VAWG services in various circumstances.[11]

There are two main reasons that organisations consider providing remote services: 1) there is no dedicated space for service in-person provision available, or 2) there is a dedicated in-person service provision space, but survivors cannot access it easily.

Although remote service delivery holds great potential for making VAWG services more accessible and inclusive, availability of and access to technology is far from universal, and women and girls often face particular challenges in accessing and using technology (see box 2). The challenges of remote service delivery, which became more evident than ever before in the COVID-19 context, speak to the importance of undertaking assessments, providing training, and adapting procedures to remote modes of delivery.

BOX 1: Opportunities and challenges with remote service delivery

Opportunities:[12]

- **Immediate access:** They allow survivors to access support immediately when they have experienced violence or are at risk, as some remote services operate 24-hours and do not require traveling to a service provision centre.
- **Greater geographical coverage:** Remote service modalities can expand access to services for women and girls in remote or inaccessible areas, where organisations do not have a permanent presence or where their operations have been disrupted due to emergency or conflict.

Challenges:

- **Digital exclusion:** Almost half of the female population in the Arab States region do not have access to a mobile phone or internet connection.[13] For example in Iraq, 98% of men have access to the internet compared to 51% of women.[14] Guidance on how to assess access to technology and choose technology platforms for remote service is found in section 2.5.
- **Reaching women and girls from marginalised groups:** While remote service delivery can help overcome certain barriers faced by marginalised groups in accessing VAWG services, women and girls from marginalised groups can face challenges in accessing and using digital devices and the internet, including women and girls with disabilities who may face communication barriers if communication is not accessible.

- **Potential to address barriers to access:** Remote services hold the potential to increase access to VAWG services and information for women and girls, and other survivors who face particular barriers to accessing in-person services, for example high levels of social stigma associated with help-seeking faced by LGBTQI+ survivors, and inaccessible transport and facilities for women and girls with disabilities.
- **Adaptable to changing context:** VAWG services can provide continuity of services for survivors where external or individual circumstances may change, and when combined with static or mobile services, they offer opportunities for service providers to adapt services to the context as well as individual needs and wishes of survivors
- **Structural challenges:** Instability of electricity and limited internet availability affect many areas in the region, which pose challenges to remote service delivery that relies on a certain level of technology infrastructure.
- **Safety and privacy** for survivors, including having a private space and their own secure device to safely make or receive calls and texts. UN Women's study in the Arab States region highlight that many survivors have found it difficult to talk about experiences of violence over the phone during COVID-19.[15]
- **Safety of CSO staff:** Safety and privacy considerations apply to staff who provide remote services as well, and there is a risk of breaches of privacy that can put staff at risk of online abuse harassment, for instance if a staff member's phone number is shared.
- **Need to prepare and train staff:** The large-scale transition to remote service delivery triggered by COVID-19 revealed that CSOs had varied level of preparedness for using digital technologies to deliver services, and meeting the changing demands for services.[16] CSOs in the Arab States region found themselves soon operating at full capacity as the number of VAWG cases were rising, while regular referral pathways were disrupted, and all staff were not trained in using digital technologies to deliver remote solutions.
- **Building trust and rapport**, particularly with new survivors, can be challenging when communicating remotely. Section 2.7 offers advice on how to use active listening and non-verbal communication to build trust and convey empathy and emotional support.

Exercise 3 in the Training Manual is designed to support participants to understand remote service delivery approaches used by CSOs in their specific national contexts and across the Arab States region.

The importance of preparedness

To be able to mobilise quickly and undertake all necessary steps to shift to or expand remote services, it is critical that organisations build up a certain level of preparedness. This includes undergoing business continuity planning (BCP) to prepare the organisation to remain operational in the face of crisis and disruption, which may be the very reason why CSOs decide to shift to remote services. In such circumstances, CSOs need to focus on remaining operational, which requires sufficient financial, human and material resources, and that they are at the same time equipped to transition into remote delivery.

UN Women's research with CSOs during COVID-19 showed that 42% of CSO respondents in the Arab States region were able to fully deliver services, while 52% reported that they were only partially operational as many had seen critical funding being re-directed, paused or cut entirely.[17] While the challenges posed by COVID-19 are in many ways unprecedented, they highlight the critical need for CSOs to undertake BCP, as the circumstances that may necessitate a shift to remote services, may also pose existential threats to the CSOs delivering those services.

BOX 2: Key elements of preparedness and BCP for CSOs

CSOs should consider having a Business Continuity Plan in place in the case of a situation that requires a rapid shift to remote services. The following six steps can be used to establish a BCP, based on a six-step BCP tool developed by the International Labour Organisation:

- Step 1: Identify your most important services using a set of criteria, for example: number of survivors using them, and impact of non-delivery of services.
- Step 2: Establish the objective of your BCP. What do you want to achieve by establishing your BCP?
- Step 3: Evaluate the potential impact of disruptions to your staff and organisation, and how long the disruption is likely to last. What resources do you need to keep delivering services?
- Step 4: List action to minimise risks, including to the lives of your staff and survivors, your processes and partnerships.
- Step 5: Establish contact lists, including contact details for staff, survivors, partners, donors and government agencies. Identify preferred communications methods to connect with staff during emergencies and to prepare for shift to remote services (e.g. WhatsApp, email, Facebook).
- Step 6: Maintain, review and continuously update your BCP including referral lists.

Source: ILO (2020) The six-step COVID-19 business continuity plan for SMEs https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---act_emp/documents/publication/wcms_740375.pdf

1.3 VAWG and remote service delivery – lessons from COVID-19

Impact of COVID-19 on VAWG in the region

Both globally and in the Arab States region, levels of VAWG have increased during the pandemic. Women and girls have been confined to their homes for prolonged periods during times of lockdowns and movement restrictions, where many have been trapped with their abusers, as well as spent more time online, where perpetrators have intensified online abuse and violence against women and girls.[18] A survey of 490 Arab women in the region, aged 18 years or over, found a significant increase in women's exposure to IPV of 7,3% during the lockdown, specifically for physical and sexual violence, as well as psychological abuse. Key predictors of increased violence were negative impact on family income, and whether the husband lost his job during lockdown.[19] CSOs in the region have also warned about rises in the most extreme forms of VAWG, including with deadly outcomes.[20] Several countries in the Arab States region have seen increased numbers of femicides during the pandemic. This has for example been reported from Algeria, where several cases of femicide have been reported during the pandemic, especially during times of confinement.[21]

BOX 3: Impact of COVID-19 in Jordan

The COVID-19 pandemic and associated social distancing measures have intensified violence against women and girls in Jordan. An online survey of 687 women found that the proportion of women experiencing violence quadrupled during the pandemic from 10% to 40%.[22] Official data from the Family Protection Department of the Jordanian Police also shows a 33% increase in reports of domestic violence during the lockdown.[23]

The crisis has had a 'double impact' on refugee women in Jordan, due to already high levels of violence and discrimination.[24] A rapid assessment by UN Women in Azraq and Za'atari refugee camps and in non-camp settings found that 62% of women felt at increased risk of physical or psychological violence due to growing household tensions and food insecurity.[25]

As women and girls have increasingly moved their social and work lives online, COVID-19 has also exacerbated online and ICT-facilitated violence against women. In Jordan, just over 80% of women and girls experience cyber sexual harassment. Some groups of women are at higher risk, including journalists, women in politics, human rights defenders, refugee women and women with disabilities. During the November 2020 elections, there was a particularly abusive campaign on social media against a blind woman who ran for parliament. 1 in 3 women candidates experienced traditional and electronic attacks on their election campaign, including insults and bullying.[26]

71% of women-led CSOs in the Arab States switched to providing remote services during the COVID-19 pandemic.[27]

Impact of COVID-19 on VAWG service delivery

The rising levels of VAWG in the context of COVID-19, coupled with lockdowns and other measures to curb the spread of the virus, have increased the demand for VAWG services. At the same time, CSOs providing these services have had to change their ways of working. Many CSOs have been forced to close safe spaces or limit in-person activities and transition to remote service delivery in part or in full. According to UN Women's research in the region, 71% of women organisations have switched to providing remote services, and 47% have re-allocated their budget to respond to the pandemic.[28]

CSOs have been able to reach many women and girls despite major changes in ways of operating and delivering services. However, the shift to remote services have impacted some organisations' ability to support women and girls to the same extent as before the pandemic, with particular challenges reaching women and girls from marginalised groups. Half of the respondents in a survey with VAWG actors in Lebanon stated that their organisation had not been able to reach as many survivors in 2020 as they did in 2019, with a comparable level of funding and resources.[29] Survey participants highlighted that adolescent girls, people with disabilities, people with low levels of literacy, women and girls who are extremely poor, members of the LGBTQI+ community and survivors of IPV who are confined with their abuser during periods of lockdown, were disproportionally affected by the shift to remote service delivery.[30] Women and girls' limited access to technology devices and internet alongside lack of privacy were identified as main reasons that limit survivors access to remote services.[31]

COVID-19 has also had a profound impact on other services, leading to closures or changes in the operating hours/locations of healthcare providers, legal services, gender desks at police stations, psychosocial and mental health organisations, and other services that constitute critical referral partners for CSOs that support women and girl survivors of violence. The disruption of referral services and changes in their ways of operating has highlighted the importance of regularly updating referral pathways – this will be explored in greater detail in section 2.1.

Strategies and approaches for remote service delivery during COVID-19

While the COVID-19 pandemic has presented numerous challenges for CSOs that respond to VAWG and support survivors in the Arab States region, organisations have adapted their services and strategies for reaching women and girls, using innovative approaches. UN Women's research found that 86% of organisations have changed how they reach out to communities and women and girls, using more technology-based platforms – with 68% of organisations being available on Facebook and 50% on mobile applications.[32]

> **86% of women-led CSOs in the Arab States** have changed how they reach out to communities and women and girls.[33]

There are numerous examples of how CSOs in the region have moved VAWG services to online and remote platforms during the COVID-19 pandemic. Many CSOs established or scaled up their **helplines** in response to an increase in calls from survivors and women and girls at risk of violence – this has involved training new staff and volunteers on how to provide information, support and referrals safely and ethically to survivors who contact the helpline, or people who call on their behalf. CSOs have also established new protocols of privacy and safety for helpline operators when making and receiving calls at home. Several CSOs providing **case management** have moved from in-person approaches to remote delivery during the pandemic. This has involved adapting and developing new standard operating procedures (SOPs) to ensure safe and confidential case management that addresses the unique challenges of remote services, and providing training to build caseworkers' skills in remote service delivery.

Organisations have increasingly used technology and digital platforms, including Facebook, WhatsApp and various mobile applications to reach out to survivors of violence, including establishing **online support groups** and digital safe spaces for women and girls. CSOs have also moved **MHPSS** and **legal support** for survivors of VAWG to remote platforms, using similar approaches as the more widely documented examples of helplines and remote case management services – using a telephone line, digital technology, or social media platforms to reach and interact with survivors. Part Three of this Guidance Note provides step-by-step guidance on establishing and providing remote case management, helplines and online support groups, as well as linking survivors to specialised services.

While most services provide support for women and girls who have experienced diverse forms of VAWG, there are fewer documented examples of how service providers respond to the growing issue of **online violence against women and girls**. Despite increased awareness of the growing prevalence of online violence against women and girls, many service providers and wider civil society have limited experience in addressing the issue. Nevertheless, there are a few regional examples of promising initiatives supporting women survivors of online violence remotely (one example from Morocco is highlighted on the map on the next page). Additional considerations and promising strategies for supporting survivors of online violence will be further explored in the In Focus section at the end of this Guidance Note.

The map on the next page highlights examples of how CSOs in the region are providing remote services to survivors of violence. Further examples to illustrate how organisations have adapted their services to remote delivery during COVID-19 are highlighted in case studies throughout the Guidance Note.

MOROCCO: The National Union of Moroccan Women (UNFM) has strengthened its remote platform, 'Koulounamaak' ("All with you") and set up a toll-free number, 8350, to provide support to women experiencing violence.

MOROCCO: The Tahadi Association for Equality and Citizenship (ATEC) established the 'Stop violence numérique' (Stop digital violence) campaign aimed at tackling online violence through the launce of a digital app which provides a database of legal references and an accessible space to file a complaint. ATEC is also offering legal and psychological support to survivors of online violence and a mobile unit for schools and vocational training centres to educate on the topic of digital safety.

LEBANON: The CSO ABAAD launched a national awareness campaign for its helpline using the hashtag #LockdownNotLockup, asking people to share their helpline number from their balconies to raise awareness for survivors in need.

LEBANON: ABAAD is running Skype counselling sessions both for survivors and for men with a history of perpetrating violence.

JORDAN: The organisation Sisterhood is Global Institute (SIGI) has used social media to raise awareness of its 24/7 phone and online service during the pandemic.

IRAQ: The VAWG sub-cluster developed technical guidance on remote VAWG case management during the COVID-19 outbreak, including remote and in-person VAWG counselling flowcharts.

SYRIA: UNFPA and its implementing partners have supported the provision of psychosocial support through phone and WhatsApp, including psychological first aid and individual counselling.

YEMEN: UNFPA Yemen and the Women's protection subcluster has developed SOPs for tele-counselling, intended to be used by VAWG case managers and psychosocial support providers.

BAHRAIN: The Supreme Council for Women, an advisory body to the government in Bahrain, provided family and legal advice through a special programme called 'Your Remote Advisor'. The programme conducts consultations for women experiencing domestic abuse via video conferencing and instant live chats via video sessions.

ALGERIA: The Wassila/Avife Network provides medical, psychological, and legal support to survivors of violence and is accessible through its Facebook page.

1.4 Adapting the GBV Guiding Principles to remote service provision

The Inter-Agency Minimum Standards for GBV in Emergencies Programming apply to all forms of remote service provision to survivors of violence.3 4 Although the principles are the same, adapting guiding GBV standards and principles to remote service delivery is an important aspect in supporting preparedness for a shift/ expansion of remote services, and should be considered prior to implementing any remote service modality. This section explores the meaning of the four guiding principles under the survivor-centred approach in the context of remote service provision, as well as provides guidance on how to adapt the key approaches of intersectionality and do no harm to remote service provision.

Survivor-centred approach

The survivor-centred approach should underpin all efforts to respond to VAWG, including when responding remotely. The survivor-centred approach aims to create a supportive and safe environment for survivors, where survivors are treated with dignity and respect, their rights and wishes are respected, and all actions taken are guided by the survivor. At the heart of the survivor-centred approach is the belief that survivors are themselves the experts on their situation – the role of the service provider is to support the survivor in understanding their own situation and the choices available to them, and recognise and support their decisions. Experiences of VAWG can have serious consequences, and survivors can often feel as if they have lost control over their situation and future – the purpose of the survivor-centred approach is to help restore the survivor's sense of self-determination and control by building on their inner strength and resilience, supporting the survivor's ability to identify their needs and wishes, and promoting their capacity to make decisions throughout the process of support and recovery.

At the core of the survivor-centred approach are the following four key principles:

- **Safety:** The safety of the survivor and their children is always the first priority when providing support to a survivor of VAWG. This includes their physical, psychological and emotional safety.
- **Confidentiality:** The survivor has the right to decide what information to share, with whom and when. Upholding confidentiality means not sharing the survivor's information with anyone, without their explicit permission and informed consent.
- **Respect:** All action taken should be guided by respect for the rights, wishes, choices and dignity of the survivor.
- **Non-discrimination:** Every survivor should be treated equally and fairly, regardless of their sex, age, sexual orientation, gender identity and expression, nationality, race, ethnicity, religion, disability, HIV status or any other socioeconomic, identity-based or geographical determinants of inequality.

What does this mean for remote services?

- Consider additional safety risks: Remote service delivery comes with additional safety risks for the survivor that need to be assessed and responded to, such as risk of reprisal if it becomes known to the perpetrator that the survivor has called or texted a remote service (see principle of do no harm and section 2.4 on safety planning). Risks need to be understood in the context of the survivor's individual circumstances, as well as in the wider context in which the remote service delivery takes place, e.g. if the service is provided remotely due to a crisis or disruption, which may pose additional risks to the survivor and their children.
- Consider confidentiality when using remote devices: Regular procedures to ensure confidentiality need to be adapted to remote services, which comes with unique challenges of data security breaches and information sharing. The procedures should include how to store recorded information in ways that are secure and protect the survivor's right to confidentiality, and how to remotely obtain informed consent to share information. See section 2.3 on data security and privacy.

3 This resource does not go through all 16 minimum standards for work with GBV prevention and response in emergencies but focus on selected guiding principles and key consideration as those are applied to remote modalities for GBV services. For additional information about the minimum standards, which the users of this guidance and Training Manual should be familiar with, see GBV AoR information and guiding resources related to the Inter-agency minimum standards, available in multiple languages here: https://gbvaor.net/gbviems/

4 Also see the Essential Services Package for Women and Girls Subject to Violence: https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence

- Inform survivor about all available options as well as risks with remote services: Respecting the survivor's wishes and choices includes respecting their preferences and needs regarding accessing remote services and remote communication. Survivors should be informed of the risks and benefits of available remote services and modalities of delivery, and be supported to make informed choices around ways of accessing remote support and communicating with the service provider, such as how and when to communicate. See section 2.4 on safety planning and section 2.5 choosing technology platform.
- Understand diversity of survivors: Remote service providers need to adopt the approach of intersectionality (see principle below) and adhere to the principle of non-discrimination. This includes understanding and be prepared for the fact that survivors with diverse backgrounds, identities and experiences will use the remote services, including women who are internally displaced, refugees, migrants, women living in rural areas, and women with disabilities.

BOX 4: Mandatory reporting and the survivor-centred approach

Mandatory reporting requirements mean that service providers are required by law to report certain types of cases to the police or other authorities. These requirements often cover cases where children are involved, and situations where the survivor may be at risk of causing harm to themselves or someone else. Organisations may also have their own mandatory reporting requirements in place for responding to cases of sexual exploitation, abuse and harassment (SEAH) that involve humanitarian workers.

Mandatory reporting requirements can be at direct odds with the survivor-centred approach as it impinges on the survivor's autonomy and right to make their own decisions. It can also risk compromising the safety of the survivor as there may be a risk for reprisals from the perpetrator or risks of legal consequences for the survivor if the incident is reported. The latter is for example true for LGBTQI+ survivors as most countries in the region have laws that criminalise or punish same-sex relationships and limit gender expression and identity.

Service providers need to be aware of the laws related to mandatory reporting and inform the survivor of any mandatory reporting requirements. Information about mandatory reporting requirements should be shared early in the conversation (i.e. during the informed consent process), before the survivor may disclose any information that the service provider is obliged to report without their consent. By doing so, service providers can support survivors to make informed decision of what information they choose to share during the call/ chat. If information is shared with the service provider which fall under the mandatory reporting requirements, the principles of the survivor-centred approach should still be upheld, aiming to ensure that as much power, control and decision-making as possible remain with the survivor.

In some contexts, survivors are required to report the incident to the police to be able to access health care, which is again in conflict with the survivor-centred approach. Such requirements risk delaying or obstructing survivors' access to essential and potentially lifesaving medical care and may prevent some survivors to seek support at all, for instance survivors whose sexual orientation and/or gender identity is criminalised in the context. The GBV Minimum Standards for GBV in Emergencies recommend that VAWG service providers operating in such contexts should coordinate with health care actors and the police to ensure that survivors can access health care before being asked to decide whether to report the incident to the police or not. This coordination should take place before service providers start operating remote services, so that the service provider can ensure that accurate information is communicated to the survivor and that it is clear in referral pathways whether services can be accessed without reporting or if reporting is required.

Consider how mandatory reporting may put survivors at risk of further harm, especially when supporting a survivor whose identity, health or social status is criminalised in the context (e.g. LGBTQI+ people), or where the violence that the survivor has experienced (e.g. sexual violence) may put the survivor at risk of being prosecuted. **In these cases, the do no harm principles overrides mandatory reporting requirements.**

Below is a list of some do's and don'ts to take a survivor-centred approach – these apply to in-person as well as remote service provision, with some particular considerations for remote service provision (highlighted in bold).

BOX 5: Taking a survivor-centred approach – do's and don'ts

Do:

- ☑ Listen to the survivor
- ☑ Treat the survivor with dignity and respect
- ☑ Respect the survivor's choices and wishes about what to do in their situation
- ☑ Consider the safety needs of the survivor (including establishing safety procedures for remote communication)
- ☑ Offer flexible times for communicating, taking into consideration when the survivor has safe and reliable access to technology/ connection
- ☑ Share information about available services and support and how to access these (including remote services)
- ☑ Treat all information confidentially and safely (following SOPs for remote services)
- ☑ Explain any limits to your confidentiality (e.g. any mandatory reporting requirements in the context)
- ☑ Ask the survivor for permission before you share any information with others or take any action (following procedure for obtaining informed consent remotely)
- ☑ Adhere to the principle of non-discrimination
- ☑ Reinforce that what happened was not the survivor's fault, and provide emotional support

Don't:

- ☒ Question the accuracy of the survivor's story and experiences
- ☒ Pressure the survivor to talk or share more information than what they are comfortable with
- ☒ Assume that you know the survivor's needs or best interests
- ☒ Persuade the survivor into reporting or accessing any types of services
- ☒ Offer your individual view or opinion on the best course of action or next steps
- ☒ Record more information than you need to (following SOPs for remote services)
- ☒ Share details of the survivor's identity or story with anyone unless you have the survivor's informed consent (obtained remotely)
- ☒ Make assumption about the survivor's background, identities, or experiences
- ☒ Discriminate against a survivor on any grounds such as sexual orientation or gender identity, disability, or marital status
- ☒ Raise false exceptions or make promises about support available that is beyond the scope of what remote services can offer, or what is available in the context
- ☒ Withhold information from the survivor

Adapted from: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

Exercise 4 in the Training Manual is designed to support participants and organisations to understand how the GBV Guiding Principles can be applied to remote services and to help them be better prepared for emergencies.

Intersectional approach

"Intersectionality" is a concept that describes how women's and girls' experiences are shaped by multiple and overlapping ('intersecting') systems of oppression such as gender inequality, racism, homo-and transphobia, ableism, and other forms of discrimination due to factors such as age, health status, legal status (including as refugee or asylum seeker), nationality, and socioeconomic status.

Who are at increased risk of VAWG?

Women and girls who experience intersecting inequalities are often at increased risk of violence. For example, global research shows that women with disabilities are two to four times more likely to experience IPV than women without disabilities (see box 6 for more information on the experience of women and girls with disabilities during COVID-19).[34] Groups who experienced intersecting inequalities prior to COVID-19 are now facing the 'double-impact' of the pandemic, and are at increased risk of violence while facing additional barriers to accessing services.[35] Rapid assessments and evidence from several countries in the region highlight groups of women and girls who were known to be at increased risk of violence in the Arab States region prior to the pandemic, are now at even greater risk.[36] These include:

- Adolescent girls and young women
- Women and girls with disabilities
- Women who are refugees and internally displaced
- Women migrant workers
- Women sex workers and women living with HIV
- Women in prisons and detention centres

BOX 6: Violence against women and girls with disabilities during COVID-19

Women and girls with disabilities have experienced challenges in accessing VAWG services during the COVID-19 pandemic.[37] Organisations for people with disabilities (OPDs) have reported members experiencing violence due to lockdowns and social distancing measures, and research has highlighted various challenges in relation to reaching women with disabilities with remote services, including due to a lack of privacy and challenges speaking freely on the phone[38]. At the same time, existing difficulties in supporting survivors, such as inaccessible transport and services, police attitude and capacity, were made worse as a result of movement restrictions and limited funding during the pandemic.[39] Government restrictions also meant that CSOs have found it challenging to provide services to women and girls in institutional settings, who are at high risk of violence from male staff and other residents.[40] For example, a survey of 751 women found that women with a history of mental illness and who were abused during lockdown had more severe symptoms of depression, anxiety and stress. Over half reported extremely severe anxiety and depressive symptoms (57.3%) and extremely severe stress symptoms (53.1%). Women found it increasingly difficult to access support structures and services. Interestingly, the study also revealed that women with higher levels of distress are more likely to demonstrate 'problematic' social media use during the pandemic, with 40% of participants addicted to Facebook.[41]

Women who face intersecting inequalities and who challenge rigid gender norms are also at increased risk of online violence, including unmarried women, women in public life (for example women journalists and women human rights defenders), and LBTQI+ women.[42] There are examples of state-sponsored online and offline violence and abuse against LGBTQI+ people in the region. For example, in Egypt state actors have used technology to carry out arbitrary arrests and torture of LGBTQI+ people and prosecute them on the pretext of public decency.[43]

What does this mean for remote services?

- **Be prepared to meet diverse survivors:** Remote services will receive survivors with diverse experiences, identities and backgrounds, including women who are internally displaced, refugees, migrants, and women living in rural areas. Remote modalities of delivery can help overcome barriers such as stigma, physical barriers such as inaccessible transport (e.g. for women with disabilities), and fear of being reported to authorities (e.g. for LGBTQI+ people). Service providers might therefore receive a higher number of calls or texts from survivors from marginalised groups than received in static service points. For example, service providers in Syria reported that the scaling up of helplines during the COVID-19 pandemic allowed marginalised survivors who were normally excluded from services to access support, including women with disabilities and LGBTQI+ people.[44]
- **Consider intersectionality in essential elements of remote service provision:** Taking an intersectional approach is important throughout various stages of preparing for and delivering remote services. The table below summarises key considerations for ensuring that services are accessible and provide safe, non-discriminatory and survivor-centred support to survivors who experience intersecting inequalities and who may be at increased risk of violence. These will be highlighted throughout the resource.

Essential element:	Key considerations for taking an intersectional approach
Updating referral pathways	When service providers are updating their referral pathways for remote service delivery, they should include an assessment of whether referral services are accessible and safe for diverse survivors, including women who are internally displaced, refugees and migrants, women with disabilities and LGBTQI+ survivors of violence. In addition, service providers should map services and organisations that are specifically equipped to address and respond to violence against specific groups such as women with disabilities, LGBTQI+ people, and refugee and asylum-seeking women, and include those in the updated list of referral services.
Coordination and partnerships	Forming partnerships and coordinating with organisations that work with different groups and sectors that provide specialised services is essential to ensure that all survivors can access safe, non-judgemental and high-quality services. This includes working with organisations that focus on women and girls with disabilities, members of the LGBTQI+ community, refugees and asylum seeking women, adolescent girls, survivors of online violence etc., and knowing how they operate in circumstances where remote service provision is required.
Data security, privacy and confidentiality	When communicating with survivors, all necessary steps and procedures to ensure data security, privacy and confidentiality should be ensured for all survivors. However, it is important to note that some survivors may face particular challenges in regards to privacy and confidentiality. For instance, survivors with disabilities who rely on an interpreter or caregiver to communicate with a service provider may find their right to privacy compromised. It should also be considered that the interpreter or caregiver can be the perpetrator of violence. It is therefore important that service providers make their services as accessible as possible and ideally offer several modes of communication (e.g. phone calls and text services) to accommodate survivors with diverse communication needs and styles and allow survivors to communicate directly with the service provider, where possible. The service provider should also explore options for using interpretation services, to be able to offer confidential interpretation and communication between the survivor and service provider.

Safety planning	When conducting safety planning with survivors, service providers need to consider the particular situation and specific safety risks that women and girls from groups at increased risk of VAWG might face. Safety plans always need to be tailored for the individual, and consider their particular circumstances and available safety strategies and resources. Examples of questions to consider include: • Does the survivor have access to support systems, such as social/ community support networks? • Is the survivor living with or dependent on a caregiver (who may be perpetrators of violence and/or control access to services)? • Will the survivor face particular barriers in relation to accessing services or executing a safety plan? Consider specific barriers, e.g. for survivors with disabilities, and adjust the safety plan accordingly. • Are there legal provisions that criminalise the survivor, for instance on the basis of their sexual orientation, gender identity and expression, and sex characteristics (SOGIESC) or based on the type of violence that they have experienced? The service provider should consider how the circumstances in which remote services are provided (e.g. following a crisis) have affected the above considerations.
Choosing technology platform	When choosing which technology platform to use for the remote service, CSOs need to consider access to technological devices and connection (phone credit, data and internet etc.), which is likely to be lower among marginalised groups such as women with disabilities, refugee women, and women and girls living in the poorest areas and in rural locations. Service providers need to understand what groups are at risk of being excluded from remote services and adjust their strategies for reaching the most marginalised and isolated survivors, either by adjusting the remote service modality or considering establishing alternative services, including low-tech alert systems for survivors who have limited access to technology.
Staff training	VAWG service providers are obliged to follow the principle of non-discrimination and should be equipped with knowledge and skills to provide support to survivors in all their diversity. This includes being able to understand the various risk factors and barriers to accessing services that women from marginalised groups may face, and how experiencing intersecting forms of discrimination can exacerbate the risk of violence. Trainings in remote service provision should reiterate how this principle applies to all VAWG service providers, and unpack what it means in the context of remote service provision.

Communicating	Remote service providers should strive to ensure effective communication that is accessible and meets survivors' varied communication needs and styles. In addition to using plain and simple language to maximise access to the service, CSOs need to consider: • What languages the service will operate in; • How the service provider will accommodate survivors with accessibility requirements for using the service (e.g. survivors who speak sign language); • If the service will use interpretation services (or in other way ensure that the communication is tailored to the variety of languages in the context). It is important that staff receive training in communicating via remote devices, including knowing how to act and what to do if they receive a call/ message from a survivor with specific communication needs.

Table 1: Key considerations for taking an intersectional approach

Exercise 5 in the Training Manual is designed to support participants to work together and unpack the essential elements of remote service delivery in their specific national context, and in relation to specific groups of women.

Do no harm principle

The do no harm approach underpins all VAWG programming and service provision, as it calls service providers to take all necessary steps to minimise the risk of exposing survivors to risk and harm as a result of their engagement with the service.

Remote services should be provided only when the service provider is able to adopt a survivor-centred approach, and sufficient measures are put in place to ensure safety, confidentiality, respect and non-discrimination. **If this is not in place, remote service provision risk putting survivors who use the services and staff providing services at risk of harm.**

There are numerous challenges associated with remote service delivery, such as risks related to lack of privacy and confidentiality when survivors call/ text a service provider from their home and on technological devices that they may not have full control over. See section 2.3 on data safety, privacy and confidentiality for guidance on how to mitigate such risks.

The survivor may also be in a situation where they are confined in the same place as their abuser, which has been the case for many women in the Arab States region during the COVID-19 pandemic. In such circumstances, contacting a remote service provider for support can be complex and put the survivor at increased risk of violence. CSOs who plan to provide remote services must understand the unique challenges of remote service provision, and plan how to address these and minimise the risk of causing harm from the early planning and design stages for a remote service.

The steps outlined in this Guidance Note and the accompanying Training Manual aim to support CSOs to ensure that they have all essential elements in place to provide different types of remote services in ways that do not expose a survivor or their staff to any risk of harm.

Look out for the warning sign in the Guidance Note – it indicates where there are particular risks to consider in relation to the outlined step or process of remote service provision.

PART TWO: Essential elements

Summary of chapter

This chapter provides guidance on seven essential elements of remote service provision. These are relevant across the three types of services which this Guidance Note focuses on, namely case management, helplines and online support groups.

Updating referral pathways and procedures for how to provide referrals remotely are key steps of the preparation for a shift to remote VAWG service provision. Referral pathways need to be updated more frequently in emergency contexts and circumstances where services have been disrupted. The process of updating referral pathways should assess potential changes in opening hours, scope of services, and mode of service delivery.

Coordination and partnerships are critical elements for ensuring timely service delivery and the continuity of care to VAWG survivors. Coordination of remote services can take place through different coordination mechanisms, such as UN-led humanitarian VAWG coordination mechanisms, coordination mechanisms led by national authorities, or through a mixed approach. Coordinating bodies can for instance play a critical role in updating referral pathways and harmonising the way remote service delivery is offered.

Data security, privacy and confidentiality procedures need to be adapted to remote service provision due to concerns around confidentiality, privacy and security. This section outlines special considerations for storing sensitive data when staff are providing remote services, including from their home, such as provisions for storing devices, physical documentation, and information.

Safety planning is an essential tool to help survivors meet their most immediate needs. In remote service provision, survivors may have limited time to speak to service providers and the safety planning process needs to be adapted to allow for a timely understanding of immediate risks. This section also provides guidance on remote assessment of suicidality thoughts and the risk of suicide attempt.

Choosing a technology platform needs to be survivor-centred and consider access and usage of technology in the local context, especially from the perspective of women and girls.

Staff training, supervision and care should be a priority for CSOs that consider offering remote VAWG services as this shift will entail potential challenges for staff, who will need to be appropriately trained, receive organised supervision, and be supported to manage their care and well-being, which can be particularly difficult in times of crises.

Communicating is an essential element of any VAWG service provision, and service providers need to consider how communication may change in remote services (e.g. the loss of some non-verbal communication) and adapt their communication styles and techniques to the mode of delivery they use, using active listening and active reading skills.

Exercise 5 in the Training Manual is designed to support participants to work together and unpthe essential elements of remote service delivery in their specific national context, and in relation to specific groups of women and girls.

2.1 Updating referral pathways

What is a referral pathway?

A referral pathway is a mechanism that connects survivors to a variety of services, including health, mental health and psychosocial support, case management, protection, and justice and legal aid providers.[45] A referral pathway typically shows how services are connected and lists key information about services including the name of organisation and focal point, phone number, email address, physical address, services offered, what groups they work with (e.g. by gender, age and other identities), hours of service, and cost of services.[46]

Caseworkers, helpline operators and other frontline staff who meet VAWG survivors use referral pathways to ensure survivors' access to multisectoral care and support in a survivor-centred, timely and coordinated way. The survivor-centred approach should be at the core of any referral process, respecting the survivor's choices of whether to be referred to services, which services, and how the referrals will be administrated.

Referral pathways are based on a service mapping of all available services in a particular area. The service mapping is typically carried out by a coordinating mechanism such as a VAWG working group.[47] The service mapping should be regularly updated (and in turn update referral pathways) and shared with all relevant actors. A service mapping or referral pathway may already exist in your area – a good place to start is to check with a VAWG working group or other coordinating body.

If there is no coordinating mechanism available to lead on a coordinated service mapping, VAWG service providers should carry out their own service mapping and assessment of services (e.g. of quality and accessibility) to inform and develop a referral system. It is recommended that **at a minimum**, referral pathways should include the common VAWG services, such as health services, women's organisations and shelters and other safe spaces options, police or other trusted security/ safety actors such as community security authorities, legal services, and child protection.[48] An inclusive referral pathway should also capture information about service providers or organisations that work with specific groups, such as organisations for people with disabilities, indigenous, ethnic and religious groups, organisations working with refugee and asylum seeking women, and LGBTQI+ organisations.

Consider in what circumstances, and for which groups, referrals to services could put the survivor at risk of harm. For example, referring LGBTQI+ survivors of violence to 'regular' services may put them at risk of discrimination, violence, and being reported to authorities. See **Box 7** for key questions to ask to assess whether a referral service is safe and accessible for survivors from marginalised groups.

Further guidance on conducting service mapping and assessments:

- The IRC's Guidelines for Mobile and Remote GBV Service Delivery sets out steps for conducting a service mapping for referrals for remote VAWG responses (IRC, 2018). It includes assessing whether service providers can receive phone-based referrals, if survivors can contact them via phone, and during what hours. IRC recommends using this Service Mapping Tool.
- UNFPA's Guidelines for the Provision of Remote Psychosocial Support Services for GBV Survivors provides guidance on how to carry out a VAWG service mapping during the COVID-19 outbreak. The resource includes a service mapping template and a checklist for the exercise.

Updating referral pathways

In normal circumstances, it is recommended that a referral pathway and list is updated at least every six months.[49] **In emergencies and contexts where services have been disrupted, referral pathways should be updated more frequently** as services may no longer be operational, or safety or quality of services can no longer be ensured. In such circumstances, it is recommended to update the referral pathways at least every one to three months or more frequently depending on the nature of the crisis and how rapidly conditions are changing.[50]
During COVID-19, it has been advised to update referral pathways every month if availability of services continues to change as a result of changes in pandemic response.[51]

Updating referral pathways requires reviewing the services that were listed prior to the crisis and assessing which services remain operational and which can continue providing services in a safe and survivor-centred way.[52] The assessment should also consider any changes to the services, such as opening hours or other operational changes, if the scope of the service has been affected in any way (e.g. some aspects of the service may have been disrupted while others remain functional), and if the mode of delivery has changed, e.g. from in-person to remote delivery.

Questions to ask when assessing a service provider during disruption of services:

- Is the service still operational?
- Have there been any changes in the types of service the organisation provides?
- What days and times is the service available?
- Has there been any reduction in the capacity of the service, e.g. number of staff?
- Have there been any changes in mode of delivery, e.g from in-person to remote?
- What does the accessibility of the service look like in current circumstances? (e.g. how can the service be reached, is it safe for survivors to travel to the provider?)
- Is the service considered essential?

Adapted from: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

The updating of the referral pathways may be conducted by the coordinating mechanism, if one exists, or by service providers themselves. The assessment itself may be conducted remotely, for instance over phone or conference calls. If the organisation has limited capacity or resources to carry out a comprehensive updating of the referral pathways, it is recommended to initially focus on updating information about providers of health (particularly for the clinical management of rape), MHPSS, and safety and security services (including local WROs), and VAWG case management providers.[53] It is important that the updating includes organisations that provide **safe and accessible support** (where these exist) to groups that are at increased risk of violence, and who often also struggle to access services, including adolescent girls and young women, women and girls with disabilities, and LGBTQI+ people. When updating referral pathways, it is also important that referral pathways integrate available information on relevant services for survivors of online violence.[54] **No organisation should start providing remote services in the context of an emergency before referral pathways have been updated.**

Do existing referral pathways include services that can support survivors of online violence? What service providers are available that have the capacity to address the specific needs of survivors of online violence, including technical support to improve digital safety and have content removed? How might you partner with them and integrate their service into the referral pathway and protocols?

Providing referrals remotely

For organisations that have shifted to remote service provisions, updating procedures for how to provide remote referrals is a key step of the preparation. The updated referral pathways and lists should be disseminated to all staff and providing remote referrals should be part of trainings to prepare staff for the shift to remote services. The staff member should always have the updated referral pathways document available during remote case management, helpline calls or other types of services.

Good practice in providing referrals remotely include:

- Provide the survivor with full information about the available and reachable services during the current circumstances to support her to make an informed decision about whether she would like to receive any referrals, and which ones.[55]
- Explain the modalities of delivery available, and how services can be accessed.[56]
- Inform the survivor if there is likely to be any delays in certain services/referrals due to the current situation. If that is the case, discuss the referral needs with the survivor and support her to prioritise which referrals are most urgent.[57]
- Obtain informed consent from the survivor before initiating the referral, using the updated referral pathway. The staff member should also establish whether they can follow up with the survivor about the referral service as necessary (e.g. in remote case management).[58]

BOX 7: Safe and accessible referrals

As highlighted in the key considerations for taking an intersectional approach, updated referral pathways should consider whether referral services are safe and accessible for survivors in their full diversity. Key questions to ask include:

- Are there any mandatory reporting requirements that these service providers are obliged to follow? Will reporting to an authority put the survivor at risk of discrimination, violence and/ or incarceration?
- Is the service (including the facility, communication, and transport to and from the service) accessible to women and girls with disabilities?
- Has the service provider received any training in diversity and inclusion, e.g. in relation to SOGIESC, ethnic diversity, and disability (among other groups)?
- Does the service provider have protocols in place to protect the survivors' information and confidentiality?
- Are there organisations/ groups that specialise in supporting marginalised groups such as LGBTQI+ survivors and women and girls with disabilities?

Adapted from: IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery and UNFPA (date unknown) Guidelines for the provision of remote psychosocial support services for GBV survivors

2.2 Coordination and partnerships

Close coordination among service providers and organisations can foster timely service delivery and ensure the continuity of care to VAWG survivors. During the COVID-19 pandemic, the interruption of in-person services offered by key organisations and the inability of survivors to move or reach a service provider due to potential curfew or movement restrictions, suggested the increasing need for CSOs and service providers to effectively coordinate their services.

The coordination of remote services should aim to:

- Regularly conduct needs assessments on VAWG to identify key trends and how they can be addressed/ mitigated.
- Establish a mechanism of coordination among the key stakeholders providing prevention, protection and response services to survivors of violence. This may include a VAWG working group, coordination platform or committee.
- Update the referral pathway of the services offered to the survivors of violence, and ensure that operational updates (e.g. interruption of services, change of working hours, change of modality of service delivery) of organisations providing these services are shared periodically and timely with other service providers.

- Harmonise the way remote service delivery is offered to survivors of violence among the different organisations.
- Identify the current capacities and prioritise capacity building and training needs of different organisations and service providers in delivering remote services.
- Provide technical assistance to organisations and partners in adapting to remote service delivery, prevention and protection interventions.
- Regularly assess the risks and challenges of remote service delivery and address them. Additionally, the coordination mechanism should aim to build evidence of what works and what does not work in this context.

In the Arab States region, different VAWG coordination mechanisms exist – these are commonly be led by humanitarian actors, national authorities, or take a mixed approach.

Humanitarian VAWG coordination mechanisms: In contexts with humanitarian contexts or forced displacement, humanitarian VAWG coordination mechanisms are usually applied and expanded. For example, in Yemen or Syria, there are UN-led humanitarian VAWG coordination mechanisms according to the IASC GBV guidelines. In these contexts, the cluster system is used to coordinate different humanitarian interventions and the response to violence is addressed through the Sexual and Gender Based Violence Sub Cluster/ Sub Working Group (SWG). The Sub Cluster/ SWG works to ensure that essential safe and accessible services are offered to the survivors of violence, and VAWG risks are identified, mitigated and addressed. In these contexts, the role of international organisations and local organisations is central to the coordination mechanisms, given the fragility or absence of a national coordination mechanism. In fact, NGOs/ INGOs often lead or co-lead VAWG humanitarian coordination mechanisms, particularly in area-based coordination.

National VAWG coordination mechanisms: In some Arab States contexts, the VAWG coordination mechanism is led by the national authorities either represented in separate ministries for women affairs (Palestine and Algeria), or in women councils or committees (Bahrain, Egypt and Lebanon), or both (Jordan). For example, the GBV Support Network in Morocco is a unique mechanism coordinated by the Ministry of Justice and Liberty for access to justice and legal empowerment. The role of NGOs/ INGOs in VAWG coordination is becoming more prominent in community outreach, prevention and protection interventions.

Mixed approaches: In contexts with protracted humanitarian contexts, particularly in refugee hosting countries, a mixed approach exists. For example, Egypt has two mechanisms for providing remote services to survivors of violence; the national coordination mechanisms led by the National Council for Women (for nationals and non-nationals), and the humanitarian VAWG coordination mechanisms led by UN agencies for service delivery for refugees and asylum seekers. In these contexts, the role on NGOs/INGOs in coordination is distinct in reaching, identifying and providing services to the most marginalised populations and those left behind.

Coordination of remote service delivery avoids duplication of efforts and services, optimal use of time, resources and capacities and ensures that access to services for the survivors is maintained. Examples of effective partnership and coordination include multi-organisation joint needs assessments or multi-organisation complementarity in service delivery or case management.

BOX 8: Coordinating remote support for survivors of online violence

Coordination mechanisms of remote support for survivors of online violence should be done on two levels.

At an Organisation Level, coordination mechanisms can:

- ✓ Review and update the referral pathway to include services tailored to address online violence.
- ✓ Mobilise capacities to build the technical capacities of organisations to respond to online violence.
- ✓ Provide technical assistance for organisations willing to develop SOPs on addressing online violence, and harmonise the existing SOPs implemented by different organisations.
- ✓ Consolidate identified challenges and risks in remote service delivery that addresses online violence from different organisations, and discuss collectively how to mitigate them.

At a Service and Survivor Level, coordinating remote support involves:

- ✓ Communicate and advertise services addressing online violence to the communities through the appropriate channels.
- ✓ Encourage survivors to seek support as fast as possible before taking any actions.
- ✓ Ensure that survivors provide informed consent that their information might be shared with more than one organisation, and how data will be managed.

For promising strategies for preventing and responding to online violence, see box 19.

CASE STUDY 1: The use of area-based coordination approach to coordinate VAWG interventions in Iraq

In Iraq, along with the Erbil-based nation-wide humanitarian VAWG coordination mechanisms led by the UN, there are seven complementary area-based coordination mechanisms in place in Baghdad, Basrah, Diyala, Dahuk, Kirkuk and Sulaymaniyah. Local and international organisations do not only contribute to the existing coordination mechanisms, but also lead the coordination mechanisms as chairs or co-chairs of these existing coordination mechanisms. The area-based coordination mechanisms give a space for organisations to locally coordinate interventions and develop tailored assistance in each area, depending on the identified risks and trends of violence.

The VAWG coordination mechanisms in Iraq were inclusive of diverse stakeholders. For example, VAWG Coordination in Dahuk is led by the national authorities (Director General of the Kurdistan Region's Directorate of Combating Violence against Women and Families (DCVAW)) and co-chaired by UNFPA. Meanwhile, organisations take the lead in coordination mechanisms in other areas, such as Kirkuk where the Norwegian Refugee Council (NRC) chairs the coordination mechanism, and Islamic relief co-chairs it.

When COVID-19 pandemic did not enable in-person service delivery for survivors of violence, the area-based coordination approach helped organisations to update the referral pathway in a timely manner in this specific area, providing support for organisations to move towards online and remote service modalities, and complement their services. The role of area based coordination in coordination with district-level, local and camp national authorities emerged to show positive impact, particularly during restriction of movement and limited face to face interaction.

Source: GBV Sub-Cluster in Iraq (2017) Coordination Structure, https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/gbv_subcluster_organogram_and_contacts_february2017.pdf

2.3 Data security, privacy and confidentiality

Protecting the privacy and security of personal information is important for all organisations, but particularly so for organisations working with people at risk of harm. Sensitive data can include personal information on survivors (e.g. name, age, address), incident details, and any services provided. Data security and privacy is not only an issue for staff providing remote services but is also a concern for survivors using the remote VAWG services.

Data security, privacy and confidentiality – staff considerations

There are special considerations for storing sensitive data when staff are providing remote services, including from home. Examples of good practice include caseworkers and supervisors signing a data protection agreement, having separate password-protected files on caseworkers' laptops, using anonymised codes for recording survivors' phone numbers, and using online systems.[59] **It is strongly advised that organisations provide work devices for staff to use for providing remote services,** as communicating with- and storing survivor data on personal devices pose risks to data security and survivor confidentiality. Using personal devices for work also poses risks to staff safety and privacy if their numbers are published, as they may be subjected to online violence and abuse during the

course of their work (be that at home or in an office) and also outside of work. It can also be more stressful for staff if they receive abuse when working from home, as they may feel more isolated and concerned about perpetrator/s finding out where they live. Using personal devices for work also poses a risk to staff well-being as it can blur the boundaries between work and personal life.

The checklist below provides some suggestions for how staff can secure and protect survivor data when working remotely.

Box 9: What do data management SOPs need to include?

✓ Secure and private devices and workspace

- Share guidance on secure practices for using devices, including phones, laptops, external hard drives and USB/flash drives. For example, all devices used for work should be password-protected, as should caseworker files. Devices should be locked when stepping away from work and all applications signed out of
- Provide a phone or electronic device for staff and volunteers to use when working from home, so they do not have to use their own devices or share with other household members

✓ Safe communication with survivors

- Anonymise survivors' details using codes, such as initials, acronyms or designated case number
- Collect minimal personal information on survivors - only collect as much data as is required to deliver the service
- Discourage survivors from sharing pictures or videos of abuse or forwarding abusive messages, which may put them at further risk
- Regularly delete any voice notes or text messages sent to survivors
- Do not share any of the survivor's information, even with a caregiver, without explicit permission from the survivor

✓ Storage of physical documentation

- Store paperwork safely when not using it, for example in a locked cabinet
- Destroy all paperwork in a secure way, for example by shredding or burning it

✓ Using digital case management tools such as Primero / GBVIMS+:

- Supervisors regularly review a selection of randomly selected files
- Agree and set access levels for any digital case management tools or databases, including who can view the data and how access is changed or revoked. Good practice is to ensure that volunteers, interns and staff who do not work directly with survivors cannot view personal information

✓ Training and supervision

- Train all staff and volunteers in data storage and privacy
- Require all staff and volunteers to sign a data protection agreement. GBVIMS have produced a sample data protection agreement
- Supervisors reinforce the importance of data security and privacy in their regular meetings with staff. Personal information on cases should not be shared during staff meetings or peer support spaces such as WhatsApp groups
- All devices should be 'fully cleaned' before disposing of, either by physically destroying the hard driver with a hammer or by overwriting data using a software program – see NIST guidelines on media sanitisation
- How to work with caregivers and family members whilst maintaining survivor confidentiality when working with survivors with disabilities

Adapted from: Tech Safety (2020) Best Practice Principles; GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

Data security, privacy and confidentiality – survivor considerations

In addition to ensuring data security, privacy and confidentiality by taking steps to protect information on own devices, staff need to support survivors to take necessary steps to minimise risks associated with using remote services and ensure their own privacy and safety, to the extent possible.

At the beginning of the remote service provision, the service provider should talk the survivor through steps that they can take to increase privacy and safety.

Good practice for increasing data security and privacy for survivors include[5]:

- **Delete call/ messaging history:** The service provider should suggest that survivors delete text/ call history on their phone/ device immediately after each interaction with the service provider, and talk the survivor through how to do this on their phone/ device
- **Do not save the contact details of the VAWG service provider:** The survivor should not save any details about the service provider on their device, such as the name of the organisation or caseworkers name with phone numbers, and should not write it down elsewhere where it can be found. The safest option is for the survivor to memorise the number. If they have to store the number on their device, it should be saved under a code-name that is not related to service provision and will not look suspicious to a perpetrator who might look through the device. The service provider should be informed about the code-name.
- **Make sure contact details are up to date:** The service provider should ask the survivor to let their point of contact (e.g. caseworker) know of any changes to phone number or the number which the text messaging service (e.g. WhatsApp) is connected to.

There are specific risks to survivors' safety and confidentiality related to phone calls and texting/ messaging.

For VAWG services provided over phone calls, the staff and survivor should discuss:

- **Device:** Does the survivor have a private device to use to make the call, or is the device shared with other family members and/or the perpetrator of violence? If the survivor does not have access to a private device, is there any other device that they can safely use (e.g. at a local safe space for women and girls?)
- **Location:** Does the survivor have access to a safe space to speak – without risk of being interrupted, overheard or seen? If there is no safe and private space at home, can they go elsewhere to make the call (e.g. a trusted neighbour or friend, or a local women's and girls safe space?)
- **Timing:** Discuss which time and date(s) that are appropriate to speak.
- **What to do if someone else picks up the phone:** The staff and the survivor should discuss what to do in a potential situation where someone else answers the call when the service provider tries to contact the survivor, and agree on a strategy to mitigate this risk, but also how to act if this would occur.
- **What to do if the call drops:** There can be many reasons why a call might drop, including technological issues, but it can also be due to safety and/ or privacy concerns encountered by the survivor. Organisations

What to do if the call is picked up by someone else than the survivor:

- Do not hang-up – this may seem suspicious
- If the number is not saved by the service provider – claim to have called the wrong number
- If the survivor has saved the number under a code-name (although this is not recommended) – claim to be a friend and say that you will call back at another time, but do not provide a specific time for this
- Check in regularly with the survivor – if the phone call continues to be picked up by someone else, the staff should furthermore share the concern with their manager/ supervisor

Adapted from: ABAAD (date unknown) Best Practices: Texting & Messaging with Survivors during COVID-19

5 Adapted from: ABAAD (2020) Best Practices: Texting and Messaging with Survivors during COVID-19, https://www.abaadmena.org/documents/ebook.1586444727.pdf

should develop standardised protocols for how staff should handle dropped-calls, and these protocols should be communicated to the survivor in advance. Staff and survivor should discuss and agree on next steps if a call unexpectedly drops, or the survivor for any reason hangs up during an ongoing call.

For communication via text messages, the general good practice for increasing data security and privacy for survivors apply, namely deleting text history, not saving storing details about the service provider, and notifying the service provider of any changes of number connected to the messaging service. An additional safety risk when communicating with a survivor over text messaging is the risk of impersonation – where someone else communicates with the service provider and pretends to be the survivor or someone concerned about the survivor. To mitigate the risk of impersonation, staff and survivors should:[6]

- Discuss the risk of impersonation in advance to of engaging in remote services via text/ messaging so that both parties are aware of the risk and have a plan in place
- Agree on a method for verifying the survivor's identity – this could be a phrase or a code-word that only the staff member and survivor knows about
- If staff note any changes in the survivor's communication via text/ messages, or note any potential signs of discomfort, they should suggest following up via a phone call

⚠ Despite following all steps outlined in SOPs and good practice in increasing data security, privacy and confidentiality, which all aim to protect the survivor and staff members from any harm, remote service provision comes with unique safety and confidentiality risks – some which ultimately fall outside the immediate control of the service provider. **The limitations of remote services via phone calls, text/ messaging services and any other modes of delivery, should be carefully explained to the survivor at the start of the engagement.**

🔗 **Exercise 6** in the Training Manual is designed to support participants to protect survivor data, privacy and confidentiality when providing remote VAWG services.

2.4 Safety planning

What is safety planning?

Safety planning is an essential tool used by VAWG service providers to help survivors meet their most immediate needs. It is an intervention that is often part of the case management process, or part of answering emergency helpline calls. Safety planning aims to make a potentially dangerous situation less dangerous for the survivor, while helping them recognise their strengths and resources. The ultimate goal is to plan with the survivor what she can do within the limits of her own abilities in order to minimise the impact and occurrence of the violence she may face.

What is required for remote safety planning?

Women-led CSOs providing remote VAWG services such as helpline operation or case management will need to have emergency protocols in place and to train their staff on conducting remote safety planning. This is especially relevant during emergencies, including those that require reliance on remote service delivery. The COVID-19 pandemic is a clear example: Lockdowns, movement restrictions, curfews and loss of jobs and livelihoods all meant that survivors are confined in their homes with/or in close proximity to their abusers. Survivors of intimate partner violence, family violence and other types of VAWG such as online violence, child marriage and sexual violence faced ongoing risk with considerable barriers in accessing support. Remote safety planning is also a key consideration for the most marginalised, including survivors with disabilities, older survivors and survivors with diverse SOGIESC, particularly in contexts where individuals with non-normative gender identities and sexual orientations are criminalised.

6 Adapted from: ABAAD (2020) Best Practices: Texting and Messaging with Survivors during COVID-19, https://www.abaadmena.org/documents/ebook.1586444727.pdf

Safety planning is a challenging intervention and becomes even more so during remote service delivery including through helplines, or during remote case management through phone calls or texting. In many cases, survivors will have limited time to speak safely and may be at imminent risk.

Timely understanding of the safety risks as perceived by the survivor will allow the service provider and the survivor to draft a solid safety plan which addresses immediate safety needs. Ultimately, the safety plan7 will support the survivor by putting in place safety strategies to minimise risks or plan for exiting the location of the incident(s) safely – if she decides to leave.

As outlined in Table 1 on key considerations for taking an intersectional approach, it is important to remember that every survivor's situation is unique, and that survivors that experience multiple and intersecting discriminations, including women with disabilities and LGBTQI+ survivors, may face particular safety risks. Safety plans for women and girls with disabilities, LGBTQI+ survivors, and survivors from other marginalised groups, have to be highly individualised – considering their specific living situation as well as the wider context, support networks, and available resources and strategies that they can use to stay safe. For example:

- **Safety plans for survivors with disabilities** should also take into account the survivor's specific disability, ways in which the perpetrator may try to exploit their disability, how the survivor's impairment may affect the implantation of the safety plan, and what disability specific items the survivor might need if she implements the safety plan (for example, medication, assistive devices, or relevant documentation for health or legal support).
- **Safety plans for LGBTQI+ survivors** may entail exploring the legal context and the survivor's experience with service providers, the police and other authorities.

Table 2 is a description of **six safety planning steps** during remote service delivery.[8]

Step:	What to do:
Step 1: Assess the situation	Prior to drafting a safety plan, it is important to conduct a safety assessment to assess the immediate safety of the survivor and to know if it is necessary to activate an emergency protocol in case of loss of communication or if required due to imminent harm. Below is a list of key questions service providers may ask to help them assess the safety risks faced by the survivor. These questions should be adapted to each context depending on available resources and emergency protocols set by the organisation or the relevant VAWG coordination mechanism: • "Do you need me to call the police (or other emergency contact qualified for urgent in-person intervention) immediately?" (Ask for directions). • "Do you need urgent medical attention?" (Ask for directions) • "Is it safe for you if I call you again?", "Should I call you again?" (Ask for the phone number)

7 A sample safety assessment template can be found at: https://gbvresponders.org/response/gbv-case-management/ (Module 15A; Handouts 15A.1 and 15A.2).

8 Adapted from: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

	In addition, it is important to find out with the survivor: • Is her life at risk right now? Are they afraid that someone may attempt to end their life? • Are they confined with an abusive person (for example, unable to leave the home or locked in the apartment without the keys)? • Is the violence escalating, becoming more frequent and/or getting worse? • Does the perpetrator have access to weapons (e.g. knives), are they threatening to kill the survivor, threatening suicide, using drugs or alcohol, or have they previously tried to kill the survivor such as by choking them until they are out of breath, or have they previously inflicted a serious wound? **If so, inform the survivor that you can call the emergency services and ask her to please stay on the line if it is safe to do so** (unless they have to hide, close the line or stop texting, or hide the phone).
	• If the survivor has children/dependents, ask the survivor if the acts of violence occur in front of them or when they are not present. Have they suffered from the violence? In what ways and what is the extent of violence they have suffered? Is there a need to activate emergency protocols to safeguard their well-being and life? • When do acts of violence usually occur? (Consider weekdays vs. weekends, use of drugs or alcohol, contact with friends/family, etc.) • What is the perpetrator's behaviour when they resort to violence? What is his frame of mind when they become violent? (Alcohol, drugs, etc.) Can the survivor think of a particular situation or argument that usually precedes those acts of violence?
Step 2: Identify the survivor's existing resources	It is important that service providers help the survivor to identify persons, locations and resources she can go to, rely on or use to feel safe. Resources include support systems and supportive relationships, financial/economic/ material means, resources available within or outside of the home, etc. Depending on each case, the service provider may help the survivor identify: • **The safest room in the survivor's home:** A room she can lock with a key, their children's room (unless the abuser is usually violent in front of/towards them), a balcony, the house/building's roof, etc. • **Safe times of the day:** Does the perpetrator work from home? Do they leave home at certain times of the day? At what time? For how long? • **Safe forms of communication** with their support network, particularly during lockdown. • **Safe ways if a survivor decides to leave:** It is essential to carefully plan their exit, as leaving an abusive relationship is the most dangerous time for a survivor of VAWG.[9] In many countries across the Arab States region, leaving the home puts the survivor at risk of "honour" killing[10] at the hands of intimate partners, male family members, or male community members as a form of retaliation. Additionally, during lockdown or acute emergencies, some places may be closed or subject to a curfew. If the survivor makes the decision to leave their home, the service provider can help her figure out if she can go to a family member or friend, or if she needs to be referred to a shelter.

9 See e.g. NCADV's online article "Why do victims stay?"

10 "Honour" killing is the crime of killing a relative, especially a girl or woman, who is perceived to have brought dishonour on the family. In many Arab countries, these murders often go unpunished, or perpetrators get minimal sanctions.

Step 3: Draft a plan	**Remember, this by no means implies the survivor's responsibility for any violence she may face.** With the survivor, draft a plan that includes key actions and needed resources to: (1) Do what is in their control to minimise the risk/ incidence of violence prior to the violence. For example: "You tell me that after losing his job, he is often violent after complaints about money. So every time he comes back home after an unsuccessful job hunt, and you're having an argument over money and the household's needs, try to change the subject and go to your children's room." (2) Minimise the harm/ severity of the injuries that may result from the violence. Examples include identifying a safe hiding place, keeping keys to the house's door in a place accessible for the survivor, removing all weapons, avoiding an intoxicated perpetrator by keeping him distracted with TV or social media and not initiating conversation or contact, etc. (3) Plan ahead to seek support or safely exit the location of the incident after the violence has occurred. Go over the plan to involve the survivor's support network in case they see any warning signs of a potential attack from their abuser. Note that a safety plan will be very different from one survivor to the other, depending on their specific circumstances and overall context. The ideas and key steps outlined in the plan need to come from the survivor, in line with the survivor-centred approach. After drafting the plan, the service provider should confirm whether the plan is realistic and help the survivor think of all the variables involved, for example, if her phone has a credit balance, if she can get out of her home safely by driving a car, etc.
Step 4: Think about temporary or permanent options	Think about temporary or permanent options to safeguard the survivor's life and safety when having to leave the home. Ask the survivor to have a backpack ready with her most important belongings, medicines, identification documents and some cash. She can ask a trusted family member or friend to keep it for her, or put it in a safe place at home.
Step 5: Agree how to handle imminent danger/ emergency situations	Help the survivor think of a keyword/ code she can use to let you know she is in danger. Encourage her to share it with trusted persons she can contact via text messages, a cell phone call or WhatsApp. That code means they need to call the police immediately. You should also agree on a code/ sign the survivor can use to let you know a police emergency response is needed or her support network must be activated, such as code words or a specific number of missed calls, for example.
Step 6: Review the plan	Ask the survivor to repeat the safety plan in her own words. Agree on next steps after the call/ chat/ meeting. Agree on remote communication methods to be initiated when needed (should you call back in some time? How can you reach the survivor and when?). Periodically update and review the safety plan as needed.

Table 2: Safety planning steps

In cases where VAWG response is provided through automatic chat services such as chat bots, service providers may need to highlight specific words or hints that indicate high risk that would automatically activate emergency protocols, such as asking the survivor via the chat if they would like to immediately get in contact with a qualified service provider through chat or call.

The steps and recommendations detailed in this section generally apply to any phone-based interaction with a survivor. However, helpline operators might need to accelerate or abbreviate the steps during an emergency call depending on the circumstances of the call. In addition, caseworkers and helpline operators who do not possess the necessary skills for conducting a safety plan can seek the survivor's informed consent to urgently/ immediately link them with a VAWG case manager who can take on safety planning.

How can you ensure safety assessments and safety planning processes support survivors of online violence? How can you ensure that staff have guidance on how to use internet intermediaries' policies to report and help survivors remove harmful content?

How can you ensure that safety plans meet the specific needs of women in their diversity, including survivors with disabilities and LGBTQI+ survivors?

Supporting survivors at risk of suicide[11]

When assessing for risk and developing a safety plan, caseworkers and helpline operators will need to carefully listen and identify any indications that a survivor has feelings about harming themself or ending their own life. Suicide is one of the most serious consequences of VAWG and should be addressed immediately. If a risk of suicide is identified (for example, the survivor might express wanting to die or wanting their life to end), the service provider should be prepared to undertake a more **in-depth suicide risk assessment.**[12]

The most important immediate action is to determine whether expressing suicidal ideation stems from a need to express extreme feelings of distress, or if these feelings are accompanied by an intention to take action to end one's life. This is done through assessing any current or past thoughts about suicide, and the likelihood that the survivor has previously, or will soon, put these thoughts to actions. Service providers can then map resources and safety support that can be put in place to respond to the risk. **In cases where a survivor expresses an intention or consideration to take action on their feelings, the VAWG responder should immediately engage a supervisor to determine the best course of action.** It is recommended that CSOs providing remote VAWG services have in place emergency protocols to guide staff when responding to risks of suicide.

As a first step, the service provider should respond to expressions of suicide ideation with empathy, by reassuring the survivor that it is okay to experience strong negative feelings and thoughts, and that all those are legitimate and normal. A suicidality assessment begins by asking survivors how they are feeling and help them express themselves. The service provider should then assess if the survivor has more than thoughts (i.e. if the thoughts come with an intention) about suicide by finding out if they:

- Have a plan of how they would end their life;
- Have previously attempted (taken action) to end their life.

If the survivor does not have a plan and/ or has no history of attempts, the risk of suicide is less immediate. The service provider can then explore coping strategies with the survivors to deal with difficult feelings and thoughts, and if needed, develop a safety agreement[13] with the survivor.

If the survivor is contemplating or planning suicide, the service provider should activate emergency protocols while following the below steps:

- Communicate with empathy. Affirm their courage in talking about this and the fact that these feelings are not unusual, and they are in fact an understandable reaction to the difficulties they are facing.

11 Adapted from GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines and Interagency GBV Case Management Guidelines and Training Tools (2017)

12 A sample suicide risk assessment template can be found at: https://gbvresponders.org/response/gbv-case-management/ (Module 12; Handout 12.4)

13 A sample suicide safety agreement can also be found in the case management forms at: https://gbvresponders.org/response/gbv-case-management/

- With the survivor, explore and identify triggers for thoughts and feelings of suicide with the survivor, and what happens to their mood or behaviour when they have these.
- Encourage the survivor to talk about what they have been thinking and/or are planning to do. In case they mention a specific method, explore with them if this method (e.g. taking pills) is at home or easy to get.
- Similarly to safety planning procedures, identify resources that the survivor possesses, and strategies that they have used or can develop to support themselves when they have these thoughts and feelings.
- Inform the survivor about available services and assess if they would like you to support them to access a mental health professional for further support.

See section 3.4.2 on MHPSS for further guidance on how to provide referrals to specialised MHPSS services.

Occasionally a caseworker or helpline operator might receive a call/text from a distressed survivor who has taken an action (e.g. taken pills) to end their own life just before getting in touch. In these cases, it is crucial to stay calm and not to panic. The VAWG responder can ask the survivor to share their name and location. They may tell the survivor that they are very worried for their safety and ask if they can call someone to come to them and support them. If the survivor cannot identify someone to be with them, VAWG responders can explore if they would like support to urgently access a health worker or mental health professional for further support. For this, VAWG responders will need the person's name and location to make the referral. In these situations, the supervisor should be on the line, or on a separate phone, to help the staff member with the survivor while the call/chat is taking place.

Adapted from: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

Exercise 7 in the Training Manual is designed to support participants in understanding the key elements of safety planning. It looks at considerations for remote safety planning, and assessing suicide risk and how to support a suicidal survivor remotely.

2.5 Choosing technology platform

Organisations that are considering shifting to remote service provision will need to assess which technology platforms are the best fit for their organisation and context, as well as how to best reach survivors. While this section discusses general considerations when choosing a technology platform, Part Four of this Guidance Note provides further insights into the benefits and limitations of four common modalities of service delivery which emerged in the Arab States during the remote service delivery triggered by COVID-19.

Survivor centred approach: All decisions around what technology to use must be survivor-centred and consider how using that platform may impact security, privacy, and safety of survivors.[60]

Understanding risks: Risks to security, privacy, and safety can vary from platform to platform, and it is important that the service provider understands the unique risks of technology platforms and assess these risks before choosing a technology platform. Risks to be aware of include whether the technology device leaves a digital trail by e.g. saving call history and storing text messages, and that someone with access to the device that the

Essential considerations for choosing technology platform:

- Follow the survivor-centred approach
- Understand potential risks with technology platforms
- Assess access to and use of technology to reduce the risk of digital exclusion (see box 9)
- Define the goals of the remote service
- Cost of technology platforms

Adapted from: GBV AoR (2020) Remote Service Mapping Template and National Network to End Domestic Violence (2019) Assessing Readiness for Digital Services

survivor is using can impersonate the survivor to access information about their location or plans.[61] See section 2.3 for further guidance on data security, privacy and confidentiality, and safe communication with survivors.

> ⚠ Consider the potential risks with technology platforms and devices, such as if a device leaves a digital trail, and how easy it is to impersonate the survivor via the device to access information that can put the survivor at risk.

Understand access to and use of technology: A pre-requisite for choosing technology platforms is to understand access and usage of technology in the local context. First, the service provider needs to consider the general availability of and quality of the telecommunications infrastructure. The International Rescue Committee's guidance on remote VAWG service provision suggests asking the following questions:[62]

- Is there electricity? How stable is it?
- Is there internet access? How stable and strong is it?
- Is there a mobile network? How strong is it?

Secondly, the service provider needs to understand access to technology devices and infrastructure, in particular women's, girls', and at-risk groups' access to and use of technology. This includes understanding patterns of ownership and control over devices. For example, do women and girls have individual access to phones or other devices, or are they likely to share access with family or community members? The GBV AoR has developed the template Rapid Assessment: Remote Service Mapping, which provides guidance for service providers on how to conduct a rapid assessment of who has access to and use technology – see the box below.

Box 10: Assessing access to and usage of technology – key questions

Below are examples of key questions that service providers can explore in relation to different technology platforms and devices (see resource for specific questions for mobile phones, web-based communication and video apps, social media; radio/television, and emergency call phones):

- What remote services currently exist?
- What are the gender, age and disability dynamics of technology use and access to digital platforms?
- What percentage of the population and sub-groups access technology platforms and devices?
- Is access to technology platforms and devices affordable (e.g. are there free services available and accessible; can economically vulnerable members of the community access technology?)
- What languages are technology services available in?
- What are the most used communication and social media apps and in the context?
- Who are the key providers of technology services – are they private or government owned?
- Are there specific risks or benefits documented in the local area in relation to using technology platforms to provide VAWG services or to communicate about VAWG?

Adapted from: GBV AoR (2020) Rapid Assessment: Remote Service Mapping Template

Define the goals of the remote service: Determining the goals of the remote service can be helpful in identifying which digital platform is best suited for the service. As part of this process, the National Network to End Domestic Violence (NNEDV) suggests asking:[63]

- Who are you hoping will use the new platform?
- What type of services will be offered? (e.g. helpline, case management, individual counselling, online support groups, appointment reminders)
- What type of technology is best suited to provide those services?

Cost of the technology platforms: A key considerations for organisations when choosing a technology platform is the total cost of establishing, rolling out, running, and maintenance of the service.[64] In addition to the one-off cost of setting up a solution for a technology platform, the decision should factor in organisational costs related to maintaining and upgrading the service, ensuring sufficient internet bandwidth for running the service, increases in phone credits and internet for staff working from home, training staff in how to use the technology platform, costs and time for developing SOPs for operating the remote service using the technology platform, and potential need to increase the number of staff and supervisors to meet shifts in total demand and workload for individual staff.

2.6 Staff training, supervision and care

When considering offering remote support to survivors of violence it is important to ensure that caseworkers and helpline staff have the right training and supervision to be able to provide safe and ethical support to survivors. It is also important that staff are supported to manage their care and well-being which can be particularly difficult when they are working remotely during a crisis.

Working from home can be a big change for staff, and organisations need to ensure in a first place that that the staff member is comfortable providing remote VAWG services from home, and they have all necessary equipment to do so. It is strongly advised that organisations provide staff with work equipment such as phones and laptops for remote service provision, both to strengthen data security and confidentiality and to support staff well-being and work-life balance.

⚠ Staff may be at risk of online violence and abuse, for example if the phone number they are using becomes publicly available or is shared beyond the circle of people (e.g. colleagues, referral services, and survivors) who need access to the number. .

This simple checklist can be used to assess if the staff member and their home environment is prepared for a shift to remote service provision from home.

CHECKLIST: What is required for delivering VAWG services from home?

The staff member:

- ✓ Is willing and feels comfortable providing remote VAWG services from home
- ✓ Keeps electronic device charged, topped-up and available when working
- ✓ Stores electronic devices and any paperwork safely when not using it (e.g. in locker box or other secure space)
- ✓ Keeps the updated referral information at hand
- ✓ Has contact information to emergency support (e.g. police or other first responders) at hand in case a survivor is in immediate danger
- ✓ Has SOPs and relevant checklists at hand

The staff member's home environment:

- ✓ Is in an area where there is reliable phone signal/ connection, and electricity to charge electronic devices (or the organisation provides battery packs and e.g. solar charges)
- ✓ Has a private space to communicate with survivors without being disturbed or at risk of being overheard
- ✓ Has sufficient desk space to keep documents and resources such as referral information, emergency numbers, SOPs and checklists readily available
- ✓ Has a safe space to store confidential information (e.g. paper work) and electronic devices (password protected) when not being used

Staff training

It is critical that staff are appropriately trained before they start delivering remote VAWG services. Training plans for staff should be included in implementation plans for the service. This section looks at the core elements that are needed to prepare staff for a transition to remote service delivery.

As set out in section 3.1 on remote case management, existing caseworkers should have already had thorough training on case management based on the Interagency GBV Case Management Guidelines, and training on

providing care to child survivors as well as on VAWG emergency response and preparedness. Case managers may be transitioned to work on helplines or may be asked to work on case management and a helpline. In other cases, new staff may be recruited to staff the helpline, who may not be VAWG specialists. Helpline staff will need initial training before the helpline is established or scaled up, and will need ongoing training. Supervisors should oversee training and capacity building of staff, and carry out scenario-based role-play training (see the Training Manual).

BOX 11: What are the core elements that should be included in trainings to prepare staff for remote services?

All caseworkers and helpline staff:

- ✓ A review of standard operating procedures , including changes made to reflect new remote modalities.
- ✓ How to use new technologies and relevant apps to provide remote services (e.g. WhatsApp).
- ✓ A review of updated referral pathways and providing referrals over the phone.

All caseworkers:

- ✓ Revision of basic VAWG issues and concepts, if needed and time allows
- ✓ How providing support via phone is different than in-person, and what basic adaptations need to be made
- ✓ Essential phone manners, e.g. initial greeting, speaking clearly and slowly, not speaking over the survivor, etc.
- ✓ Phone listening skills, e.g. active listening and listening for changes in tone without body language; use of silence; building trust and rapport on the phone
- ✓ Standard call-handling protocols in line with basic case management steps (e.g. introduction, assessment, case and safety planning, referrals, call closure)
- ✓ Managing a call with a minor
- ✓ Managing calls when survivors are at immediate risk and/or when a call is picked up by a perpetrator
- ✓ Managing calls when survivors are distressed or suicidal
- ✓ New data collection and management responsibilities
- ✓ How to delete text and call history (also important training for survivors)

All helpline staff (operators and supervisors):

- ✓ Basic VAWG issues and concepts, including:
  - Core humanitarian principles
  - GBV Guiding Principles
  - VAWG basic concepts
  - General data safety standards
- ✓ How to operate a helpline and respond to a call, including:
  - Introduction to helplines as an entry point for services and how they work
  - Operation of the helpline and service protocols
  - How providing support via a helpline is different than in-person, and what adaptations need to be made (e.g. how to build trust and rapport without using body language)
  - Use and management of resource guides and referral pathways
  - Data responsibilities linked to helplines
  - Meeting the needs of diverse callers, including friends and family who may call as co-survivors, as well as those who are calling for reasons outside of the helpline focus

Adapted from: IRC (2018) Guidelines for Mobile and Remote GBV Service Delivery; GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

Remote staff supervision

Supervision is the ongoing, regular meeting of a supervisor and a supervisee to assess and monitor skills and practice in a supportive manner.[65] Supervisors play a key role in supporting staff to prepare for and deliver remote services. The Inter-agency Case Management Guidelines recommend a ratio of 1:5 supervisor to caseworkers and no larger than 1:8. SOPs should set out this role and expectations of supervisors, as well as emergency procedures for contacting supervisors.

During remote service delivery, staff and supervisors may be in different physical locations for safety and access reasons and therefore staff supervision would be carried out remotely. Remote VAWG services are more difficult to supervise than in-person VAWG services. Services that are highly technical, such as those requiring case management or intensive skills training, usually need greater oversight from senior management.[66] The following strategies can be used by supervisors to support staff working remotely.

BOX 12: Strategies to support remote supervision

- Identify and use technology to facilitate communication between supervisors and staff, and support remote capacity building. Staff should be trained on how to use this technology (e.g. WhatsApp, Skype and Zoom).
- Issue all supervisors and caseworkers shifting to remote work with an agency phone and phone/data allowance to facilitate regular communication online or via phone. This should be at agreed times and during the caseworker's designated working hours.
- To ensure regular supportive communication between supervisors and remote caseworkers and helpline workers, supervisors should use specific technology to:
    - Implement a fast-track process for caseworkers and helpline staff for high-risk cases.
    - Conduct regular group-based and/or individual check-ins and check-outs with team members offering remote case management and crisis support. During the COVID crisis the recommendation was daily.[67]
    - Set up weekly (at the least) individual supervision calls with their supervisees and be available to provide support during the entire time their staff are working. Supervisors should adapt supervisory tools to meet new remote modalities.[14]
    - Support group or peer-based staff supervision sessions to provide staff with a safe and supportive space to discuss, reflect, share information and receive mutual support.
    - Ensure that regular checks-ins and supervision calls go beyond immediate case review/documentation and cover staff care and well-being.
- Use online case management systems (for example Primero) to facilitate regular case file review and discuss findings with caseworkers in individual or group sessions.
- Identify and use written, visual and audio tools that support the ongoing capacity building of staff. For example, Remote-offered Skill-building Application (ROSA) is an application developed by IRC to facilitate skill assessment and capacity building for frontline workers, and creates a community space for peer learning and coaching. Using tools from the Interagency GBV Case Management Guidelines, which can be downloaded on a mobile device in advance and users can access content in settings with low or no connectivity.[68]

Adapted from: IRC (2018) Guidelines for Mobile and Remote GBV Service Delivery; GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

14 See for example The Survivor-Centred Attitude Scale and Survivor-Centred Case Management Quality Checklist. See Part 4 of the Interagency Gender-Based Violence Case Management Guidelines Training Material, Module 18: Supervision. https://reliefweb.int/sites/reliefweb.int/files/resources/interagency-gbv-case-management-guidelines_final_2017_low-res.pdf

Staff care and well-being

Organisations and supervisors have a responsibility to create an organisational culture that prioritises staff safety and well-being. This is particularly critical for CSOs providing VAWG services in humanitarian settings and at times of crisis, for example during the COVID-19 pandemic, where staff are supporting survivors in a context of rising levels of VAWG and reduced access to care. In these situations, staff are exposed to high levels of stress and the risk of secondary trauma.

Providing services remotely adds an additional layer of complexity as supervision, which is critical to staff care and well-being, can become more challenging when staff and supervisors may be separated physically. In addition, staff providing remote case management and helpline support from home can find it difficult to establish boundaries and disconnect, and may feel pressure to respond to calls at any time of the day. Without proper support, staff can quickly become overwhelmed, tired, and feel a sense of powerlessness and helplessness.

When shifting in part or in full to remote service delivery, organisations and supervisors should make a specific commitment to staff care and well-being, and ensure there are strategies and approaches in place to prevent staff burnout. Several feminist, women-led CSOs have produced useful guidance on staff care during the COVID-19 pandemic (see below).

Further guidance on self and collective care during COVID-19:

- Raising Voices in Uganda How Can we Amplify Self and Collective Care?
- The GBV Prevention Network and Just Associate's Self and Collective Care
- CREA's Self-Care and Self-Defense Manual for Feminist Activists
- FRIDA's Self Care Plan

2.7 Communicating

Communication between the service provider and the survivor is at the core of the VAWG service provision. Some forms of non-verbal communication that are important in in-person service provision are likely to get fully or partially lost in remote communication, such as reading facial expressions, body language and posture of the survivor. It is important to adapt communication style to remote service provision as the service provider's communication style can help create a safe and supportive environment for the survivor, and to build trust and rapport.

General considerations for remote communication

Remote communication with survivors will generally follow the same basic approaches as when communicating with survivors during in-person services. There include:

- Using **active listening**.
- Conveying empathy, warmth and respect.
- Asking questions in a non-judgemental way.
- Conveying authenticity, e.g. do not try to answer questions that you do not have the answer to and be transparent about the limitations of the service and what you can do.

Active listening in remote communication:

- Make acknowledging sounds to show that you are listening
- Don't interrupt when the survivor is speaking
- Focus all attention on the survivor. This means removing all potential distractions in the work environment
- Do not fill every silence, but allow some periods of silence (it is important to stay alert to what the silence can mean – can it be a sign that someone has entered the room or that she is uncomfortable?)
- Once the survivor has finished speaking, paraphrase what has been said (e.g. "so what you are telling me is that…")
- Listen attentively and ask clarifying questions
- In a video call: Make eye contact with the survivor by looking in directly the camera (instead of on the screen)

- Do not impose personal advice or opinions in relation to the survivor's situation – survivors are the expert on their situation.

Non-verbal communication

It is not only what the service provider says that is important, but also how they say it. The service provider's use of their voice and tone can enhance the effectiveness of the remotes service session, for example by sharing messages and information in a clear way, building trust and conveying emotional support. The following points provide some practical considerations for service provider's during calls (phone or video):[69]

- Speak clearly and slowly to ensure that the survivor can hear you and understand the information being shared.
- Try to match the survivor's tone of voice. Also vary your tone to avoid sounding monotonous or tired.
- Try to match the pace of the survivor's speech. However, if she starts speaking very fast or uncontrolled, try to slow down the conversation and control the pace.
- Do not speak too closely into the device and speak at a normal volume.
- Avoid moving around too much while speaking as it may interfere with the connectivity or create background noises.

Check in to ensure safety and consent:

If a silence, hesitation, change in tone or other non-verbal communication may indicate that the survivor is not comfortable or safe to continue the call, the service provider should check in that they are still able to speak:

- Remind the survivor that she is free to skip questions at any time (in case a certain question made her uncomfortable)
- Ask questions that require a yes/ no answer, e.g. "Is it okay for us to continue?", "Is this still a good time to talk?", "Would you like to contact me again at another time?"
- If the survivor remains silent, or you continue hearing voices or noises in the background, remind her of your agreed safety measures including the verbal password (see box with example questions to establish survivor safety in section 3.1)

Although non-verbal communication diminishes with remote communication, some types of non-verbal communication remain, which is important to pay close attention to as they can reveal information about the survivor's state of mind and reveal changes in the survivor's surrounding such as that someone is entering the room, or that she is uncomfortable in the situation. During calls (phone and video), the service provider should try to observe the survivor's use of pauses and silences.[70] These are normal and the service provider should not try to fill every silence, but stay alert to pauses and silences that are longer than normal or are accompanied by a change is tone, hesitation, or any voices or other noises in the background. These may indicate that she is no longer safe or that the conversation is no longer private – in which case the service provider should check in with the survivor to ensure safety and consent. It is also important to pay attention to tone of voice, speed, level of clarity/ coherence, breathing patterns, silences and emotional expressions (e.g. crying or sounding panicked). These can help the service provider understand the survivor's emotional state.

Written communication

The same general considerations for remote communication via voice and video calls apply to written communications (e.g. WhatsApp, SMS, chats etc.) but following the concept of active reading instead of active listening. Texting with survivor requires its own strategies and skills such as:

- How to choose the right words when texting.
- How to respond to messages that are confusing or unclear.
- How to assess the survivor's state of mind or tone in a text message conversation.

To avoid misunderstandings, share key messages in a clear way, and convey empathy, the service provider can think about the following points when communicating via text with a survivor:[71]

- If a message is not clear, ask questions such as "I don't think I understood that. What do you mean by...?", "Based on what you're saying, I understand that...", "I don't know if I'm understanding correctly, can you elaborate on that?", "What you just told me / the things that are happening / what just happened to you... how does it make you feel?". Asking open ended questions are likely to generate more information than simple yes/ no questions.
- Try to use clear language and avoid ambiguity and words/ expressions that can be interpreted in different ways.
- Avoid using texting slang, acronyms and emojis. Everyone will not be familiar with them and understand what they mean.

Communicating with survivors with disabilities

The way service providers and practitioners interact with women with disabilities can help break down barriers and send positive messages to colleagues, partners and community members. It can also help improve the quality of VAWG services.

Remote service provision poses both opportunities and challenges for reaching survivors with disabilities. Remote VAWG services can be more accessible to women with disabilities as it does not require traveling to access a static service, however, technology devices can present other barriers if the service provider has not considered accessibility of the modality(ies) used. Organisations should consider using interpretation services and other ways of making the service accessible to women with diverse disabilities and communication needs and styles.

Providing multiple options for communicating (e.g. voice call, video call and text-based services) is a first step to making the service more accessible as people can choose the modality that they prefer to communicate in. However, organisations should also consider if they can provide interpretation services for helplines and case management (e.g. for people with hearing impairments), and other ways that services can be made more accessible, for instance by providing training to staff in how to communicate remotely with survivors with diverse disabilities.

A key principle when communication with persons with disabilities is to find out how the person prefers to communicate. For instance, people with hearing impairments may use a combination of writing, lip reading, and/ or sign language to communicate. It is important to adapt both verbal and non-verbal communication when supporting women and girl survivors with disabilities.

Further guidance on communicating with persons with disabilities:

- Women's Refugee Commission and IRC's Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings: A Toolkit for GBV Practitioners
- The Convention on the Rights of Persons with Disabilities (CRPD) is translated into many languages and can be a useful guide to using terms about disability that are both sensitive and appropriate. The full CRPD, translations, and easy read versions of the convention can be found here.

Exercise 12 in the Training Manual aims to strengthen the capacity of caseworkers, helpline operators or social workers on engaging with survivors over the phone.

PART THREE: Types of remote services

3.1 Case management

Summary of chapter

This section provides guidance on establishing and providing remote case management, helplines and online support groups. For each type of service, there is a summary of how the essential elements in part two apply to the service in question. The chapter also focuses on how VAWG service providers can coordinate with specialised services to ensure a comprehensive response.

Remote case management has the same purpose and involves the same basic steps as in-person case management; however, it follows a more condensed process as the caseworker and survivor may have limited time together. The procedures and tools need to be adjusted to remote case management, and CSOs must ensure that they have all pre-requisites in place, including sufficient staff who are experienced and have received training, new or adjusted SOPs for the service, and necessary equipment and procedures for handling the devices and storing information.

Helplines provide remote services to VAWG survivors via telephone, SMS or chat/social media applications. Benefits of helplines include that they offer anonymity and can provide information and safe referrals to a high number of individuals quickly. The main roles of helpline operators are to listen to and counsel survivors, conduct safety planning and crisis management when necessary, disseminate information, and refer callers to services and resources for further support. There are several steps that CSOs need to go through before setting up a helpline, including assessing technology platform, deciding on location and hours of operation for the helpline, determining staffing and management structure, developing SOPs, and advertising the helpline.

Online support groups can provide opportunities and spaces for people to share personal experiences and feelings, coping strategies, and first-hand information about seeking support. Facilitators of online support groups need to be familiar with using the online platforms, how to moderate the online support groups, and how to monitor signs of discomfort or risks. They also need to advise survivors about privacy and safety risks of group participation, and how to mitigate these. It is critical that online support groups are provided on secure digital platforms that ensure the data protection and confidentiality of the survivors. This Guidance Note explores four common modalities for online support groups, namely virtual safe spaces, social media platforms, mobile applications and real-time webchats/ videocalls.

Specialised services are services that the VAWG responders can refer survivors to for further support when needed, including health services, MHPSS, justice sector/ legal support, and livelihood support. Survivors may need urgent health care, for example if they have recently experienced physical or sexual violence. Survivors who experience psychological conditions that are likely to require specialised support, such as depression, anxiety and post-traumatic stress may need to be referred to specialised mental health and psychosocial support (MHPSS) services. Access to justice and legal support is both a basic human right and a way to protect VAWG survivors from further violence. CSOs may provide remote legal support to survivors or refer survivors to police and legal services for specialist support. Livelihoods support can include dignity and hygiene kits and cash for food and medicine. Service providers may also refer survivors to welfare, social services and income assistance, or to economic empowerment programmes.

Before starting to provide remote case management, organisations need to ensure that all necessary procedures are in place, and that staff and their home environment are prepared for the shift. The Essential Elements outlined in part two of this Guidance Note all apply to remote case management. This section provides a quick overview of how the essential elements apply to case management (see box below) and then provides further guidance on preparing for and implementing remote case management.

What is case management?

VAWG case management is a structured way of helping survivors. It involves one organisation, typically a psychosocial support or social services actor, ensuring that survivors are informed about all the options available to them, identifying any issues or problems facing a survivor, and following up in a coordinated way.[72] VAWG case management often links to other services, such as psychosocial support and health services (see section 3.4 on specialised services). In humanitarian settings, centralised VAWG case management services are mostly offered through static service delivery points, such as women and girls' safe spaces, or through mobile services visiting a site on a regular set interval.[73]

What is remote case management?

With the outbreak of the COVID-19 pandemic, many CSOs moved towards remote case management where caseworkers provide support to survivors, either by phone, chat, SMS, or another technological modality. Technology has been essential during the pandemic to enable immediate case management support and follow up with both existing and new users of the service.[74] The caseworker provides the case management remotely at a distance from the survivors, either from their home or from an office. Remote case management has the same purpose and involves the same steps as in-person case management; however, the procedures and tools need to be adjusted.

Summary: How do the essential elements apply to case management?

Essential element:	Specific considerations for case management:
✓ **Updating referral pathways**	Updated referral pathways are essential for caseworkers to ensure that survivors are informed about all the options available to them, based on up to date and accurate information. The caseworker should have the document with the referral pathways readily available when conducting remote case management so that they are prepared to initiate any referrals that the survivor wishes to receive.
✓ **Coordination and partnerships**	Coordinate with other service providers including specialised VAWG services for referrals. Coordinate with other service providers providing remote case management in order to coordinate support for survivors, for instance if your organisation reaches its maximum caseload capacity.
✓ **Safety planning**	Safety planning is an essential step of case management. The steps outlined in the safety planning section might need to be accelerated or abbreviated by caseworkers when survivors have limited time or in case the call/chat gets interrupted.
✓ **Data security and privacy**	Caseworkers will need to follow established procedures detailing what information will be collected from survivors, how data will be stored, and how it will be used. Organisations providing remote case management may consider using digital case management tools such as Primero/GBVIMS+ to store necessary data about the case.

✓ **Choosing technology platform**	Phone-based case management is a common approach, however, some survivors may want to have contact through other means (e.g. messages). The organisation will need to assess the most appropriate modality for the communities in which they are working, as well as consider survivors' wishes. For survivors who are already receiving case management prior to the shift to remote delivery, there is scope to discuss which communication modality they would prefer and prepare the survivor for the shift.
✓ **Staff training, supervision and care**	Prior to delivering remote case management, caseworkers should receive orientation on SOPs for remote case management (at a minimum), training in using the technology that will be used to deliver remote case management. Preparatory steps should also include reviewing each caseworkers' caseload and discuss modalities for remote supervision.
✓ **Communicating**	Communication is essential to all steps of case management, and providing emotional support is a key aspect of the process. Caseworkers will need to adapt their communication techniques and style to the modality of delivery, e.g. phone calls or text messages.

What are the pre-requisites for providing remote case management?

Prior to starting remote case management, your organisation should have updated referral pathways, selected a technology platform, and provided staff training and put in place procedures for supervision and staff care. Below are additional pre-requisites and considerations for organisations that are looking to providing remote case management.

Staffing: Providing remote case management, especially if the shift is taking place in the context of a crisis or emergency, is likely to present challenges for staff. If the roll-out of remote case management takes place in the context of a wider crisis, such as with the COVID-19 pandemic, the organisation should review the expectations on staff in terms of case load. It is not realistic to expect staff to carry on with the same caseload as before a crisis hit or when they are required to work from home. People may be personally affected by the crisis and working from home can present a range of challenges such as juggling work with childcare and other responsibilities, lack of privacy, and lack of internet/ phone connection. Organisations should carefully assess each caseworker's ability to work from home, as well as the overall caseload across the organisation. Taking all these factors into account, the caseload per caseworker might need to be adjusted, and the organisation may need to recruit more staff to be able to handle the same overall caseload as during in-person service provision.

Key questions to answer:

- How many current staff are able and willing to provide remote case management?
- Can the organisation take on new cases, considering resources and capacity?
- If yes, how will new cases be taken on? (E.g. through referrals from a hotline or through advertising about the service?)
- Does the organisation need to recruit caseworkers to be able to maintain the current caseload, or to take on new cases?

Prior experience and training: Caseworkers should have experience of in-person case management prior to the shift to remote services and receive necessary orientation and training on remote case management. A standard operating procedure document on remote case management is not enough on its own, but staff need to receive orientation on the organisation's new procedures, including having the chance to ask questions and discuss. See section 2.6 on staff training, supervision and care. With the outbreak of COVID-19 and the subsequent expansion of remote case management, there is a growing number of online resources, webinars and trainings on the topic. See the resource list at the end of this Guidance Note for suggestions which can complement the internal orientation on SOPs and

the training that the organisation can provide.

Equipment: After deciding what technology platform and modality for delivery to use (see section 2.5 on choosing delivery platform), the organisation should provide staff with necessary equipment such as phones, tablets, laptops, charges etc. as well as airtime and internet access. The organisation needs to put in place procedures for handling equipment, e.g. how devices will be stored when not being used, how will phones be topped-up, limitations for private use of devices, etc. Caseworkers should not use their own devices or numbers to contact survivors. Caseworkers should receive necessary training in using the equipment and following procedures. There might also be non-technological equipment needed for staff to provide safe and confidential case management from their home, such as notebooks and storage space with a lock.

Identify an appropriate space: Caseworkers may do the remote case management either from an office or from their home. Before starting remote case management, the organisation must assess the space from where the remote case management will take place. The organisation should identify minimum requirements for ensuring privacy and confidentiality during the interaction with the survivor, and decide what the organisation can do to support staff members who will work from home to meet minimum standards, if possible, depending on their individual living arrangements. The minimum requirements may include having a private space with a door that can be shut, where the risk of interruption or being overheard is minimal, and having a dedicated space where devices and paperwork can be stored safely (e.g. a space that can be locked). See section 2.3 on data security and privacy for a checklist of obligations and preparedness to ensure privacy and confidentiality when working from home.

If safety, privacy and confidentiality cannot be assured for remote case management delivered from the caseworker's home, the staff member should not be engaged in remote case management but be given another role. The same applies to remote case management from an office space – survivors' confidentiality and privacy should not be compromised at any step of the process.

Develop standard operating procedures: Case management SOPs are a detailed guide for the caseworker to know how to provide the service. These are also known as service protocols. Before starting remote case management, organisations need to adapt their SOPs to remote service provision or develop new SOPs for this purpose. A good way of doing this is to involve caseworkers and supervisors in the drafting of the SOPs as they are the ones who will use them and are most familiar with current procedures. The SOPs must cover all necessary aspects of remote case management, and the organisation needs to ensure that all caseworkers and supervisors are oriented on the new procedures before starting to work remotely. The SOPs should include support to survivors of online violence and staff should be trained in how to do this. The box below suggests what remote case management SOPs should include as a minimum.

Box 13: What should be included in remote case management SOPs?

- What times the remote case management service will operate and working patterns (e.g. recognising need for flexibility as staff may have care taking and other responsibilities)
- Where will the case management be provided from, and requirements on the workspace (e.g. minimum standards for ensuring privacy and confidentiality)
- Requirements in terms of orientation and training of staff in remote case management
- Role and expectations of supervisors, as well as emergency procedures for contacting supervisors
- Procedures for handling technology equipment (e.g. how to safely store devices and ensure that they are charged and topped-up)
- Procedures for handling survivor's information on devices to ensure privacy and confidentiality (e.g. deleting messages and other personal data, and not using devices for other purposes than case management)
- Call-answering protocols (e.g. introductory statements, how to communicate essential information about the service, how to obtain informed consent remotely, how to handle dropped calls and disruptions during the session, how to close calls etc.)

- Remote safely planning and safety assessments
- What to do in situations where there is an immediate danger to the survivor and/ or their children
- Procedures for documenting cases and data management
- Procedures for taking on new cases and closing cases Modalities for remote supervision of caseworkers, including procedures for when and how to contact a supervisor in an emergency
- Commitments related to staff care (e.g. access to psychosocial support)
- Support to survivors of online violence

For examples of SOPs for remote case management, see the resource list.

How can you ensure safety assessments and safety planning processes support survivors of online violence? How can you ensure that staff have guidance on how to use internet intermediaries' policies to report and help survivors remove harmful content?

Putting in place procedures for documentation and data storage: Remote case management deals with personal and sensitive information about survivors and VAWG incidents, which if accessed by the perpetrator/s of violence, could have detrimental consequences. There are steps that both the caseworker and survivor should take to ensure privacy and security of personal information in relation to the remote case management. These are further detailed in section 2.3 on data security, privacy and confidentiality.

Exercise 8 in the Training Manual focuses on understanding what needs to be in place before moving to remote case management.

Who will benefit from remote case management?

There are various reasons why an organisation decides to provide remote case management. Two main reasons are that there is no dedicated space for in-person service provision available, or survivors cannot access a physical location for service provision, which can for instance be due to remoteness or temporary restrictions in movement and social gatherings such as during the COVID-19 pandemic. In such circumstances, service providers may have little or no control over whether they can provide in-person case management or not, as there might be regulations in place that prevent them from providing in-person services. In these circumstances, there might be few or no other options available for survivors than accessing support remotely, and the organisation may need to prioritise survivors at higher risk (if the demand outnumbers the capacity of the service). In these circumstances, it is critical that coordination between VAWG service providers works effectively so that survivors can be referred to organisations with more capacity.

In circumstances where in-person case management is available in part or full, remote case management may be a complement to static or mobile services, for instance in order to expand the reach of the organisation and manage to maintain contact with survivors in areas where there is no permanent, static service available. When several service options are available, there is more room for organisations to assess whether a survivor would be likely to benefit from remote case management or whether in-person case management would be more suitable. The survivor's preferences and individual circumstances should be taken into account:

- Does the survivor prefer remote or in-person case management?
- Does the survivor have access to her own device for remote communication, and does she control the use of device? If not, is there anywhere she can safely access a device, for instance somewhere in the community?
- Does the survivor have access to a space at home (or other location) where she feels comfortable and safe to call or message from?

- Is her access to the device and space time dependant (e.g. when the perpetrator is not at home in situations where the survivor stays in the same place as the perpetrator) or more flexible?
- Is the survivor able to process information through the particular communication modality used for the remote case management (e.g. in reading for messaging and while listening for phone calls?)

If the survivor's circumstances are such that she feels safe, comfortable and equipped to be in contact with a caseworker through remote methods, remote case management can be an appropriate option.

Situations where remote case management may not be suitable, but where in-person options should preferably be explored (where possible), include:[75]

The survivor has no privacy at home, or does not have safe access to a technological device, which may belong to another family member or the perpetrator controls the device and can see, for example, call and text records.

- The survivor experiences severe mental health problems such as severe major depression, schizophrenia or bipolar disorder.
- The survivor is in a life-threatening situation or in immediate danger to herself or someone else.

Working with existing and new users of the VAWG service

Remote case management may be offered to existing and new users who approach the service. The same key steps of case management would be followed in both scenarios, however, there are some differences.

Working with existing users: When remote case management is considered for existing users of the VAWG service, staff will have the benefit of already being familiar with the survivor's situation and have an established rapport with the survivor. Staff may already have conducted an initial assessment, however, consider that the situation may have changed, for instance if there is an ongoing crisis, and they may need to review the assessment taking into account changes in the wider context and how those have affected the survivor. When working with an existing user of the service, the caseworker may have time to prepare the survivor for the shift to remote case management while they are still meeting in-person. To prepare for a potential shift to remote service provision, make sure to:

- Assess if remote case management is an appropriate option for the survivor – are there any safety concerns or privacy issues? (see section 2.3 on data security, privacy and confidentiality)
- Discuss the technology platform you will use and how it will work – answer any questions and provide support in how to use technology platforms, as necessary
- Obtain informed consent before shifting to remote case management
- Discuss any potential challenges, concerns and questions that the survivor may have in relation to the change – come up with a plan for how to address these

The remote case management with an existing user of the service will continue the process from the step that it was currently at and make necessary adjustments to the new circumstances. This may involve reviewing the safety assessment and adjusting the action plan, if this has already been developed. The caseworker should also check-in on what services that the survivor has received, and if services that the survivor may have been referred to are still operating (in the context of a crisis or change in the context).

Working with new users: The steps of the case management are likely to be more condensed when caseworkers engage with a new user of the VAWG service than when they work with an existing user.[76]
This is particularly true in contexts of crisis, such as COVID-19, where many service providers may have experienced disruption, and staffing levels might be affected. The caseworker and survivor are also likely to spend less time together when communicating remotely compared to if they would meet in-person, as survivors might only have safe and reliable access to the technological divide for a limited time (e.g. due to limited airtime, electricity, connection or restricted time frames where she can safely use the device). As a result, the approach with new users of the service is more aligned with the model of crisis case management, which is an adaptation of the standardised VAWG case management process.

Standardised vs. crisis case management:

Figure 2: The standardised case management process vs. the crisis case management approach. Source: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

There is no golden rule for how long a remote case management session will take, as that will ultimately depend on the situation and the needs of the survivor. The number of sessions will also depend on the individual needs and wishes of the survivor. The caseworker and survivor should agree at the end of each session when they will be in contact again for a new session or for check-in.

Implementing remote case management step-by-step

This section will focus on the five steps of the approach of the crisis case management, as remote caseworkers are likely to have less time with the survivor. The focus in this section is on remote case management through phone calls, but also recognises that the caseworker and survivor may communicate through other means such as messaging services.

Making and receiving calls: Before the remote case management session can start, the survivor or the caseworker need to initiate the call. For existing users of the service, the caseworker and survivor are likely to have agreed on how they will communicate and identified a time for the session. The survivor may initiate the session by calling, or by flashing or texting the caseworker, who will then call back. The organisation's call-answering protocols (see box 15) should include detailed guidance for the caseworker to follow.

Step 1: Short introduction and safety check

The first priority when starting the session is to make sure that it is safe and a good time for the survivor to speak. The questions should be asked in a way that allows yes/ no responses, in case the survivor is not by herself.

After establishing that it is safe for the survivor to carry on with the conversation, and that privacy and confidentiality can be ensured, the caseworker can continue with the introduction.

Example questions to establish survivor safety:

- Are you comfortable talking right now?
- Do you agree to continue talking now over this phone, or do you prefer we schedule a different time to speak? Or do you prefer to give me a missed call or text me when you are ready?
- Is this the right number to call on or text to? Or do you prefer me to contact you on another number?
- Are you in a room or place where you feel safe and have privacy to carry on with this conversation?
- Is there a risk that someone might walk in during our conversation? What would be the safest thing to do if that happens?
- Repeat: Are you fine talking now?

Adapted from: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

The introduction and engagement step will be briefer in remote case management than in a typical in-person session, as the caseworker cannot be sure how much time they will have with the survivor. However, the caseworker still needs to make sure to cover all critical points. These are:

- Explain the remote case management process and the caseworker's role
- Explain confidentiality, including how information that the survivor shares and personal data will be handled
- Explain limitations to confidentiality such as mandatory reporting requirements
- Explain the survivor's rights, including the right to decide how much information she wants to share, the right to decide if and how information will be shared with others (e.g. for referrals), and that she does not need to answer any questions that she does not feel comfortable answering, as well as the right to withdraw the consent and stop the session at any time
- Obtain informed consent to conduct the session (see box 16).

If the survivor is not safe:

If the initial safety questions indicate that the survivor is not in a safe in the moment, or might be monitored, do not continue with the introduction. Instead, implement the following steps:

- Ask if the survivor is in a locked room. If not, is there anywhere in the house where the survivor can escape the perpetrator?
- Ask if there is anyone the survivor can reach out to for help, such as a neighbour or someone else in the community?

Ask if you should support the survivor to call the police or other trusted security actor? The caseworker should always have emergency contact numbers at hand and know how to contact them while staying on the line with the survivor.

Once the caseworker has ensured that the survivor has understood the remote case management process and her rights during the session, and has given her informed consent to continue, the caseworker should agree on safety measures during the call, before proceeding with the case management. There are several scenarios that can take place during the call where clearly agreed safety measures will be useful. These include:

- Someone may step into the room where the survivor is calling/ texting from
- Someone in the background is asking who she is talking to or telling her to get off the phone
- The call drops unexpectedly, or the survivor suddenly stops replying to messages (see section 2.3 on data security, privacy and confidentiality for guidance on how to deal with this)
- Someone grabs the phone and starts talking to the caseworker, or hangs up
- The survivor says she needs to end the call

If the caseworker suspects that there is someone else in the room or of the survivor suddenly does not sound comfortable to speak, they should stop the case management and give the survivor the option to contact them again at a later point when she feels more comfortable, following pre-established procedures for ensuring privacy and confidentiality (see section 2.3).

BOX 14: The process of informed consent

Obtaining informed consent is a critical element at several stages of the case management. For remote case management, the informed consent is obtained verbally. To begin with, the caseworker should make sure to obtain the survivor's informed consent to conduct the session. After having explained all key information about the remote case management service and made sure that the survivor has understood the information as well as had the chance to ask any questions, the caseworker should ask if the survivor gives her consent to proceed with the remote case management.

Informed consent should be treated as an ongoing process. It is good practice to continuously check-in that the survivor is comfortable and is fine to carry on with the call. In addition to obtaining initial (and ongoing) informed consent, the caseworker will also have to ensure the survivor's informed consent to administrate referrals to other service providers, and to store any data and information in e.g. a case management application.

Survivors with disabilities have the same rights to make their own decisions about their care as everyone else. It should be initially assumed that all adult survivors with disabilities have the capacity to provide informed consent independently. Service providers should always ask the survivor with a disability whether they would like to access support to help them make an informed decision. In cases where the survivor's capacity to consent independently is not clear, caseworkers should involve their supervisor to determine whether there is a need to provide additional support for informed consent (see the GBV Case Management Guidelines for further information and a useful tool to help think through informed consent and best interest decision making for survivors with disabilities). Also see section 2.7 on communicating with survivors with disabilities.

The communication in remote case management

follows the same key principles as in in-person case management – the caseworker should communicate in a calm, compassionate and warm way, speaking clearly and slowly, and building trust and rapport with the survivor. However, it should be noted that communicating remotely is different than in-person interaction and requires adapting the tone of the voice and being alert to changes in the survivor's tone of voice. See the section 2.7 on communicating for more information on how to adapt communication to remote service provision.

To support caseworkers through the essential steps of a remote case management session, the organisation should develop detailed call-answering protocols. This may include scripts and checklists that the caseworker can easily refer to during the call.

Examples of safety measures during the call:

- Agree on a verbal password to signal that it is not safe to speak. The password should be a neutral word that does not reveal what you were talking about.
- Agree on how to delete call and text history following the session.
- Agree that the survivor should not save the number of the caseworker with an identifiable name or organisation.

Box 15: What should be included in call-answering protocols?

At a minimum, call-answering protocols for remote VAWG case management should include:

- ✓ How to make and receive calls
- ✓ How to start a case management session (e.g. scripts for introductory statements and key messages that should be shared early in the conversation)
- ✓ How to ensure confidentiality during a call, and how to explain confidentiality (including its limitations) to the survivor during the informed consent process
- ✓ How to obtain verbal informed consent
- ✓ How to ensure survivor safety during a call (to the extent possible), including how to conduct an initial safety check and how to establish safety measures for the call
- ✓ How to conduct a safety plan remotely
- ✓ Hot to handle calls from survivors who are in immediate danger (e.g. how to guide the survivor towards the safest location available, and how to contact the police or other trusted security actors)
- ✓ How to handle calls from survivors with suicidal ideation
- ✓ What to do if a call is dropped, including policies for calling/ texting back
- ✓ In what situations the caseworker should involve a supervisor in the case, and how this is done
- ✓ How to close a call (e.g. what key messages and information the caseworker should share)
- ✓ What to do if a survivor sends a message to the caseworker (outside a planned session) and how to respond if a survivor requests the caseworker to call back (this will also depend on what the caseworker and the survivor has agreed)

Source: GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines

Step 2: Assessment of immediate concerns

The assessment process in remote case management is less detailed than in in-person case management, with a stronger focus on assessing the immediate concerns and needs of the survivor. Three essential components of this step are to:[77]

- **Listen** – the caseworker should try to understand as much as possible about the survivor's situation by listening carefully to what she has to say. If there is an ongoing or recent crisis in the context (such as COVID-19), this should include understanding how the survivor has been affected by what is going on, and how it may have impacted how the survivor is at risk of VAWG.
- **Assess** – focus on understanding immediate safety concerns and needs; understanding the situation at home and social networks available to the survivor; and understanding the survivor's state of mind.
- **Summarise** – summarise what you have understood about the situation back to the survivor, to confirm that you understand what her most immediate safety needs and other concerns are.

While the caseworker listens and assess the situation, they should integrate providing **emotional support** to the survivor, including validating their experience and feelings, showing compassion, and sharing healing messages.

Step 3: Safety planning

The next step in the remote case management process is safety planning. Section 2.4 on safety planning explores this essential element of remote VAWG service provision in greater detail.

Step 4: Implementation

The main purpose of this step is to provide further emotional support to the survivor and to provide necessary referrals to services that can address the survivor's immediate concerns. The caseworker will need the information about the updated referral pathways at hand to provide information about all available and appropriate options for support, based on the identified needs and risks. For each referral that the survivor wishes to receive, the caseworker needs to ask for informed consent if they will contact the service provider on behalf of the survivor. They also need to agree how the service provider can initiate the contact with the survivor. If the remote service provision is taking place due to a crisis or other external factors that limits in-person case management, the caseworker needs to explain how the referral services are operating during the circumstances, and whether they are providing remote or static services.

Step 5: Share resources and key messages

The last step of the remote case management session will consist of sharing further resources, emphasise key messages from the session, remind the survivor of critical information, and closing the call in a safe way – aiming to leave the survivor more in a more stabilised state than when the session started.

Critical information and key messages to share include:

- Recap any next steps that the survivor has identified and agreed to, e.g. in terms of referrals to service providers, and whether the survivor has given consent for the caseworker to make contact with the service provider.
- Agree how the survivor can contact you by call or messaging, and where she can turn to if she cannot reach you.
- Assess the survivor's state of mind, and share supporting and affirming messages before closing the call, validating the survivor's experiences and feelings, and affirming her choice to seek support.

Close the session and schedule a time for the next one, if needed and if the survivor wishes to have another one. In contexts of crisis, there might be less follow up after the case management session than during normal circumstances. This has been the case for many remote case management services during COVID-19, since with the limited services available and movement restrictions, caseworkers have not been able to follow up on the cases to the same extent as they would normally. Remote caseworkers should still explore all available options to support the survivor, but will have to accept that limitations may be in place during a crisis, e.g. in terms of limited services available, as well as restrictions that may make it difficult for the caseworker to accompany a survivor to access other services. Caseworkers should be transparent about the situation with the survivor, and what services and support is available and not.

Supervision of caseworkers

There should be procedures in place for remote supervision prior to starting the remote delivery. See section 2.6 on staff training, supervision and care for further guidance.

The caseworker and their supervisor or manager should stay in regular contact during the period of remote case management, with particularly close contact when the caseworker is handling challenging cases. Good practice includes regular meetings between caseworkers and supervisors to review a random selection of cases, to identify any challenges and trends, and provide feedback.[78]

CASE STUDY 2: Remote case management during COVID-19

When the COVID-19 pandemic began, the Lebanese organisation ABAAD – Resource Center for Gender Equality experienced a rapid increase in demand for its services, with 1,472 calls in June-August 2020 compared to just 342 calls in the same period the year before.[79] Caseworkers also observed a rise in emotional, verbal and economic abuse as the financial crisis in Lebanon worsened.[80]

To ensure continuity of services, ABAAD quickly adapted its VAWG case management to remote modalities. The organisation put together a plan for implementing remote case management and other crucial services via phone and WhatsApp. Key learning includes the importance of listening to survivor needs and considering functionality, ethics and safety before rolling out any remote case management.[81]

ABAAD's 'learning organisation' approach has helped it to innovate its services to meet the changing needs of survivors during the pandemic, document any challenges and adapt its case management accordingly.[82]

Together with UNFPA, the organisation has developed a Remote GBV Case Management During Emergencies guide. The survivor-centred manual helps service providers and caseworkers adapt case management. It includes sections on caseworkers' responsibilities during home-based remote case management, new and existing users of the VAWG service, rapid safety checks, specialised safety plans, survivors at risk of suicide, male callers, setting boundaries, in-person sessions, supervision, and mitigating burnout.

It has also produced a short note for CSOs on how to communicate with survivors and women at risk of violence during a pandemic: Best Practices: Texting and Messaging with Survivors during COVID 19.

Exercise 9 in the Training Manual is designed to support participants to understand the different steps of remote case management service delivery.

3.2 Helplines

In situations that require a shift to remote service delivery, CSOs might consider setting up – or scaling up an existing – helpline service. Before starting to provide helpline services, organisations need to ensure that all necessary procedures are in place, and that staff and the location of service delivery, including the home environment, are well prepared. The Essential Elements outlined in part 2 of this Guidance Note all apply to VAWG helplines. This section provides a brief overview of how the essential elements apply to setting up and running a helpline (see box below) and then provides further guidance on preparing for and implementing helpline services.

What are helplines?

A VAWG helpline is a specialised remote service via telephone, SMS or chat/social media applications. It provides an effective way to listen to and counsel callers including VAWG survivors, disseminate information, and refer callers to services and resources for further help. Helplines rely on a network of organisations that offer case management, medical services, legal services, or access to more information. Accordingly, a helpline service should be embedded within a wider referral pathway and would not be able to operate independently.

Helplines provide accurate information and safe referrals to a high number of individuals quickly. When offering anonymity, helplines serve as a source of information that will not embarrass, label, or judge a caller. Survivors are free from being seen in a VAWG centre or clinic by friends or family. Often survivors will contact a helpline when they need a non-judgmental, unbiased person to talk to about sensitive subjects. In some cases, a helpline may provide direct case management, particularly where there are no referral services that are available, or that are safe.

How do helplines operate?

A helpline is one of the modalities for remote VAWG service delivery,[83] providing VAWG services (predominately emotional support and case management) over the phone or another technology platform (e.g. application, chat, or SMS) rather than in-person. Helpline services can be provided as follows:

1) A stand-alone intervention in places where the population cannot access services in-person, or an organisation cannot set up in-person services due to insecurity or a pandemic.
2) Implemented in tandem with static or mobile programming to expand the geographic reach of services, in which case they are often accessible on a regional or national level.
3) Implemented as part of a static or mobile service delivery approach to ensure continuity of VAWG services when in-person activities are discontinued temporarily due to insecurity or a pandemic. In this case, the functions of a helpline include:
    - Allowing caseworkers and helpline operators to speak directly with survivors and offer crisis intervention, safety planning, information resources and referrals
    - Allowing caseworkers and helpline operators to speak with community volunteers who support in-person programming (also known as community focal points) and other service providers to support their work with survivors. This is especially relevant for low-tech contexts, and/or contexts where women and girl survivors are unlikely to have access to phones or technology.

What is the role of a helpline operator?

A VAWG helpline is an entry point for providing services. Approaches to using helplines differ, but in general a VAWG helpline operator typically:

- ✓ Receives and handles disclosure of VAWG survivors
- ✓ Gives support to callers by listening to them and counseling them when necessary
- ✓ Conducts safety planning and crisis management when necessary
- ✓ Provides referral information, obtains consent and conducts referrals
- ✓ Provide accurate, updated, basic information

Source: IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery

Summary: How do the essential elements apply to helplines?

Essential element:	Specific considerations for helplines:
✓ Updating referral pathways	Updated referral pathways are essential for effective helpline services. It is important that helpline staff have a document accessible that outlines existing referral pathways including all service providers identified in locations that are covered by the helpline service. Consider updating the referral pathway every three months to have a complete list of entry points and contact information related to available services for VAWG survivors, including specialised services.
✓ Coordination and partnerships	Coordinate with other service providers including specialised VAWG services for referrals. Coordinate with other organisations with functioning helplines, e.g. if your helpline is only available during specific hours, coordinate with an organisation providing 24/7 helpline services to receive calls outside of your working hours.

✓ Safety planning	Safety planning through helpline services is an essential tool for responding to emergencies. The steps outlined in the safety planning section might need to be accelerated or abbreviated by helpline operators when survivors have limited time on the phone or in case the call/chat gets interrupted. Consider prioritising key safety elements first.
✓ Data security and privacy	Because of the crisis nature of helplines, organisations will need to think carefully about whether it is necessary to collect information from callers, and if so, what information will be collected and how will it be used. If information is collected from callers, clear protocols with staff need to be in place, detailing how data collection will be discussed with callers and how informed consent can be obtained through phone/chat. The protocols also need to highlight that the collection of data is not critical and should not be prioritised over supporting the survivor.
✓ Choosing technology platform	Phone-based helplines are common. However, some survivors might not have access to a phone, might not possess phone credit if the helpline is not toll-free, or might prefer to get in contact through other means such as chat, texting or using social media platforms (some common platforms used in the Arab States region are: Facebook, WhatsApp, Telegram etc.) Organisations setting up or scaling up a helpline service will need to assess the availability of communication technology, decide on the geographical area for the helpline and hours of operation, and agree: • What devices will staff use and how will they be managed? • What telecommunications company(ies) in the area will support the helpline? • What are the budget allocations for hardware, phone credit, and operating a free line or reimbursing callers?
✓ Staff training, supervision and care	Helpline staff should receive training on the following key topics: • Operation of the helpline and orientation on SOPs and service protocols • GBV Guiding Principles and VAWG basic concepts • Basic responses for responding to a disclosure of violence (e.g. statements that communicate validation, non-judgment and empathy) and making safe and confidential referrals • Conducting safety planning via helplines Supervision of helpline staff requires that supervisors: • Be available for emergency back-up • Conduct debriefing meetings with helpline staff, for particularly challenging calls • Establish a regular supervision time every week for staff and supervisors to check in • Conduct periodic training, role-plays and "ghost calls" Care and provision of emotional support to staff is also required, given the potentially upsetting nature of calls. This can take the form of shorter shifts on the helpline, regular supervisory sessions, and temporary task-shifting, and/or individual psychosocial support to prevent burnout.

✓	Communicating	Helpline operator's verbal communication with the survivor includes greeting the caller; speaking/texting with empathy, adopting a non-judgemental and accepting attitude when listening and responding; practicing active listening; identifying and acknowledging feelings, focusing the conversation, affirming, reflecting and speaking simply/clearly, summarising and closing. Non-verbal communication include: the helpline operator's voice and speaking patterns including the tone of the voice, breathing patterns, pauses, pace of speaking and hesitation. The helpline operator also needs to rely on the same non-verbal cues from the tone of voice of the survivor/caller.

What are the requirements for establishing and operating a VAWG helpline?

Prior to setting up a VAWG helpline, organisations need to have updated referral pathways, assessed available technology platforms (see below), developed SOPs (see box 16) for running the helpline, provided staff training and put in place procedures for supervision and staff care. Key assessment points prior to establishing and when operating a VAWG helpline include:

1) Assessing the availability of communication technology:

- What kind of technology does the population have access to? It is important to analyse access and usage of mobile devices and the internet if needed, particularly for women and girls, who often have less access than men and boys. It will also be important to understand the extent to which sub-populations vulnerable to VAWG access and use mobile phones, in order to understand whether a helpline could facilitate or expand access to services for them.
- Is there a mobile network and electricity? How stable are they?
- Will the helpline be centralised or decentralised? Will it cover specific areas only or the whole country?
- Will it be toll-free, shared, or paid number? Do women, girls and survivors of VAWG need to have internet connection to access helpline services?

For further guidance, see section 2.5 on choosing technology platform.

Deciding on location and hours of operation: The location of helpline services will depend on its size.

- Small helplines are usually located in a room within the organisation's offices. During lockdowns or instability that limits mobility, helpline operators can be home-based if the proper conditions for ensuring confidentiality and safety are available (check section 3.1 Case management – identify an appropriate space and the checklist box: "What is required for remote case management from home?")
- Larger helplines may be set up in a different part of the building or in an entirely different professional call centre. In all cases, a helpline service requires space: a private room from which case management and crisis support can be provided remotely, and space for resource folders, phone lines/mobile service, posters on walls (including referral pathways, safety planning questions, key messages).

Hours of operation can differ. Helplines can offer a 24-hour helpline service if it is needed and feasible, or it can have specific hours during the week and weekends. Ideally, organisations want to provide a helpline service that complements existing servicespline administrative issues. This guidance can be compiled into a resource folder for staff. The key point to remember when compiling the information is how staff can access it quickly when they are on a call, in case they need prompts for how to deal with specific issues. It also means putting the information together in a way that it can be added to, as more guidance is developed in order to respond to the specific needs that emerge in the context. This might mean ensuring all staff have a large ring binder with tabs indicating different information that should be with them when they respond to all calls and that can be updated regularly.

Determining staffing and the management structure of helpline: The size of your helpline, operation hours and the number of anticipated calls will influence the number of staff required. For example, large helplines typically have a helpline coordinator, a trainer or training partner, and one supervisor for every ten helpline operators. 24/7 helpline operators work in shifts of 8 hours each, handling calls only during their shift. Smaller helplines usually have four or five caseworkers who also operate the helpline, and a supervisor whose role also encompasses that of a helpline coordinator and a trainer. In places where multiple languages are spoken, it will also be important to have operators with a variety of language skills.

Answering additional design decisions: When designing or implementing a helpline, it is recommended to hold a planning workshop that includes managers, proposed helpline staff, IT staff (if available), and applicable referral pathway partners. Implementation plans should outline activities and responsibilities, helpline coverage schedule, outreach and information dissemination plans, training plans for staff and partners, and a supervision schedule. Questions to answer include:

- What devices will staff use and how will they be managed (e.g. how will they be charged, where will they be stored at night, what apps are not allowed, what happens if one is lost/stolen)?
- What telecommunications company(ies) in the area will support the helpline? This will depend on the organisation's geographical area and context.
- What are the budget allocations for hardware, phone credit, and operating a free line or reimbursing callers?

Developing standard operating procedures: For helpline operators, SOPs should include policies and guidance on GBV Guiding Principles; background information on VAWG; call-answering procedures; how to respond to frequently asked questions (see box 16). Procedures should also address management and helpline administrative issues. This guidance can be compiled into a resource folder for staff. The key point to remember when compiling the information is how staff can access it quickly when they are on a call, in case they need prompts for how to deal with specific issues. It also means putting the information together in a way that it can be added to, as more guidance is developed in order to respond to the specific needs that emerge in the context. This might mean ensuring all staff have a large ring binder with tabs indicating different information that should be with them when they respond to all calls and that can be updated regularly.

Box 16: What do helpline SOPs need to include?

- ✓ Operation of the helpline and service protocols: time of operation and working patterns (e.g. recognising need for flexibility as staff may have care taking and other responsibilities)
- ✓ Location of service delivery for helpline operators (e.g. call centre, organisation's premises, the home), and requirements on the workspace (e.g. minimum standards for ensuring privacy and confidentiality)
- ✓ Role and expectations of supervisors, as well as emergency procedures for contacting supervisors
- ✓ Requirements in terms of orientation and training of helpline staff
- ✓ Procedures for handling technology equipment (e.g. how to safely store devices and ensure that they are charged and topped-up)
- ✓ Ensuring confidentiality; how the calls/chats are answered by the staff (e.g. introductory statements, key messages that should be shared from the beginning on confidentiality)
- ✓ Informed consent and assent procedures for receiving services and referrals, and how these will be secured via phone/chat
- ✓ How to safely support the survivor (e.g. the operator can ask the caller if they are in a private place and if they feel safe, to check if the phone is on speaker, and if so to take it off so no one could overhear)
- ✓ How the calls should be closed (e.g. what information and key messages should be shared when a call is ending)
- ✓ How to respond to survivors in immediate danger and how to conduct remote and accelerated safety planning
- ✓ How to activate an alert chain for support
- ✓ How to respond to callers with suicidal ideation

- ✓ How to handle prank callers, abuse and harassment on the helpline
- ✓ Data management and related protocols
- ✓ When staff should engage supervisor for support
- ✓ How to support survivors of online violence

Strong referral pathway and information resources: Resource packs for helpline operators include the following two main resources.

- **A strong and up-to-date referral pathway**, to be able to provide relevant information and conduct referrals quickly and efficiently while on a call (see section 2.1 on updating referral pathways). This document should be physically accessible to the helpline operator and outline existing referral pathways including all service providers identified in locations that are covered by helpline services. Key details include the name of organisation and focal point, phone number, email address, physical address, services offered, hours of service, and cost of services. The referral list should be updated regularly, at least every six months. In emergency settings, this should be updated every one to three months as services change more rapidly. When updating referral pathways, it is important that referral pathways integrate relevant services for survivors of online violence where these exist.
- **A resource guide** that contains information relevant to the context, including the most common types of VAWG, information likely to be requested by callers, frequently asked questions and information about other resources. These guides should be translated and customised to the local context, and updated over time according to the calls the helpline receives. Some examples of reference materials to include in a resource guide are: safety planning, types of VAWG and impact on survivors, child survivor reference document, health factsheets (addressing emergency contraception, post-exposure prophylaxis (PEP), explanation of mandatory reporting requirements), basic legal statutes and processes (having a lawyer as a referral pathway partner on a helpline is ideal), suicide prevention plans, the organisation's emergency protocols, and guidance for how friends and family can support a survivor.

Advertising the helpline: It is important that organisations consult with women and girls to determine the best and safest way for advertising the helpline. This will allow CSOs to advertise helpline services in a way that is non-stigmatising and promotes help-seeking. Special considerations need to be put in place to ensure that the information about the availability of the helpline services reaches the most marginalised women, girls and survivors of VAWG.

Who can benefit from helpline services?

Survivors and concerned community members can directly call a helpline to disclose a VAWG incident and seek support. In addition, community volunteers and focal points who have been trained on handle disclosures can call the helpline and link the survivor to services when needed (with the survivor's consent), or in case of emergency. For example, if a woman in the community has been raped, she might not be aware of available services and entry points. A community volunteer who is made aware of this incident can, with the survivor's consent, directly call the VAWG helpline and link the survivor with services. For more information on the role of community-based approaches in remote VAWG service provision, especially in contexts with unreliable electricity and/or where women and girls have limited access to digital devices, see section 4.4 on low-tech systems.

How to respond to a helpline call or text?

Table 3 describes the basic steps of a call-answering protocol when responding to a call/chat/SMS.

Exercise 10 in the Training Manual focuses on how to respond to a helpline call or text.

Call answering protocol for helplines: To ensure consistency, a call-answering protocol should be developed and written out. A simple protocol may involve the following steps:

- Answer the call according to a standardised script
- Ensure confidentiality unless in very exceptional circumstances, such as when the survivor is a direct threat to the safety of themselves or others, or when mandatory reporting requirements apply
- Collect intake information
- Provide emotional and psychosocial support
- Provide accurate, updated, basic information
- Provide services according to identified needs including safety planning
- When appropriate, refer callers to further resources/ services

Source: IRC (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery

Step:	What to do:
Step 1: Greeting and assessment	Answering the call or text according to a standardised script ideally outlined in the SOPs or helpline resource pack. Introductory sentences should help establish contact with the caller in a way that is warm and welcoming. Greeting the caller with respect and in a way that conveys that the operator is ready and willing to listen in an unhurried manner helps establish a good rapport.
	Outlining the standards and limits to confidentiality
	Listening and conducting an initial assessment: collecting intake information, including understanding of the key concerns. Excellent listening skills are required to operate a VAWG helpline. An initial assessment will allow the helpline operator to assess the risks and needs of the survivor, as well as the urgency of the situation.
Step 2: Providing support and information	Providing emotional and psychosocial support: Callers might be calling during or directly after an incident of violence. They might be upset or in distress. They could be seeking information, or just wanting to talk to someone about something distressing that has affected them. Depending on the call and the needs of the caller, the helpline operator will provide remote psychosocial support or counselling, before sharing information about available services.
	Providing accurate information about the issues affecting the caller following an updated referral pathway.

Step 3: Providing services related to identified needs	Identifying referral needs, obtaining informed consent and referring callers to resources: Organisations should decide on a standardised procedure for documenting remote consent over the phone. For example, consent can be obtained orally during the conversation and specified as such in the referral form, or it can be documented otherwise in areas where internet connection is available, such as through email / skype/ or a WhatsApp conversation.
	Remote safety planning and crisis management: Activating emergency protocols and drafting safety plans in emergency/high risk situations such as when the caller is in imminent danger. This is especially relevant for survivors calling during or after an incident of intimate partner violence, or if a survivor expresses suicidal thoughts and/ or plans.
	Assisting with access to urgent services (shelter, health, police, legal) and expediting assistance to survivors. Another example is to directly connect callers to service providers such as local shelters, the police (where this is safe and relevant) etc.
Step 4: Call / chat closure	Ending the call in a supportive manner (specific scripts can also be part of the resource pack)
Step 5: After call / chat follow up	Completing paperwork as required and conducting referrals when needed. Depending on the assessed risk level and the urgency of the situation, referrals can be conducted directly or after two to three days as necessary. A follow up on the referrals might be necessary especially in emergency contexts, to ensure that the survivor is able to access the needed service.

Table 3: Key steps in helpline call-answering protocol

Data management and safety protocols

Because helplines use technology that can be monitored by perpetrators/abusers, particularly in situations of intimate partner violence, it is important to establish protocols to promote callers' safe use of the helpline, which should be communicated to the caller from the outset. These protocols should be adapted to your context, and may include a no call back policy, reminding the survivor to delete call logs/chats/SMS, and establishing a code-word/ phrase. These are further detailed in section 2.3 on data security, privacy and confidentiality.

Further guidance on operating helplines:

The GBV AoR's "COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines" sets out detailed guidance for responding to a helpline call, including do's and don'ts, communication strategies, and guidance on managing particularly challenging helpline calls such as: missed calls/disrupted calls, distressed callers, angry callers, silent calls, long calls, calls from male survivors, calls from a perpetrator, prank/hoax calls, calls that do not relate to VAWG and calls from the media/journalists.

CASE STUDY 3: ABAAD's response to emergencies in Lebanon including COVID-19 through scaling up VAWG helpline services

ABAAD - Resource Center for Gender Equality is a leading women-led CSO in the Arab States region, based in Lebanon. In March 2020, when the COVID-19 pandemic hit the country and months-long lockdowns ensued, ABAAD responded quickly by shifting its existing services into remote service provision, and scaling up the provision of pre-existing remote services such as its country-wide helpline.

Since the onset of the pandemic, ABAAD started responding to an increasingly high number of emergency calls. From January 2020 until May 11th, 2020, ABAAD received 1,198 calls to its pre-existing 24/7 helpline compared to 1,193 in all of 2019.[84] In response, the CSO developed internal case management guidelines to provide crisis phone counselling and emergency support services via phone, and in-person for high-risk cases. ABAAD used its pre-existing helpline number, which was already available 24/7, to provide these services. In parallel, a specialised team was also providing community-based awareness sessions on COVID-19 and psychosocial support sessions via conference calls and WhatsApp groups, while raising awareness on the availability of the helpline services.

The helpline services are even more relevant after movement restrictions have been lifted in the country. For example, in June, July and August 2020, ABAAD received 1,472 calls to its 24/7 helpline compared to just 342 during the same period in 2019.[85] The helpline now serves to respond to the compounded crises faced by Lebanon, in the aftermath of the Beirut port explosion in August 2020 which further exacerbated the country's socio-economic crisis and financial collapse. When survivors were not able to access services in-person due to the extreme lack of resources such as cash or fuel for transportation, the helpline allowed ABAAD to continue providing lifesaving VAWG response services through crisis case management and counselling, and linkages to safe in-person emergency support when needed.

From these experiences, ABAAD developed and published guidelines and practical tip sheets to help other CSOs in the region respond to increasing VAWG risks under COVID-19 remotely, namely:

- Remote Gender-Based Violence Case Management during emergencies, ABAAD and UNFPA Lebanon (2021): This guide aims to help caseworkers and their supervisors to provide remote, survivor-centred VAWG case management during emergencies.
- Best Practices Texting & Messaging with Survivors during COVID-19, ABAAD (2020). This short note by the Lebanese organisation, Resource Centre for Gender Equality (ABAAD), recommends best practices for CSOs using text messaging and other messaging platforms to communicate with survivors and women at risk of violence during the pandemic.

3.3 Online support groups

What are online support groups?

Support groups provide an opportunity for survivors to share personal experiences and feelings, coping strategies, or first-hand information about seeking care. The use of online support groups for survivors of violence increased during the COVID-19 pandemic. Many CSOs adapted their support groups or started new interventions to be delivered online to ensure continuum of care and to respond to the increasing violence during the pandemic.

Delivering online support groups to survivors of violence is different from in-person support groups. Facilitators of online support groups need to be familiar with using online platforms, how to moderate online support groups in a comfortable and engaging manner, and how to monitor signs of discomfort or risks. Online support groups should advise survivors about the privacy and safety risks of group participation, including how to use their device safely, briefing them on browser histories and spyware, and being thoughtful on the types of personal information shared with the group. Additionally, CSOs should use digital platforms that ensure the data protection and confidentiality of the survivors. It is not advised to use free email groups (e.g. Google Groups or Yahoo groups) as they allow third parties to scan the content, or social media pages (e.g. Facebook) which have been hacked by hostile parties.[86]

Summary: How do the essential elements apply to online support groups?

Essential element:	Specific considerations for online support groups
✓ **Updating referral pathways**	Share updated working hours and weekly capacities for online support groups Widely disseminate information on how survivors can access and register to online support groups
✓ **Coordination and partnerships**	Harmonise SOPs for using online support groups among organisations
✓ **Safety planning**	Support group facilitator shall orient participants the safety and confidentiality procedures that should be followed
✓ **Data security and privacy**	Use close encrypted digital solutions whenever possible Review and assess the current digital solutions used and mitigate potential risks
✓ **Choosing technology platform**	Put the survivor's preference and best interest at the centre of remote services. Choosing a technology platform should be guided by these principles
✓ **Staff training, supervision and care**	Invest in training the online support group facilitators on online facilitations and how to adapt their approach to online service delivery
✓ **Communicating**	Survivors should be aware of the potential risks of attending online support groups, and how they are mitigated through guiding roles and principles to ensure their protections Communicate with survivors how to logistically prepare for online support group. e.g. internet connection, mobile or computer internet, how to use the online platform

Forms of online support groups

This section will focus on four major digital solutions used by CSOs in Arab States for online support groups: **virtual safe spaces, social media platforms, mobile applications** and **real-time webchats/ videocalls**. CSOs usually use more than one digital platform to coordinate and organise online support groups. For example, social media platforms are used to offer information and orientation on services and how to access them, while mobile applications, closed social media and real-time technologies are used in delivering targeted activities and online support groups for survivors.

Virtual safe spaces: Organisations adapted their in-person safe spaces to a virtual space for women and survivors of violence by organising online social activities. This virtual space offers women and girls the opportunity to come together to access information, report incidents, seek care and access services. UNICEF and partners piloted virtual safe spaces for adolescent girls in Iraq and Lebanon to access information on VAWG and sexual and reproductive health (SRH). The pilot showed a space for expanding the scope of the virtual safe space beyond information on VAWG and SRH, to include interventions in life skills; self care and empowerment.[87]

Social media platforms: CSOs used social media platforms including Facebook, and messaging applications (e.g. WhatsApp, Facebook messenger and Viber) to reach out to survivors, share updated information on services and how to use them. Social media platforms are also used to make logistic arrangements for organising the online support groups, for example, by providing information on timings, registration methods, and how to use the online support platform.

When using social media platforms, CSOs should consider open or closed digital systems when establishing a social media platform to communicate with survivors. An open social media platform is a public information sharing channel where the public can know their members and can read their contributions or interactions, for example a Facebook page. Closed social media channels offer stronger privacy and the administrator can control who can be granted access, for example a closed Facebook group or WhatsApp group. CSOs usually use a mix of both open and closed social media platforms, where open social media channels are used for disseminating information of prevention and seeking care, and the closed social media channels are used for more targeted interventions with survivors of violence.[88]

Mobile applications: The use of mobile applications in targeting and delivering care to survivors of violence emerged and was scaled up mainly after COVID-19. Mobile applications often provide secure and easy-to-use information and services.

For All Foundation, with the support of UNDP, delivered a successful pilot of the first VAWG application in Yemen. The application aims at mapping out protection and aid services across Yemen and link women and girls to the appropriate services through the referral services. In December 2020, the application was rolled out across the country to ease access for all Yemenis requiring VAWG support.[89] Another example is the "Harassment Help" mobile application, launched by the Union for Egyptian Women, in partnership with the national authorities and several CSOs. The application aims to identify and report sexual and gender-based harassment and link survivors to legal and specialised services.

Real-time technologies: Real-time technologies refer to chatbots and videocalls (through Zoom, Skype or similar platforms) that can be used in online support groups for survivors of violence. The real-time technologies can increase access to remote services, as videos can create a more personal experience and provide visual and auditory indications for service providers to assess the survivor's frame of mind and tone. They reduce the possibility of misunderstandings. Online chats/chatbots are easy to use in contexts with limited privacy.

Etijah, a CSO based in Egypt, used Zoom calls for support groups of VAWG survivors. Their support group facilitator reviewed the registration with the case managers to ensure the group had the right participants. Then the facilitator created a password protected Zoom link that is shared only with the participants. Instructions on how to download Zoom and use it are shared with the participants through other platforms (email, Facebook groups or WhatsApp). The identity of the participants is verified by videos at the start of the call. Lastly, the facilitator of the support groups continues to observe and identify any signs of discomfort or risks among the participants.

Considerations when delivering online support groups

Delivering online support groups requires CSOs to adapt their approach to accommodate remote and online service delivery, considering on the support group format (size, duration and composition), modality, safety, confidentiality and facilitation.

Format: CSOs facilitating online support groups are advised to keep the group size at a manageable size, ideally 8-10 members. For larger groups, two facilitators or more can share the tasks in moderating the support group. Duration of the support groups are advised to be shorter than in-person support groups, to avoid group fatigue. The composition of the support groups should be discussed closely with the case managers to ensure that the participants are at an appropriate stage in their process to share and receive experiences of other survivors.

Modality: CSOs may use one or more digital solution to provide online support groups to strike a balance between reaching out to survivors and at-risk communities, and providing safe and private services. It is important to prioritise privacy, minimise data collection, and think about barriers such as whether survivors will need to download an app or create an account. Some tools as well-suited to protect privacy: ResourceConnect for web chats and texts, Gruveo for video calls, and Cyph for video calls, messaging, and groups. When choosing a tool, it is important to prioritise privacy, minimise data collection, and think about barriers such as whether survivors will need to download an app or create an account.

Safety: Facilitators should provide advice to survivors about the privacy and safety risks of group participation, including how to use their device safely, browser histories and spyware, and being thoughtful on the types of personal information shared with the group. CSOs should avoid using platforms that allow third parties to scan the content.

Confidentiality: CSOs should set criteria for protecting the confidentiality of the support group participants and to create a safe and supporting environment for the survivors to share their experiences and feelings.

Facilitation: Moderation of the online support groups should be done by a staff member to check in with survivors,

monitor what is posted on online forums, and signpost people to additional sources of support or services. Facilitators can use interactive methods, visual aids, expression tools to encourage the participants to share their experiences and put participants at ease in using digital tools. Facilitators should be trained to observe, identify and professionally manage any signs of discomfort, potential risks or conflicts for the participants. The safety and confidentiality of all the participants should be prioritised, and follow the 'do no harm' principle.

CASE STUDY 4: Lessons from PWWSD in facilitating online support groups in Palestine

The Palestinian Working Woman Society for Development (PWWSD) is a leading CSO working to respond and mitigate VAWG in Palestine. With the COVID-19 pandemic, PWWSD observed an increasing trend of violence and recognised the need to adapt their programming and services to provide online and remote services, including in remote support groups.

With the support of UN Women, PWWSD used various digital platforms to strengthen the preventive measures offered to women and girls at risk of violence and violence survivors, during the lockdown and restriction of movement. PWWSD formed over 36 WhatsApp and closed Facebook groups, where each group gathered 10 survivors to provide cognitive psychosocial support and online support group interventions to over 360 women and girls. PWWSD reached out to the community through Facebook live broadcasts to strengthen community preventive measures and psychosocial resilience by sharing information on anger management, psychological first aid, crisis management, how to spend quality time with family and important health information regarding COVID-19 prevention and treatment.[90]

The way PWWSD combined open and closed digital tools to address both VAWG prevention and response during COVID-19 had a profound positive impact on girls and women. At that critical time where little was done to prevent the silent epidemic of violence against women in Palestine, PWWSD stepped in to shed the light on the need to provide remote services along with prevention.

3.4 Specialised services

3.4.1 Health services

Survivors may need urgent health care, for example if they have recently experienced physical or sexual violence or if they are suicidal. In cases of sexual violence, it is important to be ready to refer survivors quickly due to the time-sensitive and potentially life-threatening health impacts – 72 hours for HIV post-exposure prophylaxis (PEP) and 120 hours for emergency contraception.

Access to quality, essential health services to support survivors of violence is often stretched during emergencies. Hospitals and clinics can become quickly overwhelmed with additional patients, but fewer staff. During pandemics, there may also be extra measures in place due to social distancing. The box below has a list of useful questions to consider.

Examples of questions to consider when referring survivors to health services remotely:

- Do you have the latest contact details and opening hours of health services?
- Are sexual assault forensic exams still being conducted?
- Do healthcare providers have private spaces for survivors of violence and are appropriate transmission precautions in place during any health emergencies?
- Are there different contact details for health services for children / minors?

3.4.2 Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) refers to "any form of local or external support that

protects and promotes the psychosocial well-being of individuals and/or prevents, or treats mental conditions".[91] MHPSS for VAWG survivors can thus be provided as part of different types of services – for instance, it is closely linked to case management services as these include providing emotional and psychosocial support to survivors. As such, much of the best practice in remote case management (see section 3.1 on remote case management) also apply to remote MHPSS, such as ensuring that SOPs are in place that cover call-answering procedures and measures to ensure privacy and confidentiality during remote MHPSS service provision. Some survivors may also need to be referred to specialised MHPSS services (clinical mental health care) provided by doctors, nurses or clinical psychiatrists. This includes for instance survivors who experience psychological conditions that are likely to require specialised support over a series of sessions, such as depression, anxiety and post-traumatic stress.[92]

Information needed for providing immediate referral to emergency care:

- Up to date information about specialised MHPSS services in hospitals or other emergency services with capacity to admit cases of attempted suicide or survivors at high risk of attempting suicide
- Contact information of a focal point at the hospital or other specialised service provider to facilitate the referral

Adapted from: UNFPA (date unknown) Guidelines for the provision of remote psychosocial support services for GBV survivors

If a VAWG service provider suspects that a survivor may have suicidal thoughts or they become aware or suspect that a survivor engages in self-harm, they should conduct a remote suicidality assessment (see section 2.4 on safety planning for step-by-step guidance). For example, these can be signs that a survivor may have suicidal thoughts and needs specialised MHPSS:[93]

- The survivor expresses feelings of despair and concern over an uncertain future.
- The survivor is thinking about dying or disappearing or says they cannot deal with life anymore.
- The survivor has suicidal thoughts and has thought of a plan, but has not attempted to commit suicide.
- Suicidal thoughts, self-harm behaviours, previous attempts, severe stress factors in the survivor's life, and other intense psychosocial risks.

If the suicidal assessment finds that the survivor is at high risk of attempting suicide, the survivor should be provided information about emergency care and offered referral.

Any signs of suicidal risk warrant exploring if the survivor would like to access emergency care though an immediate referral, or specialised MHPSS services for situations that do not require immediate care. Information about available options should be shared with the survivor, and if the survivor would like to access specialised MHPSS and give informed consent, the service provider can offer a referral to a specialised MHPSS service provider.

One of the challenges during COVID-19 has been to reach out to women and girls who experience, or are at risk of experiencing violence, including with information about MHPSS services. Nevertheless, there is some emerging promising practice from the Arab States region of MHPSS being provided remotely:

- **Lebanon:** The Restart Center for Rehabilitation of Victims of Violence and Torture has launched a manual on providing telepsychology. The manual includes guidance on delivering psychological interventions by pho phone and was developed for use by practitioners in the context of COVID-19.[94]
- **Libya:** Since 2019, a UNFPA hotline provides free psychosocial support services and legal consultations to survivors of VAWG, as well as provides referrals to specialised services. In 2020, over 4,090 calls were successfully responded to, providing psychosocial support to survivors of various forms of VAWG.[95]
- **Yemen:** UNFPA supports 18 toll-free hotlines for tele-counselling, established to assist survivors of VAWG and provide information on COVID-19 prevention. The hotlines offer one-off as well as repeated counselling sessions by specialist counsellors.[96] [97]

In locations where formal MHPSS services are not available, service providers should identify other potential sources of care, which may include families, social groups, women's groups and safe spaces, community leaders, religious leaders, and traditional healers, and seek to understand what psychosocial support these actors may already be providing in their communities. In the absence of formal MHPSS services, service providers should explore collaborating with other actors that play roles in providing community-based MHPSS.[98] [99]

Further guidance on remote MHPSS:

A comprehensive guidance developed by UNFPA Country Offices and the Regional Offices in Latin America and the Caribbean provides practical guidance for the provision of remote MHPSS services for VAWG survivors in the COVID-19 context, which can be adapted for different types of remote services including psychological first-aid and psychosocial support helpline. For example, the document includes:

- Remote psychosocial support tools with detailed guidance of how to use these over phone, text or email (e.g. relaxation techniques, problem solving and decision-making, emotional regulation, and coping strategies)
- Step-by-step preparation for provision of remote support
- Considerations when communicating remotely with survivors
- Protocols adapted for remote use (e.g. informed consent, suicidal behaviour management, communication scripts, personal self-care assessment and plan, and annexes with all remote tools)
- Good practice for support of staff delivering remote services

The IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic is another useful resource that offers guidance on how to adapt psychological support services to the COVID-19 context, which can be used by VAWG service providers.

3.4.3 Justice sector services/ legal support

Access to justice is both a basic human right and a way to protect VAWG survivors from further violence. During emergencies, such as the COVID-19 pandemic, formal legal and justice services have been very limited. For example, women in Lebanon reportedly struggled to access justice during lockdown periods, with court services closed or operating at reduced capacity.[100]

There are multiple sources of legal and justice services in the region, both formal and informal, although this guidance focuses on formal systems:

- Formal legal and justice systems usually centre around the court system with law enforcement agencies such as police, prosecutors and the judiciary playing key roles.
- Informal legal and justice systems consist of customary, religious and indigenous rules and practices. It includes traditional and religious leaders and restorative justice. Mediation can be dangerous in cases of intimate partner violence or sexual violence and is therefore not recommended.[101]

Examples of questions to consider when referring survivors to police and legal services remotely

Do you have the latest contact details and opening hours of police and legal services?

- Are police able to respond to cases of violence?
- Are judges issuing protection orders for domestic cases, either in court or remotely (e.g. by email)?
- Can police enforce court orders during this time?
- What are the mandatory reporting requirements?

Based on information from Legal Action Worldwide and Norwegian Church Aid (2020) Five Key Guidelines for Providing Remote Legal Aid to GBV Survivors.

Box 17 outlines special considerations when providing remote access to formal justice and legal services, including referring survivors to police and legal services (see section 2.1 on updating referral pathways).

Some organisations have adapted their services during the COVID-19 pandemic to provide remote legal support to survivors, e.g. by email, text messages or over phone/video calls. Digital and remote tools can help increase

survivors' access to justice by faster case processing through reductions in travel time and costs, user-friendly and convenience, and faster case processing. There is also potential for video-conferencing technology to be less traumatising for survivors who can testify remotely in a safe, secure environment away from the physical presence of the defendant.[102]

However, remote legal solutions have inherent ethical risks which require careful attention to ensure they are confidential, private and secure. For example, perpetrators of violence could access survivors' private messages or pretend to be the survivor, which poses risks to the safety of the survivor and their children. There are also risks of digital exclusion and it may be necessary to put in place measures to provide 'assisted' applications to guide survivors through the process.[103]

BOX 17: How to provide remote legal support for survivors?

Confirming the identity of the survivor: If it is not possible to obtain original identifying documents in-person, options include the survivor holding up a photograph ID by their face and sending via WhatsApp, Signal or SMS, or a video call (if safe). If the survivor does not have official ID, a photograph of any identifying document is an alternative, or a trusted intermediary can confirm the survivor's identity.

Obtaining informed consent and Power of Attorney, either verbally through a secure messenger service such as Signal or an audio file. If the survivor does not have access to a phone, a trusted intermediary can use their phone to contact the lawyer and record themselves reading the consent form to the survivor and confirming the consent to each element.

Storage of case files: Legal aid providers working from home should follow all internal policies on data security and privacy. Rather than transporting physical documents, important survivor files can be photographed and stored on a secure database.

Conducting remote interviews with survivors is possible but requires assessing whether it is safe for the survivor to do so. Survivors should be offered psycho-social support both before and after the interview. If possible, the interview should be recorded to reduce the potential re-traumatisation of the survivor repeating the testimony again later.

Adapted from Legal Action Worldwide and Norwegian Church Aid (2020) Five Key Guidelines for Providing Remote Legal Aid to GBV Survivors.

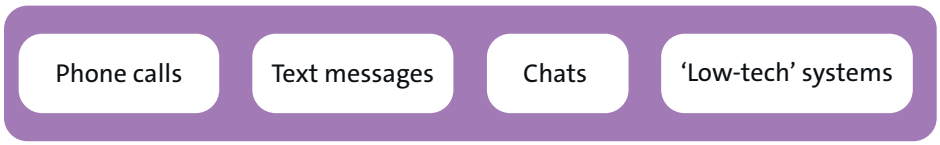
3.4.4 Livelihood support

During emergencies, women may be at higher risk of violence due to the financial strain on households and job losses.[104] Many organisations provide emergency relief, such as dignity and hygiene kits and cash for essential food and medicine. Others refer survivors to welfare, social services and income assistance. Livelihood support is important for financial independence – women are less likely to leave abusive relationships and more likely to return to it when they are financially dependent on their partners.

Organisations can also offer remote support to survivors who have experienced economic abuse, leaving them with no money of their own or even in debt. Research in Jordan found that 38% of women experience economic abuse, and in most cases it is closely associated with other forms of intimate partner violence.[105] For women who have experienced economic abuse, it is useful to provide advice on available welfare benefits or cash assistance, as well as financial skills such as how to develop a budget, safely open a bank account, and advice for dealing with debt.

Some organisations offer economic empowerment programmes to survivors to help them get back on their feet again. During emergencies, these programmes can be re-designed to provide women and girls with a source of income, for example training them in the production of masks and reusable sanitary pads during COVID-19.[106] Where participants have access to the internet, it may be possible to move to remote programming through virtual safe spaces for women and girls (see section 3.3 online support groups).

PART FOUR: Modalities of delivery



Summary of chapter

This section provides guidance on how CSOs can select the most appropriate modality for remote VAWG service delivery. It explores the pros and cons of four main modes of delivery: phone calls, text messages, chats, and low-tech systems.

Phone calls is a cost-efficient modality for both service providers and survivors and can be used to deliver a range of services. However, phone calls requires that survivors have access to a private space and a safe device to prevent the risk of the survivor being interrupted, monitored or overheard when they are speaking.

Text messages can be used to communicate with survivors and groups at risk of violence, as well as with the wider community. It is an efficient way to reach a wide audience, for example by delivering one-way messages with information about VAWG and how to access services. It can also be used to interact between the service provider and survivor/ person at risk of violence. Text messages are sometimes used as a way of communicating in case management, especially if there are privacy and security concerns for making phone calls. However, there are also safety and confidentiality concerns with text messages that need to be considered.

Chats are an efficient modality to respond to inquiries from survivors or individuals at risk of violence, such as how to access different types of support. Common chat solutions include real-time chats hosted by a website or a mobile application, where a specialised service provider or case manager respond to inquiries or immediate needs of survivors.

Low-tech systems do not rely on digital technology and infrastructure to deliver services to survivors. These are particularly useful in communities with limited access to mobile phones and other devices, weak internet connection, unreliable electricity, and other infrastructure challenges. Low-tech solutions can include investing in strengthening community pathways to support survivors and training non-VAWG service providers in identifying survivors and providing safe referrals to VAWG services.

When designing remote services to survivors of violence, selecting an appropriate modality to deliver is an important area of discussion. When choosing a modality, it is important to consider the purpose of the service (service delivery vs. prevention), the survivor's preferred modality and ability to access it, whether the modality could put survivors at risk, and the CSO's operational capacity. including the number of staff, financial resources and capacity to use different modalities. See also section 2.5 on choosing technology platforms.

Four major modalities of service delivery have emerged in the Arab States region when delivering remote services: phone calls, text messages, and chats.

Exercise 11 in the Training Manual on modalities of delivery aims to help participants to identify and decide on the most appropriate modality to deliver remote VAWG services

4.1 Phone calls

Phone calls appears to be the most common modality reported by CSOs when delivering remote VAWG services in the Arab States region. As a modality of service delivery, phone calls are usually linked to a helpline that receives the case report and links the survivor with a case manager that works with the survivor to design a plan of interventions as explained in section 3.1 on case management. Phone calls are also used by various CSOs to deliver psychosocial support, provide legal assistance, link to referral services and to follow up the progress of the survivor.

Phone calls are a cost-efficient modality for delivering remote services. Calls can be used by small-scale organisations with limited resources and number of staff members, but also as part of large-scale national response to violence against women, for example a system of toll-free telephone helplines were established that were linked to the court system in Morocco.[107] For survivors, phone calls are easy to use, usually affordable and do not require logistic arrangements, connecting to the internet or special gadgets. Additionally, illiterate survivors can usually use mobile phones for communication and seeking care.

There are a couple of good examples for implementation of telephone helplines in fragile contexts, for example, over 18 CSOs in Yemen developed operational helplines as an alternative to in-person services at the start of the COVID-19 pandemic.[108]

Despite being an efficient modality to deliver remote services, mobile phones are not the solution of choice in contexts with limited privacy or confidentiality where the survivor does not have a private space to speak freely, without the risk or fear of being heard or seen. Additionally, mobile phones that are shared by more than one family member might put the survivor at risk if their abuser discovering the reporting of violence.

Adapting to remote service delivery through phone calls requires a set of procedures, for example:

- Notifying the survivors about the change of service delivery modality and explaining how the change of modality may affect the way they receive the services.
- Discussing with the survivor whether phone calls are suitable for their conditions, and agreeing any preferred times and dates. Scenarios for calls picked up by anyone other than the survivors, or sudden call cut should be discussed and agreed actions should be developed. Safety measure that the survivor is recommended to follow shall be shared, e.g. deleting the call history (see section 2.3 on data security, privacy and confidentiality).
- Developing a phone call script and SOPs to receive calls from survivors.
- Training and developing the capacity of case managers and staff to provide services and support through phone calls.
- Providing the right devices and equipment to the team members (e.g. phones, SIM cards and solar chargers where there are frequent power cuts) – staff members should not use their personal phones for phone calls with survivors.

There is increasing evidence and lessons learnt from using phone calls in delivering remote services emerging from the Arab States region. For example, ABAAD offers a set of good practices for phone call communications when delivering care for girls and women in Lebanon.[109]

Exercise 12 in the Training Manual aims to strengthen the capacity of caseworkers, helpline operators or social workers to engage with survivors over the phone.

4.2 Text messages

Text messages are an efficient way to communicate with the community, survivors and population at risk of violence. The use of text messages increased dramatically during COVID-19 to deliver remote services and preventive interventions in the Arab States region. Text messages can be used to disseminate one-way messages, for example information on VAWG or how to access services, or as an interactive two-way messaging with survivors and communities at risk. Text messages can be in the form of SMS or application-based text messages (e.g. WhatsApp, Viber, Telegram).

Text message modality is an efficient way to reach a wide audience when disseminating awareness raising and sensitisation messages on VAWG. They can reach a big number of mobile users, at a relatively efficient cost. SMS text messages are usually short and summarise key messages in concise, simple language. Application-based text messages offer a space to have two-way communication with the case manager or service provider, particularly when the survivor has limited space for privacy to make a phone call or to go to an in-person service.

Acknowledging its limitation, text messages offer a restricted space for interaction and expression by survivors, where their verbal expressions are not shared with the service provider. Additionally, survivors with limited or modest literacy skills may not be able to access this service. When delivering remote services in multi-lingual communities, using text messages in different languages can be challenging, especially when the community is not adequately profiled. Similar to phone calls, potential risks to the survivor safety and security should be considered when using text messages in communication with survivors. Service providers should ensure that no-one has access to the survivor's phone and it is not shared with others (see section 2.3 on data security, privacy and confidentiality).

Many CSOs in the Arab States region used text messages to deliver messages on prevention to their communities and provide services to survivors. Based on their experiences of using text messages in Lebanon, ABAAD recommends a set of good practices, including:[110]

- Exploring with the survivor the best modality of service delivery, highlighting the advantage and limitation of each modality
- Discussing safety planning and practices with the survivor to strengthen their privacy, for example deleting message history and not saving contact details of the service provider
- Safely storing the survivor's number and details, including not saving the survivor's full name on the service provider's phone and deleting all voice notes – staff should not use private phones for this.

4.3 Chats

Women-led CSOs and national authorities are increasingly using chat digital solutions to facilitate remote service delivery and prevention services of violence. Chat solutions include real time chat hosted by a website, or a mobile application, where a specialised service provider or case manager is responding to the inquiries or the needs of the survivor immediately. Also, chat solutions include artificial intelligence chatbots that are programmed in a way to track key words of the inquiry and provide information according to these key words. In cases where automatic chat services such as chat bots are used, service providers may need to highlight specific words or hints that indicate that the survivor is at high risk and that would automatically activate emergency protocols, such as asking the survivor via the chat if they would like to immediately get in contact with a service provider.

Chats can be an efficient way to address inquiries from survivors on how to access care, or for the communities or the population at risk to seek information on VAWG. For example, the Supreme Council for Women in Bahrain, developed a programme that uses live chat to provide legal and family advice. When delivered in an automated way, it decreases the reliance on human resources in providing information and contributes to the reduction of operational costs of delivering care to survivors of violence.

Some CSOs in the Arab States region are using innovative remote services such as 24/7 chat-based services. However, it should be noted that there are challenges associated with the large digital divide in most communities, which is gendered.

4.4 Low-tech systems

Communities with limited access to mobile phones, weak internet connection, infrastructure and electricity challenges, or low levels of literacy may face challenges accessing services, and the needs of these communities are often overlooked. Therefore, CSOs may consider alternatives to mobile and digital solutions when designing remote service delivery for survivors of violence. There are global emerging good practices in delivering low-tech solutions. In Nigeria, CSOs worked to adapt physical safe spaces into phone booth stations where survivors can call caseworkers at set times in private phone booths, taking into consideration COVID-19 hygiene measures.[111] Several high-income countries with strong national social protection mechanisms have good experiences with creating a codeword scheme for survivors to signal their need for help in pharmacies and supermarkets.

In the Arab States region, there is limited but growing evidence of approaches to provide remote assistance in low-tech settings. These include working through community-based committees and volunteers; frontline workers in health care centres; and community radios.

Community committees and volunteers: Investing in strengthening community-based approaches can be particularly important where there is limited access to electricity, internet and mobile phones. In such settings, many CSOs works through community committees to provide referrals, legal aid, counselling interventions and other essential services to VAWG survivors. This has proved to be a promising approach in Sudan, where CSOs created a 24/7 community-based referral mechanism during the COVID-19 lockdown. A selection of community leaders and volunteers were offered mobile phones to link survivors to immediate care.[112] Another example comes from Iraq, where during the first year of the COVID-19 pandemic, community-based protection teams were able to reach areas where there is no electricity/internet service (e.g. in camps for Iranian and Shabak refugees in central and southern Iraq). They played an important role in strengthening referral pathways and reaching women and girls at a time when the UN and NGOs were unable to be present in these locations.[15]

Training frontline workers in health clinics: Examining alternative entry points to identify, reach and provide services for survivors of violence is another approach used in Jordan. The Jordan River Foundation has trained frontline workers in health clinics to provide safe referrals to VAWG services for communities with limited access to tech-based solutions and the national referral pathway.[113]

Community radios: The wide possession of radios across most communities in low-tech settings makes using community radios a viable option to disseminate messages and information campaigns on response and prevention of violence. There are a couple of successful previous interventions in using community radios in the Arab States region, for example, community radios in Jordan and Morocco disseminated messages on prevention of violence during the 16 Days of Activism to combat violence against women.[114]

CASE STUDY 5: The use of community radio in Libya

UN Women and women-led CSOs have used community radio to reach out to women and girls with messages on VAWG, women's health and accessing services. This is particularly effective to reach women and girls in low-technology settings, and using stories is recognised as a powerful tool to engage women and girls' listeners. In the early stages of the COVID-19 response, UN Women engaged with a core network of radio stations across the country to produce COVID-19, VAWG and women's health (physical and psycho- social) related stories to be shared over the radio.[115]

Women-led CSOs were seen to use radio to communicate messages more frequently during the 2020 16 Days of Activism against Gender-based Violence. The campaign in Libya focused on the impact of COVID-19, highlighting the increased risk of VAWG, and calling for action to promote the rights of women and girls. Women-led CSOs led the development and dissemination of key messages for the campaign, including through participating in radio programmes.[116] The campaign was supported by UNFPA and the Ministry of Social Affairs who marked the start of the campaign on the International Day for the Elimination of Violence against Women, and supported CSOs to disseminate the messages on VAWG.[117]

15 Information shared during the consultations with women-led CSO in November 2021 to discuss and review the toolkit.

IN FOCUS

Supporting survivors of online violence

Supporting survivors of online violence

What is online violence against women?

The rise of the use of the internet and other information and communications technologies (ICTs) has led to the emergence of many new online forms of VAWG. These newer forms of violence are part of the continuum of gender-based violence that women and girls face throughout their lives and are rooted in the same systems of patriarchy, oppression and gender inequality as offline violence.

How is online violence defined? Online violence against women is a form of discrimination and human rights violation. It should be viewed in the context of international and regional frameworks and commitments to end violence against women. Whilst the rapid pace of the development of new technologies has made international definitions of online violence difficult, the UN Special Rapporteur on violence against women, its causes and consequences, 2018, has said:

"Online violence against women therefore extends to any act of gender-based violence against women that is committed, assisted or aggravated in part or fully by the use of ICT, such as mobile phones and smartphones, the internet, social media platforms or email, against a woman because she is a woman, or affects women disproportionately."[118]

What does it look like? Online violence includes, but is not limited to, digital threats of death and violence, non-consensual sharing of intimate images and videos,16 cyberstalking, harassment, hate speech, cyber bullying, sextortion, publication of private information (including doxing), and electronically enabled trafficking. These are used as tactics by perpetrators to subordinate women.

Who is at risk? All women who have access to the internet and ICTs are at risk of online violence. However, those who experience multiple and intersecting discriminations, for example Black women and LGBTQI+ people, and women in public life, including women journalists, human rights defenders and politicians, are often at increased risk. Whilst this toolkit does not provide specific guidance on supporting girls under the age of 18, they can also be at increased risk of online violence due to high levels of social media usage in some contexts.

What are the impacts on women? The impacts of online violence are long-lasting and have a profound psychological effect on women due to the difficulties faced in removing harmful content and the potential for re-victimisation with sharing of harmful content. Self-censorship is common as women are often left with little or no recourse to justice. Online violence against women also has broader social and economic impacts on survivors and their families.

How does it relate to offline violence and other human rights? Online violence is often an extension of in-person or offline forms of violence, for example technology can facilitate intimate partner violence. It also negatively impacts the enjoyment of other human rights, including the right to privacy, freedom of expression and to have access to information shared through ICTs.

How is online violence against women different to offline violence?

The key GBV Guiding Principles – ensuring the safety of VAWG survivors, ensuring confidentiality, respecting the survivor, and practicing non-discrimination – are applicable to all survivors of violence, both offline and online violence. Whilst all forms of online violence are part of the continuum of violence against women, and are often an extension of offline violence, there are several important aspects which differentiate online and offline forms of violence. In supporting survivors of online violence, it is important to be aware of these differences as these affect the impact on the survivor and the support needed to be able to respond swiftly and effectively.

16 This is also known as image-based abuse and image-based sexual abuse (IBSA). It is also known as revenge porn. Many feminists reject the term 'revenge porn' because 'revenge' reinforces survivor blaming as it suggests initial wrongdoing on behalf of the woman, and the term 'porn' as it conflates images meant for private consumption with public content. See https://www.genderit.org/articles/5-important-reasons-why-we-should-not-call-it-revenge-porn

BOX 18: How is online violence different to other forms of violence offline?

- Online spaces can amplify the reach of transmission and harm to survivors.
- Online violence can be carried out at increased distance, speed and rates.
- Online violence can be easily perpetrated using low-cost technology, limited skill, time and effort.
- Anonymity and encryption can protect perpetrators from being known to survivors and authorities.
- Online violence is commonly perpetrated in public spaces, amplifying the impacts and harms.
- As well as primary perpetrators there can also be a large number of secondary perpetrators when people download, forward and share harmful content.
- There are often delays and difficulties in removing harmful content and content may remain available for a long time and in some cases indefinitely.

Adapted from: Aziz (2017) Due Diligence and Accountability for Online Violence against Women; GBVAoR Helpdesk (2021) Learning Series on Technology-Facilitated Gender Based Violence.

Women are more likely to experience online violence and to have more serious consequences compared to men and boys,[119] and experience long-term mental and psychosocial impacts linked to the public nature of the abuse, including anxiety, depression and suicide.[120]

Despite the growing prevalence of online violence, many VAWG service providers and wider civil society have limited understanding, knowledge and experience of the issue, how it manifests, its impact on survivors and how to respond effectively. The box below sets out promising strategies that will be useful for CSOs wanting to provide support services to women survivors of online violence, including services provided remotely. There may be significant potential in providing remote support to survivors of online violence, in terms of being able to offer them immediate support in the online spaces that they frequent and to address the severe psychological impacts they experience.

BOX 19: Promising strategies for preventing and responding to online violence, remotely and in-person

- Build staff and organisational capacity to better understand online violence, its impact on survivors and how to respond. This will enable organisations to respond and/or refer quickly and effectively to address psychological and physical safety threats survivors may face. This may include building technological capability within the organisation and partnering with technology or digital rights organisations to help provide technical support for the service and survivor. See for example, the Feminist Tech eXchange: Safety Reboot training curriculum for trainers who work with women's rights and sexual rights activists on internet safety.
- Share information about online violence, what it is, how to report and what support is available. This will help raise awareness to survivors on how to safely and confidentially report abuse and access support. Remote support through phone-base helplines or online may be particularly helpful for sharing information and providing support, so that survivors can access information and services anonymously.
- Provide direct support to survivors to remove abusive content and prevent further abuse. This may involve providing support and training on digital citizenship[17], helping survivors report to the online/social media platform, working directly with social media platforms on a survivor's behalf to request content is removed, or working with experts to remove the content.

17 Digital Citizenship refers to the ability to engage positively, critically and competently in the digital environment, drawing on the skills of effective communication and creation, to practice forms of social participation that are respectful of human rights and dignity through the responsible use of technology

- Case management: Integrate online violence into case management protocols and practice, including in safety assessments and safety planning processes.
- Referral pathways: Integrate relevant services that can support survivors of online violence into referral pathways and ensure new partnerships are included in updated pathways.
- Develop relationships with organisations that have the capacity to provide digital support to survivors (for example, on digital safety, digital citizenship and how to remove harmful content) and include these in referral pathways.
- Create virtual safe spaces and peer groups where women can get together anonymously to share their experiences and seek support (see section 3.3 online support groups).
- Build the capacity of other service providers, the police and judiciary to develop a survivor centred response to online violence.

Adapted from: GBVAoR Helpdesk (2021) Learning Series on Technology-Facilitated Gender Based Violence.

Exercise 13 in the Training Manual is designed to support participants to understand online violence against women and what women-led CSOs can do to support survivors of online violence through remote service provision.

Staff providing remote VAWG services can be at increased risk of online violence and abuse as helpline numbers are publicly available. In addition, there have been instances where staff members' phone numbers have been published to promote the service and they have been targeted for abuse. Organisations should carefully consider whether it is safe to publish work phone numbers of individual staff members and, where this is unavoidable, ensure that appropriate measures are put in place to mitigate the risks of their staff being abused, and ensure swift support is provided in cases where they are abused online.

RESOURCES

Referral pathways and service mapping

- The IRC's Guidelines for Mobile and Remote GBV Service Delivery sets out steps for conducting a service mapping for referrals for remote GBV responses (IRC, 2018). It includes assessing whether service providers can receive phone-based referrals, if survivors can contact them via phone, and during what hours. IRC recommends using this Service Mapping Tool.
- UNFPA's Guidelines for the Provision of Remote Psychosocial Support Services for GBV Survivors provides guidance on how to carry out a GBV service mapping during the COVID-19 outbreak. The resource includes a service mapping template and a checklist for the exercise.

Data security, confidentiality and privacy

- ABAAD (date unknown) Best Practices: Texting and Messaging with Survivors during COVID-19, https://www.abaadmena.org/documents/ebook.1586444727.pdf
- National Network to End Domestic Violence (2019) Technology Safety: Best Practice Principles for Digital Services, https://www.techsafety.org/best-practice-principles

Safety planning

- GBV AoR (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines, https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf
- UNFPA (2019) The Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming, https://www.unfpa.org/minimum-standards
- Specific safety planning guidance, tool and templates can be found at IRC's GBV Responders Network: https://gbvresponders.org/response/gbv-case-management/

Technology platforms

- National Network to End Domestic Violence (2019) Choosing a Digital Services Platform, https://www.techsafety.org/choosing-a-platform
- National Network to End Domestic Violence (2019) Assessing Readiness for Digital Services, https://www.techsafety.org/assessing-readiness-for-digital-services#privacy-risks-ds

Staff training and care

- Raising Voices in Uganda How Can we Amplify Self and Collective Care?
- The GBV Prevention Network and Just Associate's Self and Collective Care
- CREA's Self-Care and Self-Defense Manual for Feminist Activists
- FRIDA's Self Care Plan

Communicating with people with disabilities

- Women's Refugee Commission and IRC's Building Capacity for Disability Inclusion in GBV Programming in Humanitarian Settings: A Toolkit for GBV Practitioners
- The Convention on the Rights of Persons with Disabilities (CRPD) is translated into many languages and can be a useful guide to using terms about disability that are both sensitive and appropriate. The full CRPD, translations, and easy read versions of the convention can be found here.

Helplines

- The GBV AoR's "COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines" sets out detailed guidance for responding to a helpline call, including do's and don'ts, communication strategies, and guidance on managing particularly challenging helpline calls such as: missed calls/disrupted calls, distressed callers, angry callers, silent calls, long calls, calls from male survivors, calls from a perpetrator, prank/hoax calls, calls that do not relate to GBV and calls from the media/journalists.
- UNICEF (2020) Not just hotlines and mobile phones: GBV Service provision during COVID-19
- Stratten, K. and Ainslie, R. (2003) Setting Up a Hotline/Helpline: Field Guide; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs Online support groups

Mental Health and Psychosocial Support

- A comprehensive guidance developed by UNFPA Country Offices and the Regional Offices in Latin America and the Caribbean provides practical guidance for the provision of remote MHPSS services for survivors in the COVID-19 context, which can be adapted for different types of remote services including psychological first-aid and psychosocial support hotlines.
- The IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic is another useful resource that offers guidance on how to adapt psychological support services to the COVID-19 context, which can be used by VAWG service providers.

Justice sector

- Legal Action Worldwide and Norwegian Church Aid (2020) Five Key Guidelines for Providing Remote Legal Aid to GBV Survivors.

Online violence against women

- Feminist Tech eXchange: Safety Reboot training curriculum for trainers who work with women's rights and sexual rights activists to use the internet safely, creatively and strategically. The training includes a module on online VAWG, as well as on creating safe online spaces, mobile safety, the Feminist Principles of the Internet, and risk assessments.

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