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

Purpose

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

Background

History has demonstrated that crises such as disease outbreaks affect women and girls differently to men and boys, and in ways that place women and girls at greater risk of GBV, particularly in contexts where gender inequality is already pronounced. They can include increased exposure to intimate partner violence due to tensions in the home in the face of dwindling family resources and under confinement conditions, while the economic impact can place women and girls at higher risk of sexual violence and exploitation[2]. Women's rights organizations, researchers, and service providers across the globe are already reporting increases in GBV incidents reported to them since the COVID-19 outbreak, including in countries most directly affected[3]. It is clear, however, that most cases of GBV will remain unreported due to the lack of available, safe, ethical and quality responses services as well as fears of stigmatization, reprisal, and lack of access to appropriate information on seeking help. These existing barriers will be further compounded by the inundation of health services responding to the Covid-19 outbreak, and restrictions to movement and physical socialization resulting from national government responses to contain and control the spread of COVID-19. Ensuring that women and girls can access GBV support services remains a critical and lifesaving activity. At the same time, maintaining the health and wellbeing of GBV caseworkers and contributing to rigorous efforts to stop the pandemic are of critical concern, a present a challenge to traditional modes of GBV service delivery. A flexible and adaptive approach is needed to ensure that life-saving services continue to be made available without compromising the safety of GBV caseworkers or survivors[4].

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

COVID-19 is an airborne and respiratory virus, and although the virus has a much lower mortality rate than Ebola, for example, it is in fact, more contagious[5], harder to detect and many carriers of the virus are asymptomatic[6]. The way in which the virus is transmitted, its level of potency in a country at a particular time, the stark differences and exponential changes in national government responses - all demand a higher level of flexibility, and a more layered approach to GBV case management service delivery than in past epidemics.

Decisions about whether to continue static, face-to-face case management services, scale down, or dramatically change in favor of other modalities such as remote case management, will depend on a number of factors including:

- **The strategy of national response to the coronavirus, i.e. containment, delay or mitigation**. Each carries various levels of risks and restrictions that make some modes of service delivery more possible than others.
- **Resources (including donor flexibility)** for the service provider to maintain stringent IPC[7] standards at all stages of the pandemic, and in preparation for more advanced stages.
- **National government guidance and policies** that affect freedom of movement, ease of obtaining official permissions including formal exceptions which are required to operate static services in the event of national lockdown.
- **Risks and *perceived* risks for staff and others**: It is critical to weigh actual risks not only to the health of staff, but to the health of others whom may be exposed by the delivery of services, including movement to and from. In addition, *perceived* risks also affect staff and clients.
- **Location of static services:** GBV case management services situated within official clinical settings are more likely to be able to provide static, face-to-face services for the duration of the pandemic.
- **Organizational policies:** Each service provider interprets government guidance and policies in a more or less flexible manner, which can influence service provision.

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

The below diagram and checklist are based on and designed to complement the *GBV Area of responsibility (AoR) Research Query on GBV Case Management and the COVID-19 Pandemic*[8]. The *Research Query*

[5] Zhanwei Du, Xiaoke Xu, Ye Wu, Lin Wang, Benjamin J. Cowling, Lauren Ancel Meyers. Serial Interval of COVID-19 from Publicly Reported Confirmed Cases. *Emerging Infectious Diseases*, April 2020
[6] Infection Control Today, Asymptomatic carriers of COVID-19 Make it Tough to Target. Accessed 18/3/2020
[7] Infection, Prevention and Control.
[8] http://www.sddirect.org.uk/media/1882/guidance-on-gbv-case-management-in-the-face-of-covid-19-outbreak-final-draft.pdf

provides a more detailed layout of Covid-19 national strategies to respond to the spread of the virus, and its implications for GBV service providers and GBV case management service provision.

The below diagram represents the **different models for case management service provision** that can be considered based on scenarios for the Covid-19 pandemic and their possible impact on service provision. These are based on current national responses to Covid-19, which can be roughly classified into three strategies: containment, delay, and mitigation[9]. Full description of each strategy can be found in GBV AoR Helpdesk note "GBV Case Management and the Covid-19 pandemic". In quick summary:

- Containment strategies enable public life to be minimally affected and as such, static face-to-face GBV case management services can largely continue.
- Delay and Mitigation/suppression strategies see tougher restriction on movement and assembly, making face-to-face case management challenging without high-level official permissions and adequate resources for protective equipment for caseworkers.

The four models are based on how programs are likely to adapt service provision based on the different national strategies outlined above. These include: (1) continuation of face-face static service provision, (2) shift to remote service provision, (3) shut down of services and (4) sudden lockdown that requires immediate adaptation of service provision.

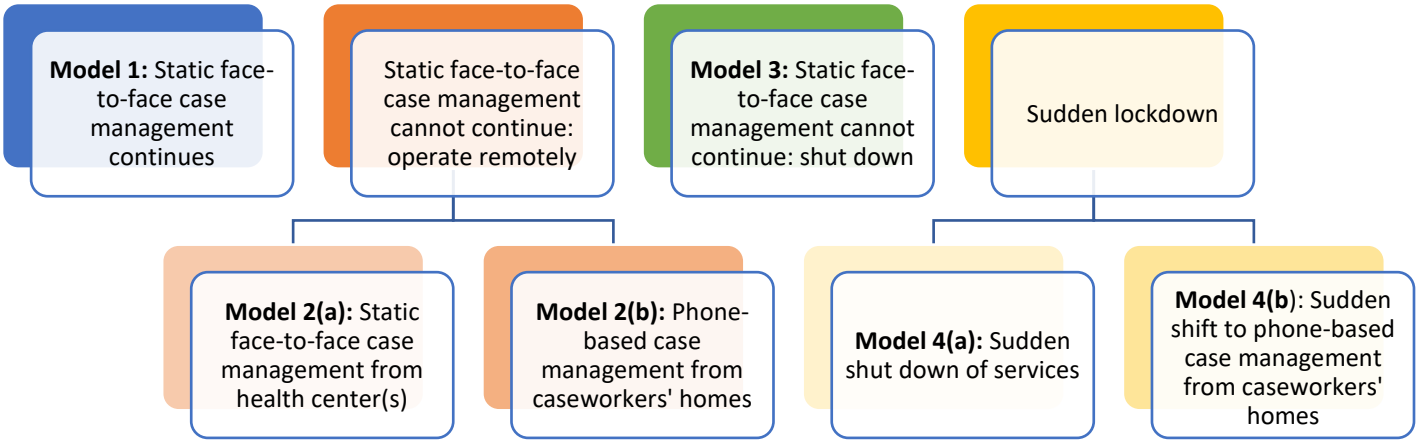

Figure 1 Suggested models of GBV case management according to national response strategies to Covid-19

Organizations will need to prepare; in the context of Covid-19 the shift from one modality to the other is quite rapid. Organizations need, therefore, to have a plan in place to rapidly adjust.

The below checklist highlights considerations to include in GBV response programming based on the different models highlighted above. Items in red are directed towards service providers as well as GBV Sub-Sector/Sub-cluster coordinators for inter-agency response[10]. Organizations need to have a plan in place to rapidly adjust to these changes in their programmes.

[9] Lancet, COVID-19: delay, mitigate, and communicate, March 2020

[10] If models 1, 2(a), 2(b) and 4(b) are not applicable or not safe for survivors and case workers, organizations will have to consider moving to suspension of services (or reduction of services focused on case closure) – models 3 or 4(a).

Models	Prerequisites[11]	Recommended actions
Model 1: Static face-to-face case management continues	• Social/physical distancing measures can be implemented in the center to ensure safety of staff and survivors. • IPC[12] procedures can be implemented in the center.	• Update referral pathways with a focus on health facilities and medical service providers as these are most likely to remain open even during mitigation or lockdown. Inform key communities and service providers about the updated pathways. • Set up or identify existing hotlines in preparation for possible interruption of service provision [13] • Prepare for shifting to phone-based case management (Check: are caseworkers prepared to handle GBV disclosure? Do they have up-to-date referral pathways? Is there an induction plan for newly recruited caseworkers that includes GBV emergency case management and basic concepts?) • Put a plan in place, if possible, shifting to remote, phone-based coaching and technical support for non-GBV staff in medical facilities when the shift is being considered depending on the evolving situation (Conditions to provide services in health centers: check safety of medical and casework staff and survivors, availability of female case workers, confidentiality of data in health center, etc.) • Identify GBV staff or focal points working within operating medical facilities who can provide survivors with crisis counseling and a more specialized response. • In preparation to shift to phone-based case management, procure mobile phones and credit (including data bundle) for GBV caseworkers / supervisors, and if needed also procure charging devices for use in settings with poor/unreliable power.

[11] If these conditions are not there, programs should consider shutting down and resorting to functioning services for referrals based on the 'do no harm' principle.
[12] Infection, Prevention and Control.
[13] GBV AoR, Guidance note on remote service mapping.

		• Draft / update an internal organizational communication tree to ensure support for caseworkers in the interests of duty of care. • Caseworkers discuss the changing climate and contingency plans with survivors. • Caseworkers review safety plans with survivors in case of a lockdown, especially those living with their abusers, considering the risks to shifting to phone-based case management. • Discuss safe storage for existing paper files in the static women's center in case of lockdown and data storage protocols for remote GBV Case Management • Collect phone numbers of survivors and store them with the consent form, separately from the case files. • Obtain informed consent of survivors to potentially shift to phone-based case management. • Inform communities on the availability of safe and confidential phone-based services and on the modalities to access this support so that survivors wishing to access care for the first time are able to access services if they are shifted to phone-based.
Model 2(a): Static face-to-face case management from health center(s)	• A confidential and safe space is available in the health center to provide GBV case management services. • Caseworkers are already or can be deployed in health facilities. • Social/physical distancing can be implemented in the health facility to ensure safety of staff and survivors. • IPC procedures can be implemented in the center.	• Train receptionist and medical staff on how to deal with GBV survivors (e.g. GBV basic concepts, confidentiality, a survivor-centered approach, and GBV guiding principles; referral to services that would still be functional such as helplines, etc.) • Disseminate information on availability of service provision and referral pathways in health centers through SMS, WhatsApp or other communication means.

	• Locked cabinets are available in the case management room in order to store consent forms and case files separately. • At least one female caseworker is available to provide case management services.	
Model 2(b): Phone-based case management from caseworkers' homes	• Caseworkers feel safe and comfortable offering case management services from their homes and over the phone. • Caseworkers have a private and confidential space available in their homes to speak to survivors over the phone. • Living conditions of caseworkers have been assessed by supervisors as being safe and confidential to conduct phone-based case management. • Caseworkers have obtained informed consent from survivors to conduct phone-based case management. • Caseworkers have assessed with survivors that they feel safe being contacted by phone for case management services based on their living conditions (e.g. live with an abusive partner, space to isolate to speak confidentially, working hours, etc.)	• Caseworkers store survivors phone numbers using survivors' codes. Phone numbers connected to survivors' codes can be saved in office or personal phones. Separate information on survivors' codes related to survivors' names & other identifying information should be stored in a paper in a locked cabinet/drawer or in password protected electronic form on desktop. • Caseworkers can store survivors' case files in digital case management tool (e.g. Primero/GBVIMS+). **Alternatively, no information related to a survivor's case should be documented in writing to ensure data confidentiality. Do not store case files information in caseworkers' homes[14].** • Caseworkers shift to emergency case management[15] and focus on safety planning, especially for IPV[16] survivors. • Ensure availability of updated referral pathways for functioning services and consider that listed services follow WHO recommendations in terms of IPC measures and social/physical distancing.

[14] This recommendation is meant for immediate transition to home-based case management and based on best practices. Each organization should decide how to adapt this guidance should this situation last for longer period of time and adapt their services and data protection accordingly.
[15] See IRC's Emergency Preparedness and Response Handbook, pp. 46-49 : https://gbvresponders.org/wp-content/uploads/2018/04/GBV-Emergency-Preparedness-Response-Participant-Handbook.pdf
[16] Intimate Partner Violence.

	• Phone credit (and data bundle) is made available to caseworkers and plans are made for remote refills of credit for at least a 2 month period.	• Review Case Management SOP to include regular remote supervision of caseworkers[17]. • Review Case Management SOP to include staff care considerations that can be implemented remotely. Supervisors are encouraged to establish daily contact with caseworkers to discuss experience and stressors, encourage them to actively reach out for support and connect them to psychosocial support and mental health professionals18. • Information is disseminated to the community on how to access GBV case management services through accessible communications methods.
Model 3: Static face-to-face case management cannot continue: shutdown occurs	• Procedures for handover top operational services if any, referral and closure of cases are in place. • Implement data evacuation plans if existing or agree on data evacuation of case files based on data protection checklist if case files cannot be safely stored in the center/office[19].	• Supervisors are encouraged to check in with caseworkers to monitor their wellbeing[20]. They can establish a support network across caseworkers[21]. • Caseworkers inform survivors about the service shutdown by phone if they obtained consent to contact them by phone and it is assessed safe. Information about the shutdown can be done face-to-face if situation allow, safety of staff and survivors is ensured, and IPC protocols/social distancing measures are in place. • Caseworkers refer survivors, upon their informed consent, to services that are still operational. Alternatively, they inform survivors who to contact if they need help. • Plan for awareness raising-activity at the end of the pandemic to inform communities in which they work that services have reopened using a variety of communication means.

[17] Supervisors should plan for regular individual and/or group sessions. Group supervision could be organized through online platforms such as WhatsApp, Skype or Zoom. Supervision tools can be found in the Case Management Guidelines (2017), pp.161-162 and annexes here: http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf
In addition, if Primero/GBVIMS+ is rolled out, supervisors can conduct remote case files review by using functionality such as custom export, case plan/closure approval, and flags.
[18] Staff care tools can be discussed between caseworkers and supervisors – such as Self-Care inventory available in Module 19 of the Case Management guidelines training material: https://gbvresponders.org/response/gbv-case-management/
[19] See Data Protection checklist here : http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-CHECKLIST.pdf and Data Protection Agreement Protocol here: http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-PROTOCOL.pdf
[20] Cf. footnote above.
[21] For example, they can create WhatsApp groups to monitor daily wellbeing of all staff.

Model 4(a): Sudden shutdown of services	• Implement data evacuation plans if existing or agree on data evacuation of case files based on data protection checklist if case files cannot be safely stored in the center/office[22]. • Review existing or revised data evacuation plans and assess what can be done remotely or if someone can access the center/office to ensure safety of case files. • Review all considerations from model 3	• Case management supervisors are encouraged to check in with caseworkers to monitor their wellbeing[23]. They can establish support network across caseworkers[24]. • If caseworkers have survivors' contacts, if consent was obtained to contact them by phone and if it is assessed safe, contact survivors to inform them about the shutdown of services – refer to model 3(b). • If caseworkers do not have survivors' contacts, disseminate information on other available services through social media, SMS to affected populations (e.g. registered refugees/IDPs), WhatsApp or other communication means.
Model 4(b): Sudden shift to phone-based case management from caseworkers' homes	• Implement data evacuation plans if existing or agree on data evacuation of case files based on data protection checklist if case files cannot be safely stored in the center/office[25]. • Review all consideration from model 2(b) • Review existing or revised data evacuation plans and assess what can be done remotely or if someone can access the center/office to ensure safety of case files.	• Case Management supervisors are encouraged to check in with caseworkers to monitor their wellbeing[26]. They can establish support network across caseworkers[27]. • If caseworkers have survivors' contacts, if consent was obtained to contact them by phone and if it is assessed safe, contact survivors to inform them about the shutdown of services – refer to model 2(b). • Inform communities of the shutdown of services and provide information on how to access remote services.

[22] See Data Protection checklist here : http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-CHECKLIST.pdf and Data Protection Agreement Protocol here: http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-PROTOCOL.pdf
[23] Cf. footnote above.
[24] For example, they can create WhatsApp groups to monitor daily wellbeing of all staff.
[25] See Data Protection checklist here : http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-CHECKLIST.pdf and Data Protection Agreement Protocol here: http://www.gbvims.com/wp/wp-content/uploads/DATA-PROTECTION-PROTOCOL.pdf
[26] Cf. footnote above.
[27] For example, they can create WhatsApp groups to monitor daily wellbeing of all staff.

Adapting GBVIMS and Primero/GBVIMS+ to national responses

The below tables presents the adaptation to the GBVIMS and/or Primero/GBVIMS+ for the models outline on page 1 of this guidance note. For models 2(a), 2(b) and 4(b):

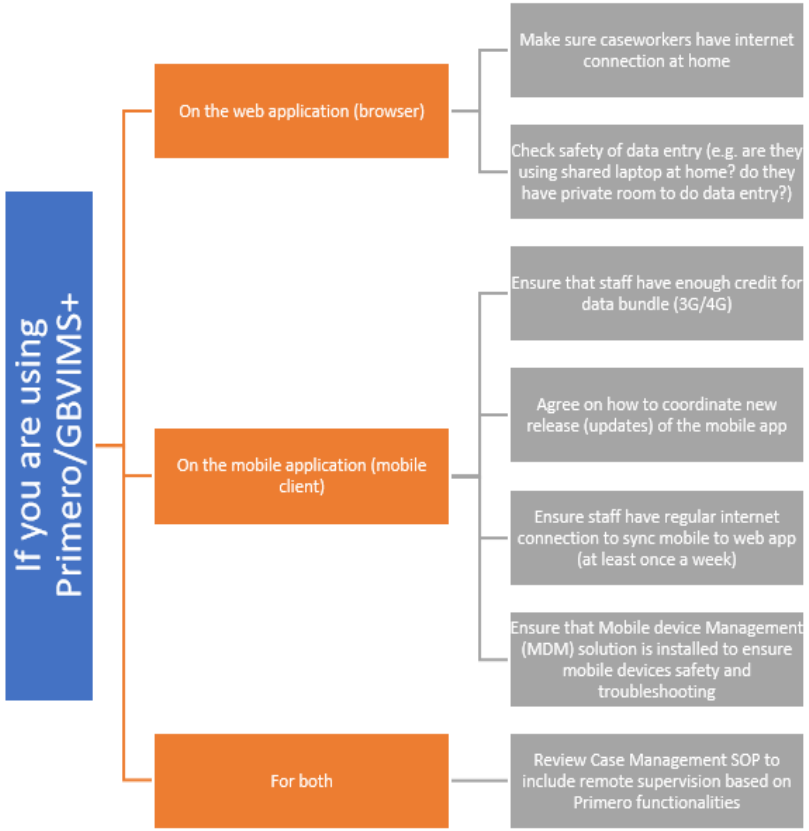

Figure 2 Adaptation to the GBVIMS and/or Primero/GBVIMS+ for models 2(a), 2(b) and 4(b)

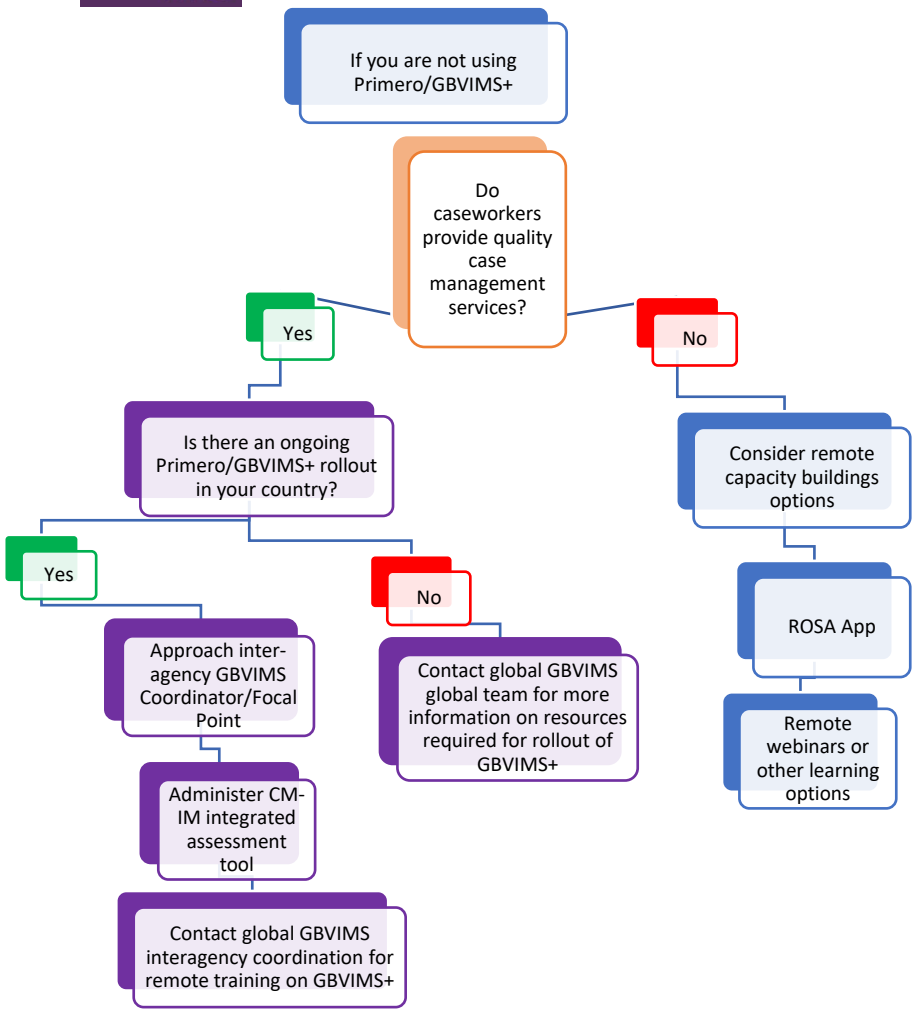

Figure 3 Adaptation recommended for non-Primero/GBVIMS+ Users

For models 1, 2(a), 2(b) and 4(b): If you are using GBVIMS and are a Data Gathering Organization (DGO) / Service provider

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

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

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

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

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

Figure 4: Recommendations for GBVIMS User Organisations during response models 1, 2(a), 2(b) and 4(b)

For models 1, 2(a), 2(b) and 4(b): If you are using GBVIMS and are GBVIMS Interagency Coordinator/Focal Point

Collection

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

Storage

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

Compilation

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

Analysis & Reporting

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

Sharing

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

Figure 5: Adaptations for response models 1, 2(a), 2(b) and 4(b) for GBVIMS Interagency Coordinators/Focal Points

Strengthening GBV case management information management in response to Covid-19

Usage of Primero/GBVIMS+[28]

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

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

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

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

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

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

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

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

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

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

The use of GBVIMS or Primero/GBVIMS+ in the context of the Covid-19 pandemic is interlinked with the changes in modalities of GBV service provision (e.g. from center-based to home-based) and should therefore be adapted correspondingly. Whenever possible, remote capacity-building opportunities for GBV caseworkers and supervisors should be considered. In this regard, International Rescue Committee's 'Rosa' mobile application[29] is recommended. The Remote-Offered Skill Building App (Rosa) was designed to utilize technology and keep the community and continual skill building ongoing for staff working remotely outside of traditional offices. Rosa provides key content on GBV, case management, communication and attitude skills; offers self- or supervisor-administered skills assessments; and a community space for users to expand their learning through facilitated remote discussions and distance supervision.

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

[29] https://www.rescue-uk.org/perspective/why-we-need-go-mobile-protect-women-violence