

Guidelines for Establishing Hotlines to Support Survivors of Gender-Based Violence



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Establishing Hotlines
to Support Survivors
of Gender-Based Violence



UNFPA Asia Pacific Regional Office

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Individuals shown in the photos are not necessarily survivors of violence against women.
No images that identify survivors have been used.

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Hotline social media cards contributed by UNFPA Country Offices from Indonesia, Lao PDR, Maldives, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Thailand, and Vietnam illustrate this guide.



Terminology

Case worker in this guide is used to refer to a person trained to provide specialized case management services, including assessment, safety planning, psychosocial support, and referral support, to GBV survivors.

Gender-based violence is an umbrella term for any harmful act perpetrated against a person based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private spaces. Common forms of GBV include sexual violence (rape, attempted rape, unwanted touching, sexual exploitation and sexual harassment), intimate partner violence (also called domestic violence, including physical, emotional, sexual and economic abuse), forced and early marriage and female genital mutilation.¹

GBV guiding principles are safety, respect, confidentiality and non-discrimination. Application of these principles at all times is mandatory. They serve as the foundation for all humanitarian actors when coordinating and implementing GBV-related programming.²

Hotline/helpline are terms that generally refer to similar services. For the purpose of distinction in this guide, hotline is used to denote a service in which callers are connected directly to specialized GBV response services, while helplines refer to phone services that provide general information on a range of issues, usually along with referrals for specialized support.

Hotline staff refers to individuals who answer calls to a hotline. Depending on the staffing decisions made by a hotline agency, hotline staff may also be GBV caseworkers.

Identifying information is information that can directly or indirectly reveal the identity of a particular survivor. Examples of data that directly identify an individual include name, address, national ID number, etc. Data that can indirectly identify a survivor could include, for example, a workplace and position name, or specifying how a survivor is related to a known or named individual. Identifying data should be restricted to use by a GBV service provider, with informed consent from a survivor, for the sole purpose of arranging or delivering the services the survivor has requested.

Informed Consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent the individual must have the capacity and maturity to understand the services being offered and be legally able to give their consent. To ensure consent is “informed”, service providers must:

- Provide all the possible information and options available to the person so she/he can make choices.
- Inform the person that she/he may need to share his/her information with others who can provide additional services.
- Explain to the person what will happen as you work with her/him.
- Explain the benefits and risks of services to the person.
- Explain to the person that she/he has the right to decline or refuse any part of services.
- Explain limits to confidentiality.³

Referral pathway is a flexible mechanism that safely links survivors to services such as health, psychosocial support, case management, safety/security, and justice and legal aid.⁴



Introduction

The purpose of this guide is to bring together relevant standards, information, and regional experiences to support the planning and operation of GBV Hotlines. It is not intended to be a comprehensive reference for GBV case management, but rather to highlight how the process of implementing GBV response services **through a hotline** differs from onsite GBV response. Hotline planning requires thinking through a number of elements from a new perspective, including use of technology, documentation and data protection, and staff

training and support. This guide therefore aims to raise issues and questions to be considered by those planning and implementing GBV hotlines.

Within the wide range of sociopolitical, physical, and cultural contexts in the Asia and Pacific Region, each hotline must be formulated to fit local needs, but the steps in establishing the service follow the logical flow illustrated below. While some steps may proceed concurrently, information gathered and decisions made as part of the first four steps will inform how the remaining steps are structured and implemented.

Steps for establishing hotline services



Each section of this guide covers one of the ten steps and contains the following elements:

- **Discussion**

An overview of the activities included in the step, along with information to help guide planning. Note that discussions are centered on how the step pertains **to hotlines**. For example, in Step 7, Training, the purpose of the discussion is to highlight the additional trainings and training adaptations needed to prepare hotline staff, rather than to review all of the baseline training needed for GBV response staff. Reference materials that provide in-depth treatment of the general topic of each step are found under “Tools and Resources” in each section.

- **Decision points for consideration**

Questions to consider in determining how to proceed. Some decisions will be constrained by resources or by infrastructure; others require internal discussions to set priorities and policies. For this reason, it is crucial to include not only GBV specialists in the discussion but also staff with expertise relevant to each step, e.g. IT specialists, legal and policy experts, monitoring and evaluation staff, etc.

- **Relevant standards**

Ethical requirements, recommended practices, and quality benchmarks from UNFPA as well as from recognized sources of global GBV guidance are provided to support decision-making for each step. Identification of specific relevant guidance does not indicate that they are the only key sections of the reference documents mentioned. Guidance reproduced in this section is intended to highlight information closely related to the step under discussion and to point the reader to the source material for deeper understanding.

Key standards referred in this document include the following:

The standards outlined in the **Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming**⁵ are based on a foundation of guiding principles and approaches to

be observed in all humanitarian GBV interventions:

- GBV Guiding Principles: **confidentiality, safety, respect, nondiscrimination**
- A rights-based approach
- A community-centered approach
- The humanitarian principles: **humanity, neutrality, independence, impartiality**
- Do no harm
- The principles of partnership: **equality, transparency, a results-oriented approach, responsibility and complementarity**
- The best interests of the child

The Essential Services Package for Women and Girls Subject to Violence⁶ provides systematic guidance for instituting quality GBV interventions, including these key characteristics for service delivery:

- **Availability, Accessibility, Adaptability, Appropriateness**
- Prioritize **safety**
- **Informed consent** and **confidentiality**
- **Effective communication and participation** by stakeholders in design, implementation and assessment of services
- **Safe data collection** and information management
- Linking with other sectors and agencies through **coordination**

These foundational standards are not repeated for each step in this guide but should be thoroughly read and understood from the source material and applied when designing, implementing, and monitoring hotline operations.

Additional sources used to inform the Relevant Standards are the Interagency GBV Case Management Guidelines, the GBVIMS Steering Committee Minimum Requirements for GBV Survivor Data Management, the Humanitarian Inclusions Standards for Older People and People with Disabilities, and the Handbook for Coordinating Gender-Based Violence in Emergencies.

- **Regional examples**

Examples and narratives are included if relevant to illustrate how a particular UNFPA country program or partner has managed aspects of the step or addressed challenges (see text boxes).

- **Tools and resources**

Annexes, reference materials and links that provide more detailed information, templates,

forms, training slides, and tools specific to the topics covered by the step. Materials provided here may be directly adapted for use (with acknowledgement) or may serve as inspiration for development of new materials.

UNFPA APRO's "GBV Hotlines Overview" presentation material has been collected in Annexes 1, 1A, and 1B, which are PowerPoint files that accompany this guide.



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ASSESSMENT AND SERVICE MAPPING

DISCUSSION

GBV hotlines are intended to expand a population's access to GBV response services and information. This may be a geographic expansion, reaching a location where onsite GBV services are limited or nonexistent; or it may be a complement to existing programming in an area where there are physical, security, health, or other obstacles that impede some populations from seeking services onsite.

So, while hotlines are a form of **remote service**, they may be implemented in conjunction with onsite services. In every service area, there are individuals who feel they cannot safely or comfortably approach a facility to request assistance with GBV, e.g. people with disabilities, male survivors, elderly people, or LGBTQ+ individuals. Hotlines can therefore be a mechanism for greater inclusion of underserved groups.

Often however, hotlines are initiated as a standalone service or in conjunction with mobile teams that periodically visit a location. Adverse political conditions, security threats, environmental barriers, resource constraints, or public health emergencies may all result in remote service provision being the most feasible option. When possible, scheduled onsite visits to locations (**mobile services**) can follow up on contacts initiated by hotline callers, and can introduce mobile service users to the assistance available through the hotline in between mobile visits.

Because GBV happens everywhere and is under-reported worldwide, **obtaining GBV incidence data is not a pre-requisite or a priority when initiating response services in a new location.**⁷ While assessments are essential to refine programming to meet survivor needs, basic response services should be available before formal assessment of GBV is made. Onsite consultations may not be immediately possible under conflict or pandemic conditions.

Therefore, hotline providers may need to use **secondary data sources** (census data, household surveys, public reports, etc.) to plan how to initialize services. These should be augmented with any primary sources (key informant interviews, focus group discussions, service provider interviews, etc.) that can be conducted even if only remotely.⁸ Once it is possible to conduct onsite assessments safely and ethically, more comprehensive multi-sector assessments can be made to inform and refine GBV programming.

For any type of hotline, it is essential to analyze whether sufficient **access to phones and/or internet** exists within the target community to make hotline service a realistic option. This question pertains not only to the level of telecommunications coverage in an area, but to the accessibility, affordability, and comfort level with phones/internet usage among potential users. In situations of political crisis, the overall security conditions should also be considered in terms of whether staff and survivors feel safe in using mobile phone networks. *See Step 2, Technology Evaluation, for more information.*

Part of the relevance of an assessment for hotline providers comes in understanding what GBV response services are currently available and whether existing service providers on the ground have the capacity and willingness to address any of the basic GBV-related needs. **Service mapping** is the process of identifying providers of health, psychosocial, protection, legal, shelter/safe accommodation, livelihoods, and other services that are integral for GBV support. **In areas where the hotline will be a standalone service or connected to a mobile response**, make a determination about whether sufficient health and protection services (at a minimum) exist in the area, and how callers can be linked to them through the hotline. **For hotlines that are one component of existing GBV programming and onsite services in the area**, verify that current referral partners are active and consult with them about how they will engage with referrals made through the hotline. Any additional services to meet the needs of anticipated callers must also be identified and contacted.

Typically information such as hours, locations, forms of assistance available, and eligibility for assistance is gathered. However, service mapping also provides the first opportunity to understand the degree to which the provider has survivor-centered practices in place or is willing to adopt them. The information will become the basis for the development of the referral pathway. See *Step 4, Information Resources*.

Consultations with potential service providers should include discussion of how the basic pre-requisites for survivor-centered GBV care are observed: **respect, confidentiality, safety, nondiscrimination, and informed consent**. Information gathered as a result of this decision-making process, along with an analysis of the available technology in Step 2, will form the basis for determining the practicality and usefulness of a hotline to expand GBV service access in a given location.

KEY DECISION POINTS FOR CONSIDERATION

- What information is available about the demographics in the target area? Are there recent previous assessments that can be used to inform planning?
- What are safe methods of obtaining additional information from women and girls, LGBTQ+ individuals, people with disabilities, other at-risk groups, service providers, and key informants?
- What are the known GBV risk factors? Are there specific increased risk factors such as military bases, border crossings, irregular migration areas, displaced populations, environmental disasters, civil unrest, etc.? How will these conditions affect the types of GBV that hotline staff must be prepared to address and make referrals for?
- Are there existing local or national policies or coordination bodies that govern GBV reporting mechanisms or services? If so, what information can be shared that will inform hotline service mapping (e.g. identification of service gaps, functionality of existing providers, disruptions in the referral pathway, etc.)?
- Do basic local health and protection services exist to which callers seeking help with GBV incidents can be referred? How have these services been affected by the situational factors identified above? Are the services currently following survivor-centered practices, or are they willing to adopt them?
- Given the risks and existing services identified, can hotline services meaningfully support better access to GBV response for survivors? What ground support would be necessary, and is it possible to provide the identified type of support (e.g. community focal points, pre-positioned phones and/or supplies, transportation services, etc.)?

REGIONAL EXAMPLE

Nepal's National Women Commission Hotline: Expansion of access through remote (phone) support



Source: UNFPA Nepal

Through the provision of remote support over the phone, the NWC helpline provides an excellent opportunity to bridge the access gap for GBV survivors. A caller receives information; basic emotional support (listening, acknowledging, reassurance of help and encouragement to seek comprehensive services at the NWC in partnership with NGOs for legal, psychosocial, shelter and child protection within the four pilot districts); and referral to police and

other service providers in districts outside of the pilot districts. Often rescue is facilitated over the phone for survivors calling in during an emergency and phone-based intervention has been provided to survivors presenting with suicide ideation.

In a country with a topography like Nepal, where even basic health services are difficult to access physically, remote support could revolutionize the way in which women are able to access help for themselves. Women in general, and particularly those with limited exposure, are not aware of their rights and the range of services that they are entitled to. Their first call to the helpline is possibly the first time that these women have received such information and listening support from a service provider. It has been widely acknowledged that the first response to a woman seeking support significantly influences the subsequent steps she takes towards getting help. Remote provision of information and assurance of support (emotional support) over the phone has likely had a strong influence on women actually walking into the NWC office to access specific services.

The 24/7 toll-free helpline service (Khabar Garaun #1145) operated by NWC is the only ICT-enabled helpline for survivors of GBV in Nepal. Its relevance has been demonstrated by the sharp increase in the number of GBV survivors accessing its services. At the time of this assessment (February to March 2020), the pilot project had provided over 10,000 services [...], the majority in the four pilot districts, with an increasing number of calls from other districts across the country. This is a four-fold increase in the number of survivors accessing GBV response services from the NWC since the helpline's inception. In fact, the number of GBV survivors who have accessed NWC helpline services far outnumber those provided by One-Stop Crisis Management Centers, the other one-window multi-sectoral GBV service provider in the project districts.

Excerpts from External Assessment of GBV Helpline Services in Nepal 2016-2020, World Bank Group

RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 16: Assessment, Monitoring and Evaluation: 15 Key Actions, including:

Before collecting new data, review and analyse existing secondary data [...] to inform decision-making.

Undertake mapping on GBV response services (e.g. existing quality and scale of multisectoral services, national legal and policy frameworks) to inform GBV-specialized programming priorities and coordination with child protection, health and other key response actors.

Work with and through community structures and groups such as religious groups, youth groups, health facilities, community-based organizations and local NGOs to gather data; use multifunctional teams, including local partners, to make initial contact when the affected population might be scattered in an urban or remote area.

Handbook for Coordinating Gender-Based Violence Interventions in Emergencies

Part 2, Core Functions, Chapter 3: GBV Coordination Functions and Roles

Make use of available service mapping data from other sectors (for example, health sector mapping) where possible. Information from mappings should be verified to ensure that services meet GBV quality and ethical standards. (p. 87)

The purpose of an assessment is to more clearly understand the situation and how it affects the lives of the affected population in order to design appropriate and effective interventions across multiple sectors. It is not for collecting prevalence information in order to make the case for GBV interventions. (p. 92)

GBV can be difficult to assess or measure directly for reasons of protection and access, particularly in the earliest stages of a crisis. Establishing a solid foundation of secondary data [...] is crucial to understanding the overall GBV situation. [...] Secondary data review is a sound assessment method that is as valid as front-line interviews. (p. 95)

Essential Services Package for Women and Girls Subject to Violence

Module 4, Essential Service 3: Helplines

3.1 Availability: Ensure the help line has access to resources where necessary to ensure the safety of women and girls including:

- To support the emergency transport of women and girls to safe accommodation regardless of location
- Provision of immediate basic personal and health care items including food and clothing, either directly or through local services
- Links to immediate and appropriate police and justice responses, when considered as safe, requested and/or when necessary

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slide 2

Annex 2: International Rescue Committee (2018). Service Mapping Tool

Annex 3: GBV AoR (2020). Focus Group and Key Informant Interview: Sample Questions. Rapid Assessment Remote Service Mapping Template.

International Rescue Committee (2018). GBV Responder's Network, Emergency Assessment Tools. Full toolkit available at: <https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/>

GBV AoR (2020). Webinar: Remote GBV Assessments and Transitioning to Remote Service Delivery. https://drive.google.com/file/d/1BK6c3D0Nic_Ih5NDClYw92Sdfp_0XVvl/view

GBVIMS (2017). Chapter 2: Understanding the Context for GBV Services. InterAgency Gender-Based Violence Case Management Guidelines. http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf

UNFPA, Asia and Pacific Region Office (2020). Decision tree: Data Collection on Violence against Women and COVID-19. <https://asiapacific.unfpa.org/en/resources/decision-tree-data-collection-violence-against-women-and-covid-19>



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TECHNOLOGY EVALUATION

DISCUSSION

A hotline can only be a viable method of intervention when adequate access to the hotline mechanism (phone or internet) exists within the target population, and when the population is willing and able to use that mechanism without compromising their safety.

The question of access is addressed first by finding out what the **quality of the telecommunications infrastructure** in the area is: how much of the area has coverage, and whether that coverage is somewhat reliable.

Next, it is necessary to get an estimate of the **rates of ownership** of whatever devices can be used to connect to the hotline (mobile feature phone, smart phone, tablets, etc.). Rates of phone/device ownership must also be understood in terms of disparities based on gender, displacement status, ethnicity, rural/urban residence, and socioeconomic status.

It is essential to investigate the disparity between male and female ownership in the planned hotline location, as well as to understand issues of the **gendered control over the asset** if it is shared. If a family or couple owns a mobile phone, for example, who controls the usage? A 2020 study⁹ indicated the gender gap in mobile phone ownership in South Asia remains fairly wide (65% of women own a mobile, a gap of 23% compared to men, totaling 207 million unconnected women). In East Asia and the Pacific, the gap is much lower (95% mobile ownership by women, a gap of 1% compared to

men, totaling 44 million unconnected women) but would still require analysis at a local level. In planning hotline services, it is **essential to realize that women's and girls' access may be monitored by partners and family (including perpetrators) which could expose them to further harm.**

Literacy and affordability are the most common barriers to mobile ownership for women in Asia but it should be noted that in some societies, social disapproval and family prohibition is a highly relevant factor in women's ownership and use of mobile/internet devices.

Access to electric or solar power for charging phones, as well as methods of arranging free calls or mobile credit for calls/data must be considered. Setting up a **toll-free number** will benefit those accessing the number from a landline, so a toll-free number is a standard under the Essential Services Package (see *Relevant Standards in this section*). If national telecommunications systems can support this it should be factored into the GBV program/hotline budget. However, be aware that in most cases callers using mobiles will either be required to use minutes (to call using the phone) or data (to call using an app) unless they have unlimited mobile plans. Investigate whether it is possible in your context to arrange an emergency number for the hotline that does not require use of mobile credit, and if not, how a system for distributing mobile credit or linking callers to pre-positioned phones can be established.

In some locations, particularly in areas of conflict or political unrest, it is advisable to understand whether the technology used by the hotline may allow other actors to intercept calls made through standard mobile networks. If this is a risk, consult an ICT specialist to determine whether use of particular VOIP applications or encryption is suitable and legal in your context. Mitigation measures can also be taken through the policies instituted for documentation (*Step 8*) and data protection (*Step 9*).

There are often age disparities in familiarity with using mobile apps or other online tools. When considering use of **texting, messaging apps, or video calls**, determine whether these tools can be used safely in the context and what level of digital readiness the intended users possess. Not all messaging apps offer equivalent security, so if this

mode of communication is used, identify apps with appropriate end-to-end encryption and privacy features (e.g. Signal). See the *Tools and Resources* section for guidance that covers digital service safety.

The hotline service must be **accessible to people with disabilities**. Callers may not have access to specialized assistive equipment so if technological solutions are not available in the context, consider what accommodations can be made by use of text or messaging apps, or assisted calling procedures, e.g. through GBV focal points.

A less- than- perfect telecommunications environment does not mean that a hotline is an unsuitable intervention. However, the gaps, risks, and mitigation options do require examination and discussion with stakeholders as well as ICT professionals.



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KEY DECISION POINTS FOR CONSIDERATION

- What level of network coverage exists in the area? Are telecommunications networks in the target area sufficient and reliable enough to support the chosen hotline mechanism (phone/internet)?
- In addition to the technical components of coverage, is phone/internet access used as a measure of political control of the population? Are frequent blackouts imposed over phone/internet in the area that will affect access? Is this a significant barrier to providing reliable service?
- What percentage of the population in the area owns a type of communication device that can access the hotline (mobile, landline, tablet, etc.)? Can disaggregated data in terms of age, sex, language/ethnicity, and type of disability be obtained in order to determine how to support users with access in a manner they are comfortable with? Note that regardless of whether disability data is obtained, the hotline should develop accommodation methods for those needing assistance in communicating by phone.
- What is the gender gap in ownership? Will women and girls have reasonable access? What safety concerns are associated with accessing the hotline if a device is shared or monitored, and what steps can be taken to guide callers in safer use of the phone/device?
- How familiar are targeted users with the technology? Is it culturally acceptable? Are there digital literacy gaps for women, girls, older people, rural populations, or people with disabilities? If so, what support can be provided in familiarizing users with it?
- What resources are needed to support the community in accessing phones (e.g. solar chargers, phone/data credit, designated focal points in the community or service providers to offer private phone/internet access for hotline calls)? Can toll-free lines be established?
- What equipment needs to be available for hotline staff to operate the calls? Are there features or apps that must be added to basic phone/internet service (e.g. three-way call capability to support interpretation, supervision or emergency needs)? How will any apps used for hotline response be kept discreet and secure?
- Will calls be received through a centralized system that assigns callers to an available hotline staff, or will the line be open for only one call at a time? Will the system accommodate direct transfers to other GBV specialists or to service providers?
- What are the optimum hours of operation? What will happen when callers try to access the hotline outside operating hours? Can voice mail or texts be received overnight? If so, what call back or text back protocol will be adopted?
- What laws or policies guide the telecommunications carrier regarding sharing of identifiable data (lists of phone numbers calling the hotline, for example) with external actors?
- Is call interception a realistic threat in your environment? What equipment and/or applications could be implemented to increase call security and privacy?

ARE YOU FACING VIOLENCE AT HOME? DO YOU NEED HELP?

Call:

- Ministry of Women and Children Affairs: **109**
- National Legal Aid Services: **16430**

For more information, go to www.YFHS.Asia/helpline

Source: UNFPA Thailand

Technology Considerations for Establishing Rozan Counseling Helpline, Pakistan



Source: Rozan Counseling Helpline, Pakistan

UNFPA Pakistan initiated a psychosocial support (PSS) and GBV referral initiative in collaboration with government departments and civil society partner Rozan to ensure that women and girls confined to their homes during COVID-19 could reach quality services as GBV risks rose. The initiative created community and stakeholder awareness regarding how to reach help for GBV through tele-PSS and GBV referrals. As part of a wider capacity building effort, four federal and provincial government-led helplines were provided with human resource and technical support to provide survivor-centric PSS and GBV services.

At the Rozan Counseling Help Line (RCHL), newly hired staff were based in various cities and at times, COVID circumstances required that they work from home. Therefore, the help line had to be set up in such a way that it could be accessed by counsellors both from the premises as well as remotely. An exchange system was developed with Jazz (Telecommunication Company), whereby one main toll-free number was assigned to Rozan and could be accessed by both landlines and mobile phones. Mobile phones were a necessity not just because of counsellor locations, but also because of signal issues affecting the toll-free number.

To accommodate as many calls as possible, offering 24-hour access to the help line was considered and trialed for some time, but it was found that few calls came during later hours. Therefore RCHL returned to daily operating hours but expanded these to increase access into early evening.

RCHL utilized an online data-based management system that recorded all calls that came through on the help line number, even those that were missed when counsellors were busy on other calls or after-hours. Whether or not to enable a call-back option for callers was a source of much discussion within the Rozan team.

Survivors will usually make calls based on when they have privacy and are safe to reach out to the help line, but this may not be the case when counsellors call back. While there were definite advantages to allowing the service to record numbers from which missed calls have been received so that counsellors could call back, it was ultimately decided, based on Rozan's extensive experience working with GBV survivors, that the risks posed to survivors with this option was too great.

RELEVANT STANDARDS

<p>Essential Services Package for Women and Girls Subject to Violence</p>	<p>Module 4, Essential Service 3: Helplines</p> <p>3.1: Availability: Provide helplines free of charge or toll-free</p> <p>3.2: Accessibility: Ensure the telephone service is accessible via mobile phones</p>
<p>Humanitarian Inclusion Standards For Older People And People With Disabilities</p>	<p>Inclusion Standard 2: Safe and equitable access</p> <p>Older people and people with disabilities have safe and equitable access to humanitarian assistance.</p>

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slide 3

https://reliefweb.int/sites/reliefweb.int/files/resources/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf

Annex 4: National Network to End Domestic Violence, Safety Net Project (2019). Using Mobile Phones to Communicate with Survivors: Policy and Practice Recommendations

National Network to End Domestic Violence (2019) Digital Services Toolkit.
<https://www.techsafety.org/digital-services-toolkit>

Age and Disability Consortium (2018). Humanitarian inclusion standards for older people and people with disabilities.

IFRC, 2020. Assessment, p. 6 – 11. Hotline in a Box.
<https://communityengagementhub.org/guides-and-tools/hotline-in-a-box/>



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DISCUSSION

The **service profile** of a hotline describes how it will be structured to reach users and provide services. It is based on decisions made during the planning stage about:

- The identity and needs of the intended users (informed by geographic and demographic assessment data from Step 1)
- The identity and training of the staff who will answer hotline calls
- The scope of functions the hotline will perform, including whether and how case management will be provided (crisis only, ongoing remote case management, transition to onsite, etc.)
- The positioning and framing of the hotline service within the home agency, within the community where it will be implemented, and within the existing community of GBV response organizations

Intended users

From the assessment data gathered for the location, **identify the population(s) of concern** that the hotline will focus on. Age, sexual or gender diversity, ethnicity, language, religion and culture, displacement status, citizenship, socioeconomic level, disability, dependence on high-risk behaviors for survival or income generation – all of these

aspects of a target population influence the hotline positioning, as well as determine the knowledge, skills, and attitudes that hotline staff must possess in order to provide appropriate GBV response.

Implementation models

GBV services can be provided through phone/ internet in several different ways, and the structure that is chosen will affect multiple aspects of programming including human resources.

If the number is not disseminated publicly and is primarily used to reach an **on-call GBV case worker**, then the reach of the service will be largely to those who have existing contact with the worker or a service provider on the GBV referral pathway. As a COVID adaptation, many GBV case workers began conducting their case management sessions by phone. In some instances, new survivors who could not reach onsite facilities were connected by GBV focal points in the community with a GBV caseworker for phone-based case management. This model can provide a viable alternative for some survivors (under COVID or other restrictions). However it is not a fully functional hotline since access is controlled through gate keepers who provide the survivor with the number and contact information. Other callers, including those who do not want to approach a gate keeper for access and those who want to remain anonymous, are unlikely to know how to obtain help.

Another common model is a **general helpline** with a publicly disseminated number that receives calls from the community about a range of multisectoral services. **Phone staff can provide information to help callers reach a GBV organization, but if they are not GBV-trained workers who are competent to provide safety planning, psychological first aid (PFA), and GBV referrals at a minimum, it is not a fully functional GBV hotline.** This model might be more accurately called a referral line or general helpline. In some situations, the functionality for GBV response could be achieved by adding the necessary staffing and technology to transfer GBV calls in real time from the helpline to an on-call GBV specialist after obtaining proper consent.

A **fully functional GBV hotline model** is one which has a **publicly available number at which GBV staff are on hand to provide callers with skilled support.** It can be accessed directly by callers with no pre-existing relationship with a GBV service provider or focal point. Hotline staff are prepared with both GBV training and specific protocols including a referral mechanism adapted for phone/internet (see *Step 4, Information Resources, and Step 7, Training*). **This guide is oriented to the process of establishing a functional GBV hotline.**

Scope of functions

At the most basic level, hotline callers should be able to receive PFA for GBV, safety planning support, and appropriate referrals made with informed consent. While a GBV hotline should not be used in place of a call to police, such calls will likely occur at times, so hotline staff must also be able to provide emergency guidance and assistance in obtaining protection or medical services on behalf of callers where indicated. Hotline staff must also be trained on suicide intervention skills.

A more robust level of service comprises the above components along with crisis case management (assessment of immediate concerns, safety planning, implementation, key messages) and skilled psychosocial support. This could include basic healing education about GBV (such as disputing harmful myths or self-blame), and discussion of positive coping mechanisms and self care.

Comprehensive case management is generally not a function of hotline service, since it is based on a relationship maintained over time for in-depth assessment, case action planning, and follow up. The first call must proceed as if it will be the only contact because there is no guarantee a caller will have access again (see *Tools and Resources in Step 7, Training*). However, if the hotline intends to routinely provide or connect a survivor to ongoing case management, plan how this will be managed in a way that avoids having the survivor re-explain the case to a series of staff (e.g. safe methods of scheduling follow up calls with an assigned case worker, or developing a secure process for sharing the case with an onsite/mobile case worker). This level of service will require appropriate staff training, call documentation, and data sharing and protection protocols.

Hotline positioning

The hotline must be carefully positioned within a community in a manner that **encourages callers to reach out for help while not stigmatizing GBV survivors** (e.g. calling it “GBV Hotline”). The name of the hotline, and the explanation of it given during community awareness raising activities, will therefore usually not focus explicitly on GBV but on a wider, umbrella topic. Be aware, however, that the hotline name and public framing will set expectations that the hotline staff must be equipped to meet.

For example, a hotline positioned as being “for women and girls” will get both GBV calls and calls that are not related to GBV situations. These can be sensitively addressed and referred to other service providers if they exist, such as sexual and reproductive health care providers, legal aid, nutrition programs, child protection, etc. Otherwise, staff must be equipped to provide basic information.

Hotlines positioned in a framework of “family violence” may receive calls from perpetrators looking for support in reinforcing their power and control over a survivor or requesting mediation support. Hotline staff must be equipped to address these calls without providing counseling of perpetrators, which is not appropriate for GBV staff

whether done remotely or in person. Mediation of GBV cases is not recommended as it is often not supportive or safe for the survivor. A hotline positioned as a family resource will also receive calls about forms of violence in which GBV is not a factor, such as violence resulting from severe mental illness, elder abuse that is not gender-based, etc. This reinforces the need for a thorough service mapping that goes beyond GBV service providers alone.

Another consideration is whether the name and positioning will **exclude some users** from approaching the hotline. Male survivors, for example, are less likely to see a “women and girls” hotline as a resource for themselves. Survivors

of a stranger rape or sexual exploitation may not contact a “family violence” hotline.

Coordination of GBV response should also be a factor when positioning the hotline. If it is a hotline operated by a one organization in an area where similar hotlines are present, determine how to avoid duplication of services, make best use of resources available for GBV in the community, and prevent confusion among potential hotline users. If the hotline is a joint operation with other GBV responders, it will require development of Standard Operating Procedures with agreed operational procedures, training, standards, communications, an information sharing protocol, and a single supervision line.

KEY DECISION POINTS FOR CONSIDERATION

- Who are the intended users? How does that impact the name of the hotline?
- How will the hotline’s purpose be explained to the community?
- How do callers reach skilled GBV response? Will access be controlled through gate keepers (focal points, service providers, etc.), linked through a multisectoral helpline, or reached directly through a publicly disseminated number?
- What services will the hotline make available to callers? Can a minimum of PFA, GBV safety planning, and referrals be provided?
- What days/hours will the hotline operate? How are callers directed to help outside those hours? What is the hotline’s call-back policy?
- Are there similar hotlines operating in the same area? How can the functions for each be clearly defined and coordinated?
- Will the hotline be a joint effort with multiple GBV responders? If so, what process will be used to develop shared SOPs on hotline implementation, policies, standards and practices, supervision and communication lines be developed?
- Will the hotline operate from an agency that has an existing mobile GBV program? If so, what internal structures and protocols need to be created to link hotline callers with mobile teams for response and follow up?
- Will the hotline routinely provide comprehensive ongoing case management, or connect a caller to onsite case management? If so, what process will be created to safely ensure continuity of care for the survivor?



Source: UNFPA Philippines

RELEVANT STANDARDS

Essential Services Package for Women and Girls Subject to Violence

Module 1, Chapter 2: Accessibility

- Women and girls are able to access services without undue financial or administrative burden. This means services should be affordable, administratively easy to access, and in certain cases, such as police, emergency health and social services, free of charge.
- Services must be delivered, as far as possible, in a way that considers the language needs of the user.

TOOLS AND RESOURCES

Annex 1: UNFPA APRO GBV Hotline Overview Presentation (2020). Slides 4-7.

Annex 5: IFRC, 2020. Hotline in a Box. Define Your Purpose and Scope worksheet

Annex 6: UNFPA APRO, 2020. Emergency Flowchart for Hotline Calls. For use in protocol development

International Rescue Committee (2018) Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery. International Rescue Committee.

https://gbvresponders.org/wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf



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INFORMATION RESOURCES

DISCUSSION

Information, both that provided to callers and that used by hotline staff to guide their work, is a crucial resource for an effective hotline. Information resources can be considered in three general categories:

- **The referral pathway.** The pathway links survivors to health care, protection/police assistance, psychosocial support, and legal/justice systems, and it includes specific mechanisms for how referral partners receive and use survivor information.
- **Protocols for hotline staff** on handling GBV response remotely. Some protocols will overlap with standard GBV guidance on survivor assistance and just need adaptation for phone/internet delivery; other protocols are for information that is specific to hotlines and must be developed.
- **Desk references** for hotline staff. This material provides staff with information to address the range of calls that may fall outside the hotline's scope (e.g. providing a national or other number to a caller outside the hotline's catchment area); calls that are within the "umbrella" of the hotline but are not GBV issues (e.g. information on child nutrition programs provided to callers to a "women's hotline"); and technical information that can be shared with survivors as referrals are discussed, such as what happens during forensic evidence collection, or what forms of GBV are recognized under the law.

Referral pathway

The referral partners on the pathway are added after the process of service mapping (*Step 1*) and screening to determine whether the partner is able to comply with basic GBV principles (confidentiality, respect, safety, nondiscrimination, and informed consent). In areas where services are limited, it may be necessary to include referral partners who do not fully uphold these principles but if so, **the survivor must be fully informed of any limitations and potential consequences of using the service before the referral is made.** The hotline organization, in coordination with other GBV responders, should continue to advocate with those referral partners to adopt survivor-centered practices and to offer capacity building support.

In sites where a **GBV focal point** system has been initiated, determine what role focal points will play in the referral pathway. Particularly in areas where the physical presence of relevant service providers is limited, these community members may be integral to facilitating the referrals made by the hotline (for example, arranging transport) or facilitating survivor access to the hotline (for example, by distributing mobile data cards or providing a safe place for survivors to use phone/internet).

Referral partners must agree on mechanisms (how the referrals will be made and received) along with agreements on protection of survivor information, and shared understanding of how follow up with

referred survivors will be managed. Even where hotlines are initiated in areas with existing referral pathways and partners have SOPs, it is important to contact them to discuss the new service modality, processes, and standards that apply to phone-based referrals.

Hotline protocols

Specific protocols are necessary for hotline operations. Depending on the context, these protocols may be developed as part of interagency Standard Operating Procedures, through government coordination bodies for GBV, or established as an internal SOP at the hotline organization.

Areas for hotline-specific protocols and adaptations include:

- Using the equipment and understanding system features (adding third parties, recording messages, etc.)
- Responding to emergency calls
- A “script” to begin each call which quickly covers the basic elements regarding safety and callback policy
- Establishing call safety (current safety as well as a plan for handling call interruptions)
- Addressing suicidal or homicidal thoughts
- Communication techniques for establishing rapport remotely
- Crisis case management (abbreviated from comprehensive case management)
- Transition from crisis case management to comprehensive case management and/or mobile case management (if part of the service profile)
- Pathway and protocols for referrals by phone, including documenting verbal informed consent
- Call documentation formats, standards and practices
- Data usage and protections standards for identifying and non-identifying information collected during hotline calls



- Handling non-survivor calls (perpetrators, prank calls, silent calls, abusive calls, calls from survivor’s family/friends, security threats)
- Handling follow up calls from survivors
- Expanded technical guidance for working with callers from underserved groups. For example, hotline staff may have received standard training on working with male survivors or LGBTQ+ survivors, but be unfamiliar with applying this knowledge due to lack of experience with these survivors approaching onsite services.

Reference materials

In addition to protocols, quick reference materials should be readily available with basic health and legal information relevant to GBV. While the hotline staff’s role is not to provide medical or legal advice, it is important to be aware of and be able to discuss with the caller information on topics such as the timeline for receiving HIV prophylaxis and emergency contraception after rape. This type of information supports the survivor in making a timely and informed choice about referrals.

Other examples of reference materials: maps of the area; hotline numbers or GBV service providers in locations outside the intended catchment area; contact information for social services that are not part of the GBV referral pathway; basic information on legal aspects of GBV in the location, such as rights of GBV survivors, what GBV is recognized under the law, etc.

KEY DECISION POINTS FOR CONSIDERATION

- Which service providers will be included in the referral pathway?
- Are there limitations in terms of survivor-centered practices that any referral partners are practicing? Who are the decision-makers with the power to change these practices? Are they open to training or support in modifying the practices? If not, how will the pathway communication materials reflect these limitations? How will hotline staff be prepared to explain these limitations as part of seeking survivors' informed consent?
- What referral protocols and mechanisms can be agreed with referral partners?
- How will new referral partners and protocols be developed and integrated with existing GBV referral pathways? How will information about the referral pathway be disseminated?
- Will GBV focal points be included in the pathway? Is it safe to identify them?
- Will the hotline organization be able to support referral uptake with financial assistance? Can funds or materials (dignity kits, mobile credits, etc.) be prepositioned in more remote areas so that survivors can reach them?
- How often and by what process will the hotline referral pathway be verified and updated?
- How will verbal informed consent for referrals be documented?
- What areas of hotline operation require the development of new protocols?
- Do interagency or internal SOPs for GBV response exist? If so, how can they be adapted to include hotline standards and practices?
- What types of calls outside GBV response can reasonably be expected, and what information do hotline staff need to connect callers to the appropriate assistance?
- What feedback mechanism exists for hotline staff to flag gaps in protocols, outdated referral information, or need for new additions to desk reference materials?



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RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 7: Referral Systems

Referral systems are in place to connect GBV survivors to appropriate, quality, multisectoral services in a timely, safe and confidential manner.

15 Key Actions including

- Establish a functional and context-appropriate referral pathway that builds on existing GBV services and community-based structures.
- Identify and address barriers to GBV survivors' access to services (e.g., transport, knowledge of services, language, literacy, disability, age, etc.) through meaningful consultation with diverse groups of women and girls.
- Build on initial mapping of services to develop standard operating procedures among all service providers to ensure the referral pathway promotes the safety and dignity of survivors and is updated regularly. In addition to priority services (e.g. health, legal and psychosocial support), include services that support longer term recovery and reintegration (e.g. livelihood, education).
- Reassess and update the referral pathway every six months at a minimum, including service providers' contact information.
- Continuously address challenges that prevent the referral system from functioning (e.g. barriers for survivors in accessing services, challenges for coordinated service provision and case management).

Essential Services Package for Women and Girls Subject to Violence

Module 4, Chapter 3, Section 3.2: Guidelines for Foundational Elements Specific to Essential Social Services

- Referral processes must incorporate standards for informed consent
- Services have protocols and agreements about the referral process with relevant social, health and justice services, including clear responsibilities of each service
- Procedures between services for information sharing and referral are consistent, known by agency staff, and communicated clearly to women and girls
- Services have mechanisms for coordinating and monitoring the effectiveness of referral processes
- Services refer to child specific services as required and appropriate

Module 4, Essential Service 3: Helplines

Ensure the helpline has protocols connecting it with other social services and health and justice services to respond to individual circumstances of women and girls.

UNFPA Minimum Standards for Prevention and Response to GBV in Emergencies

Standard 11: Referral Systems, Key Actions

Undertake a rapid assessment/mapping of all GBV services for inclusion in the referral pathway. Assessments should seek to answer the following questions:

- What services existed prior to the emergency?
- What services are still functioning?
- Are these services safe, accessible and adequately staffed?
- Are minimum standards of service delivery met or is further capacity building required?

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview. Presentation slides 8-9.

Annex 7: UNFPA, LACRO/SROC (2020). Guidelines for the provision of remote psychosocial support services for GBV survivors. Annex 16 Remote Support Checklist.

GBVIMS (2020). Case Management and COVID-19 Video Series: Adapting Referral Pathways. <https://www.youtube.com/watch?v=4SV17TQQCDg&feature=youtu.be>

GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-Based

Case Management and Hotlines. Updating Referral Pathways in the Context of COVID-19 (pg. 52-54). <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>

For recommendations on managing difficult calls:

UNFPA Myanmar (2021). GBV Helpline Standard Operating Procedures, p. 23-29.

<https://docs.google.com/document/d/1dOSZ1ZhvJN--k7etRHMbqQOqximvorAa/edit?usp=sharing&oid=112880614441586256995&rtpof=true&sd=true>





DISCUSSION

The tasks involved in human resource management for hotlines include the **recruitment, training, scheduling, supervision, and support for wellbeing of the staff** who will provide remote services. Ultimately the quality of hotline staffing will determine whether the hotline is an effective method of GBV response. The nature of hotlines means that callers can easily end an interaction that is intimidating, unhelpful, or otherwise not meeting their needs. Staff must be able to quickly convey both empathy and competence in order to gain the caller's trust.

Employers must in turn facilitate staff wellbeing through providing a supportive working environment that offers continuous skill development. This becomes crucial for staff whose work involves responding to violence and trauma.

The decisions made and information gathered in Steps 1 - 4 will be relevant for determining how many and what type of hotline staff are required under the chosen service profile, along with what specific qualifications and attributes are needed to work with the intended hotline users in the assessed location.

Recruitment

The demographic profile of hotline users will affect some aspects of hotline staff recruitment. This is specific to each community so the factors of language, familiarity with the culture, gender and age of the hotline staff, may all be relevant in determining what diversity of staffing is necessary.

In the case of gender, for example, consider how staffing will affect the feeling of emotional safety for female callers (likely to be the vast majority). How will the first voice she hears—male or female—affect her willingness to continue the call? Depending on the intent of the hotline to reach particular groups of survivors, it must also be considered whether a mix of male/female staff is needed for some locations.

In hiring hotline staff, personal qualities of patience, the ability to remain calm in crises, local language skills, excellent communication skills, empathy and ease in engaging in problem solving with callers (who will likely be more limited in their access to typical referrals and resources) will be useful attributes.

Some hotlines, particularly those providing very limited case management, employ entry-level hotline staff and invest in significant training to prepare them for the specific GBV and hotline skills needed. More often, experienced GBV case workers are employed for hotline duties, making use of their existing technical skills and focusing the training on adapting to hotline counseling.

Whichever approach is taken, hotline staff will need to be able to demonstrate competency in GBV knowledge, skills, and attitudes before taking hotline calls (see *Tools and Resources* for a sample Terms of Reference).

Training is more fully discussed in Step 7. See also the supervision notes below as they apply to ongoing learning opportunities that supervisors can arrange.

Scheduling

It is exceedingly difficult for hotline staff to manage on-call hotline duties while simultaneously handling their other routine work. Whenever possible, establish dedicated shifts and staff for the hotline. Develop clear and realistic standards for shift length, recovery time, breaks, and backup support.

Supervision and support

Hotline work typically involves callers in high-stress circumstances. Hotline staff often never learn the ultimate outcome of the caller's situation, and usually have no second chance to engage the survivor or refine a safety plan. Over time, this can lead to feelings of anxiety, inadequacy, and burn out. The practices put in place to supervise hotline staff can make a considerable difference in whether they feel supported and fit to continue in this frontline position. **Training cannot be seen as a one-time activity but as an ongoing process** that is refreshed through supervisor mentoring and peer group meetings in which SOPs are discussed and protocols are applied to real (non-identifying) hotline situations.

Arranging **regular peer support meetings** is a promising approach for encouraging staff wellbeing among hotline workers. One qualitative evaluation done of hotline workers during the Ebola epidemic in Sierra Leone determined that "respondents all reported that the support group was beneficial. They most valued being able to increase their knowledge to help the callers and having a safe, re-energizing space to meet. The respondents described how the support group helped them at work in handling abusive calls, managing stress and developing counseling skills."¹⁰

Difficult calls should trigger **individual debriefings** with a supervisor in which the hotline staff is helped to recognize their emotional reactions and concerns as well as to request particular training and resources. As a routine part of communication with staff, ensure that they understand what internal or external **psychosocial support services** are available for them and know how to access them. Supervisors with appropriate training may include group PSS as part of regular mentoring/coaching sessions.



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Standards should be set for whether supervisors will review all call documentation or samples, how frequently the review will be done, and how feedback will be provided to the staff. The latter can be accomplished through **group or individual mentoring meetings** in which specific and constructive suggestions for improvement are made. These meetings should be regularly scheduled and frequent, with an emphasis on learning rather than staff evaluation.

Make sure to have systems for **hotline staff to give feedback** on what they need to improve their assistance to callers: training and skills practice, new protocols and forms, revisions to SOPs, expanded referral pathways, hardware and equipment, supplies, etc.



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KEY DECISION POINTS FOR CONSIDERATION

- What are the demographic characteristics that are important for hotline staff to have in order to increase community acceptance and use of the hotline?
- Will hotline staff be recruited internally from experienced GBV staff, externally, or both? What levels of professional education and/or experience will be included in the Terms of Reference for hotline positions? What other competencies will be included?
- Will there be an applied skills demonstration as part of the selection process for hotline candidates? As part of regular assessment of hotline staff?
- Will hotline staff have dedicated shifts (i.e., they are not required to answer a hotline while also managing regular position duties)? How many hotline staff will be needed per shift? How will backup staffing be handled in case of emergency?
- How will interpretation be handled? Do hotline staff who are expected to converse in multiple languages have adequate capacity? If interpreters are recruited, what internal training and assessment will be provided to ensure their GBV/PSS competence?
- Will all hotline staff provide the same services? If not, how will specific skill sets be assigned to different positions, and how will that impact scheduling?
- What number of hours will a shift include, and how will breaks during and between shifts be handled?
- What staff to supervisor ratio will be established?
- What supervision mechanisms will be used to ensure hotline staff receive ongoing skills development, practice, and debriefing?
- What monitoring practices will be instituted to check on hotline staff' knowledge, skills and attitudes? What mechanisms will supervisors use to check on staff's emotional wellbeing?
- What psychosocial support will hotline staff have access to (internal and external)?
- How will hotline staff be involved in developing, assessing, and improving protocols and information resources?
- How will hotline staff feedback on the work environment be elicited?

REGIONAL EXAMPLE

Encouraging hotline staff self-care in Sri Lanka

In Sri Lanka, UNFPA supports 1938, which is a national GBV hotline operated by the National Commission on Women, a division of the State Ministry of Women and Child Development, Pre-School & Primary Education, School Infrastructure & Education Services. This hotline was established to provide a resource for women facing any form of discrimination, harassment, or abuse, so while the focus is GBV, staff must listen to and be able to refer callers to a range of services.

In 2020, UNFPA conducted a three-day training for the hotline staff that included a session on staff wellbeing and self-care. Recognizing that feelings of anger, fear, and helplessness are common for staff, an MHPSS counselor was engaged to discuss how to develop and support boundaries that will preserve staff's ability to manage the emotions related to the work. Along with this, the workshop taught specific techniques for stress management and identification of coping skills. As staff practice these skills in their own lives, they also become more aware of how to discuss self-care with callers. NCW's Hotline Guidelines, produced in 2021 with UNFPA Sri Lanka's technical support, offer a section on self-care tips along with recommendations for supervisors in terms of structuring peer support sessions to give staff opportunities to assist one another in processing their shared experiences.



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RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 3: Staff Care and Support.

GBV staff are recruited and trained to meet core competencies and their safety and well-being are promoted.

12 Key Actions for Staff Care and Support, including:

- Establish a GBV programme team with sufficient staff, resources and support, including female personnel and ethnic diversity, to facilitate quality programming
- Develop job profiles with specific responsibilities in line with the GBV Core Competency Framework for GBV in emergencies
- Establish regular supervision to provide technical and psychosocial support for all staff delivering GBV response services
- Establish access to psychosocial support for all staff working in GBV, recognizing that support needs will be different based on individual experiences of stress and trauma
- Promote an organizational culture in which complaints are taken seriously and acted upon according to defined policies and procedures

Promote staff well-being in emergencies and facilitate a healthy working environment:

- Prioritize self-care and safety for staff (e.g., clear job description, systematic on-boarding and operational support, at least one day off per week, clear working hours, appropriate insurance and provisions for medical evacuation, parental leave, rest and relaxation or home leave for staff in complex humanitarian emergencies, staff well-being activities, etc.);
- Promote access to health care and psychosocial support for staff;
- Create spaces for staff to discuss quality of life and safety concerns.

Guidance Note 2: Enhancing programme quality by supporting staff safety and care
Humanitarian organizations must ensure the physical and psychological health and safety of staff. Staff working on GBV may face additional and unique safety risks due to the nature of their work. For these reasons, their organization's safety and security team must address and respond to any potential threats and protection concerns.

Working with GBV survivors can be particularly stressful. It is common for staff to experience everyday stress, cumulative stress, burnout, vicarious/secondary trauma and critical incident stress. Vicarious/secondary trauma may be identified by a change in the staff member's ability to engage with survivors and a decreased ability to cope with stress. It is typically a cumulative process that builds over time after prolonged exposure to other people's suffering. GBV coordinators and managers should be aware of their staff's stress levels, and establish routine mechanisms for acknowledging and supporting staff safety and well-being.

Interagency GBV Case Management Guidelines

Section 3.1.4 Staffing Structure: Benchmarks for good practices

- Caseworkers that speak the language(s) spoken by survivors so survivors can communicate in their first language.
- The gender of caseworkers should also be considered. [Consider the emotional safety of survivors in the context of the program.]
- The ethnic, religious and cultural background of caseworkers should also be considered, and caseworkers should be hired to create a staff mix that is proportional to the makeup of the population being served.
- A supervisor to caseworker ratio of 1:5 and no larger than 1:8.
- Ongoing training, learning, support and other capacity building opportunities for caseworkers to further develop core qualities and skills and for supervisors to advance their technical and management abilities.

Standard Operating Procedures (SOPs) for the Bolo Helpline Khyber Pakhtunkhwa (UNFPA Pakistan-supported hotline)

Hotline Staff Safety Provisions, Section 5.1

- The staff dealing with callers will not reveal their real names and will be assigned code names instead and share with the caller/survivor that these are their counselling names.
- No personal information about the staff member will be given to any caller
- A guard will available at the premises at all times
- The Director will establish contact with the local police and alert them to potential security issues at the Bolo helpline office.
- Emergency/police numbers will be displayed at the Bolo Helpline office
- Mobile numbers assigned to staff for after-hours will not be traceable
- The support staff shall be oriented on all code of ethics of helpline

TOOLS AND RESOURCES

Annex 1: UNFPA APRO. (2020) GBV Hotline Overview. Presentation slides 10-11.

Annex 8: One Future Collective (2019). Self Care for Caregivers.

Annex 9: UNFPA Sub regional Office for the Caribbean. (2020). Excerpts from Terms of Reference, GBV Helpline Specialist.

The KonTerra Group (2016). Essential Principles of Staff Care: Practices to Strengthen Resilience in International Relief and Development Organizations.
<http://www.konterragroup.net/admin/wp-content/uploads/2017/03/Essential-Principles-of-Staff-Care-FINAL.pdf>

GBVIMS (2017). Interagency GBV Case Management Guidelines. Chapter 3, Section 3.1, Staffing GBV Case Management Services, pg. 29-32. <https://gbvresponders.org/response/gbv-case-management/>

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming. (2019). Standard 3, Guidance Note 1: Contextualizing the GBV Core Competencies.

GBVIMS (2020). COVID-19 Series/Episode 7: Remote Supervision and Staff Care: <https://soundcloud.com/gbvims>

हेल्पलाइन		
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Source: GBV Hotline, Nepal

PHYSICAL INFRASTRUCTURE

DISCUSSION

Hotline operation requires a physical space for staff to receive calls. This may be a room within a women's center, an agency's office, a hospital or clinic, or other facility.

In some instances the only physical space for receiving hotline calls is in the staff member's home; this may be true in situations of conflict or pandemic, for example, in which working from home is required. If there is no alternative to taking calls in staff homes, ensure that:

- **private workspace** is established, including financial support for methods to make the space more insulated in terms of sound (partitions, carpets, wall hangings, fans/white noise machines, etc.)
- appropriate decisions are taken about **collection and protection of call data** (see Steps 8 and 9) and if it is unavoidable to store data onsite for any length of time, secure provisions have been arranged.
- phones, laptops, or other **equipment necessary to answer the hotline are provided for staff** to use in their homes.
- equipment available in the hotline staff's home will support obtaining backup, emergency help, translation, or supervisory assistance to the staff member on duty.

- supplies, including mobile credit if applicable, and reference materials are disseminated to each hotline staff member.

Once the environment is stabilized, relocation of the hotline to a secure office or facility is advised. Hotline planning and resource mobilization should include funding for a private, dedicated hotline space.

Ensure that the hotline area is quiet and protected from both the public and from office foot traffic. Hotline staff should be able to speak audibly without danger of being overheard outside the room. Within the hotline room, consider the benefits of having an open floor plan, which allows staff to learn from each other and to hear when a colleague needs backup; a closed plan, which allows complete privacy for calls; or a hybrid plan. The hotline office must be a dedicated space, i.e. hotline staff are not meeting there for other activities during operational hours.

There should be **adequate space for storing and locking files and call documentation**. Depending on what files or call documentation are kept in the room, and in what format, there must be protection in place to guard against any unauthorized entry (e.g. lockable doors and steel cabinets, passwords on electronic files, voice mail systems, etc.). Ensure sufficient space to arrange materials and supplies that the hotline staff needs to have readily available.

A hotline that is operated from a standalone facility, in which there is no security presence or system of controlled entry, is more vulnerable to physical threats from perpetrators. Similar to other GBV response sites, a careful assessment should be made about what threats exist (e.g. potential for unauthorized access) and how staff can be protected. If the hotline is a 24-hour operation, leaving a staff member onsite overnight alone is potentially dangerous. In any case where the hotline is housed in a standalone space, consider keeping the location confidential and/or posting onsite security personnel.

Providing secure access to GBV services through a hotline depends not only on staff safety but caller safety. Consider what measures can be taken to establish access to the hotline for callers in the target location who may be unable to safely call from their homes or their family phone/internet devices. Options may include approaching other service providers or agencies that have a physical presence in the location (health clinics, nutrition centers, etc.) to establish access through a code word; arranging for GBV community focal points to offer access; or identifying trusted community leaders who can safely provide a private space and mobile for hotline callers when needed.

KEY DECISION POINTS FOR CONSIDERATION

- Where will the hotline be housed? How will privacy be arranged so that hotline staff are not overheard or interrupted while on calls?
- If hotline staff must take calls at home, what financial support or materials will be supplied to ensure a private space is established? How will the space be approved and monitored?
- For hotlines housed in shared facilities, has an MOU been developed to establish requirements for privacy and confidentiality?
- What equipment, furnishings and storage are needed in the space? How will files and documentation be physically protected?
- How will the physical safety of hotline staff be protected? What systems and staff will be engaged to control entry to the hotline space?
- What physical spaces can be identified in the target community to allow callers to reach the hotline if they do not personally have safe access to phone/internet?

RELEVANT STANDARDS

<p>COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines</p>	<p>Safety and Privacy, p. 6.</p> <p>Safe delivery of GBV services requires, at minimum, privacy. This means ensuring that phone-based service providers have a separate facility or room where they can receive calls. In some settings, staff may still be able to work in private rooms in an existing GBV case management service facility (e.g. a safe space), or in some other facility (e.g. a health facility) that is able to put in place adequate protective protocols and equipment.</p> <p>If taking calls from home, staff must ensure a private space where no one else can listen in on the calls...it means having an allocated private space, where there will be no interruptions and where confidentiality can be maintained during designated working hours. Where they are implemented, it is important that home-based work environments are assessed by supervisors in the early stages of planning.</p>
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TOOLS AND RESOURCES

Annex 1: UNFPA APRO GBV Hotline Overview Presentation (2020). Slide 12.

Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (2003) Setting Up a Hotline/Helpline. Chapter 8: Setting Up a Telephone System and Hotline Room. https://pdf.usaid.gov/pdf_docs/PNACU541.pdf

GBV Area of Responsibility Helpdesk (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>



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DISCUSSION

Hotline staff will need an additional measure of training beyond the baseline for workers providing onsite GBV response. The technology, communication style, priorities for the interaction, referral practices, and documentation will all pose differences from how services are delivered in person.

Based on these factors, and including any other new or adapted protocols that have been developed for the hotline (*Step 4*), **even experienced GBV staff who are hired or shifted to hotline work will require additional training and mentoring.**

Based on the service profile that is selected, staff will need training and coaching to move to a crisis case management approach rather than the usual comprehensive approach.

Another example of a difference between hotline and in-person services is the necessity for setting up a **call safety plan**, so that both parties know what to do if the caller is surprised or interrupted by others during the call. The staff and caller should discuss what will happen if the call is disconnected. It is also critical for hotline staff to be prepared to manage calls that originate as or develop into emergencies.

Without being able to use body language to communicate, hotline staff will need additional practice on using **verbal communication skills** to create rapport and establish a feeling of emotional safety and acceptance for the caller. Practice in guiding the phone conversation to elicit the most critical needs is also important since time on the call may be limited.

Another new training component will be the **management of calls that are coming from**

people other than the intended users. Staff should receive guidance and practice in handling harassment calls, abusive calls, silent calls, and calls from suspected (or admitted) perpetrators.

It is essential that hotline staff are provided with extensive and recurring opportunities for skills practice and that they receive regular constructive feedback. Therefore, training and refreshers should incorporate methods such as role plays and scenarios. As outlined in Step 5, group experience sharing and support sessions for hotline workers are not only part of staff care but are also educational opportunities that provide a useful way for peers to learn from one another in a more relaxed environment. Make sure to capture new ideas or best practices from these sessions to improve training materials or SOPs.

Arranging periodic briefings for hotline staff from relevant service providers is another way to support learning, whether the providers are part of the formal referral pathway or have services that may be otherwise related to the population of concern.



Source: 24/7 Helplines, Viet Nam

KEY DECISION POINTS FOR CONSIDERATION

- What baseline training will be required for all hotline staff? Which existing training components require adaptation for hotline work?
- What new training topics will be added for hotline staff? How will new hotline protocols/SOPs be integrated into training components?
- Are supervisors and trainers proficient in the types of interactive training techniques needed for building capacity of hotline staff? If not, how can they be supported?
- For what period of time will new hotline staff be paired with supervisors or other experienced staff?
- What assessment standards will be used to determine if a hotline staff is ready to take calls? Will assessment include skills demonstration?
- How will feedback from hotline staff regarding their on- the- job experiences and questions be integrated into training materials?

REGIONAL EXAMPLE

COVID-19 Opens Window of Training Opportunity in People's Democratic Republic of Lao



Source: UNFPA Lao PDR

With the first wave of COVID-19 community transmissions, GBV agencies around the world braced for increased risk of violence against women and girls as they became isolated in their homes and their access to usual forms of support through community services became limited. In Lao PDR, UNFPA provided urgent support to Lao Women's Union (LWU), a government ministry, to expand their GBV hotlines to operate 24/7 with national scope. This expansion was accompanied by comprehensive training in hotline counseling and responding to COVID-19 related stressors.

With the second wave of community transmissions one year later, additional capacity building was conducted on MHPSS for the counselors of LWU, Lao Youth Union, Vientiane Youth Clinic and the National University of Laos, including training on providing MHPSS to survivors of GBV. Further training is planned on Psychological First Aid, consistency of GBV hotline data collection across sectors to align with GBVIMS, and referral processes. Because UNFPA was able to quickly respond to meet the expressed needs and requests of the GBV hotline provider, trust was built and relationships strengthened so that the Country Office GBV team is well placed to offer continuing opportunities for expanded skills training to government-run GBV responders.

RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 3: Staff Care and Support

GBV staff are recruited and trained to meet core competencies, and their safety and well-being are promoted.

Human resources should continuously build the capacity of staff to respond to GBV in emergencies, and all staff must be trained on the survivor-centered approach and basic GBV programming concepts. In an emergency, staff working on GBV programming must receive training to meet context-specific responsibilities (e.g. GBV case management, psychosocial support, GBV prevention, women's empowerment and livelihoods support). Managers must invest in staff capacity development by dedicating time for participation in GBV response and prevention training.

Share GBV training resources with all staff.

Conduct an internal staff capacity assessment across programme areas to identify gaps in knowledge, capacity and attitudes, and develop a strategy to build staff capacity and address identified needs.

Essential Services Package for Women and Girls Subject to Violence

Essential Service 3: Helplines

3.1 Availability. Ensure that staff answering help lines have appropriate knowledge, skills and are adequately trained.

Source: UNFPA Philippines

Source: UNFPA Maldives

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slides 13-16.

Annex 1A: UNFPA APRO (2020). Hotline Call Safety. Presentation slides and exercises.

Annex 1B: UNFPA APRO (2020). Safety Planning for Hotlines. Presentation slides and exercises.

Annex 10: GBV AoR Helpdesk (2020). Training GBV Caseworkers to Provide Phone Based Services. COVID-19 Guidance on Remote GBV Services Focusing on Phone-Based Case Management and Hotlines.

GBV AoR Helpdesk (2020). Training Hotline Staff. 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>

International Rescue Committee. ROSA: Remote Offered Skill Building Application. Download at Google Play Store or iTunes. Information available

at: <https://gbvresponders.org/rosa-skill-building-application/>

IRC. (2018). Guidelines for Mobile and Remote Gender-Based Violence (GBV) Service Delivery. Annex 5: Additional Guidance for Implementation of a Telephone Hotline.

https://gbvresponders.org/wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf

GBVIMS (2020). COVID-19 Series/Episode 4: Taking a crisis call – what to say and how to say it: <https://soundcloud.com/gbvims>

GBVIMS (2020). COVID-19 Series/Episode 5: Safety planning with survivors over the phone: <https://soundcloud.com/gbvims>

UNFPA (2012). Managing Gender-based Violence Programmes in Emergencies: E-Learning Companion Guide.

<https://www.unfpa.org/publications/managing-gender-based-violence-programmes-emergencies>

Ikaw ba ay isang survivor ng Gender-Based Violence?

Kailangan mo ba ng isang mental health professional?

Pag-usapan natin 'yan.

Libre at walang panghuhusga.

Viber: 09617173855 / 09155262622

fb.com/PMHACommunityBasedMentalHealthProgram

pmha.mhps4womenandchildren@gmail.com

Monday - Friday, 8:00AM-5:00PM

Source: Philippines Mental Health Association

TIPS MELINDUNGI DIRI DARI KEKERASAN

Rumah seharusnya menjadi tempat yang aman bagi perempuan. Lakukan beberapa hal berikut untuk melindungi diri dari kekerasan di rumah:

- Identifikasi tetangga, teman, kerabat, atau tempat penampungan yang bisa didatangi untuk mencari perlindungan.
- Siapkan beberapa barang penting (misalnya dokumen identitas, telepon, uang, obat-obatan, dan pakaian).
- Buat kode dengan tetangga dan teman terpercaya sehingga mereka dapat membantu Anda jika terjadi keadaan darurat.
- Simpan nomor-nomor layanan medis darurat di sekitar tempat tinggal Anda. Untuk respon cepat, hubungi layanan darurat di nomor 112, atau ambulans di 118 dan 119.
- Jika Anda ingin melaporkan insiden kekerasan selama pandemi, hubungi layanan yang bisa memberikan tanggapan sesuai kebutuhan Anda.

Simpan nomor-nomor penting ini

- Layanan darurat 112
- Layanan ambulans: 118, 119
- Medula COVID-19: 081 901 8
- Medula KPPN: 021 5715 1234, 021 512 2311, pengabdian@kemppn.go.id, https://tts.ly/bankasapain
- Medula Perempuan: 1600 775757 (Toll Free 021)
- Rumahnya Perempuan: 021 3603663
- jalurpanggilandemandan@kemppn.go.id
- Libur APN: 021 3602 3601 (WA), jengpanggilandemandan@gmail.com
- Ngayun Putih: 021 943 9233
- E-counseling: <https://jalurpanggilandemandan.org/formulir-dan-layanan>

STOP! KEKERASAN TERHADAP PEREMPUAN & ANAK

4A bkkbn UNFPA Australian Aid

Source: UNFPA Indonesia

DISCUSSION

Hotline organizations must decide **whether and how information from callers will be recorded**. A number of factors influence this decision, including the physical space being used to receive calls; whether information will be captured on paper or electronically; any security concerns around call interception; whether hotline callers will be connected at some point to mobile or static GBV providers for onsite assistance; and what the intended use is for the information.

In general, **a model that allows calls to be answered from the hotline staff's home should not use a paper-based documentation system that includes any caller-specific data**. Concerns about the potential for caller information to be exposed make this a security issue. If home-based hotline staff are able to use electronic methods of call documentation (such as PRIMERO/GBVIMS+ on phones or tablets), data protection is then possible, so there is more scope to consider collecting caller information.

A hotline operating in an environment where state actors are frequent perpetrators of GBV may experience demands for call documentation to be turned over to authorities. Hotlines in such areas should carefully consider what information will be gathered in their documentation system.

The service profile of the hotline also affects the need to record information. If a hotline is operating in conjunction with mobile GBV services, what

information needs to be shared (with consent) to facilitate an onsite visit? Hotlines that will carry out ongoing case management by phone/internet should develop codes or call back protocols that will allow the survivor to speak with the same hotline staff over time and to store coded phone numbers for survivors. For hotlines with no provisions for ongoing or onsite case management, the interaction with the caller will typically be one-time, and there is no compelling reason for documenting identifying information such as the caller's name and address. Asking about the survivor's location is still important in order to make appropriate referrals, but specific addresses do not need to be documented.

Under any hotline model, **callers should have the right to speak anonymously with the hotline staff** unless they decide that they want direct assistance in making referrals. Requiring that callers disclose their identity discourages calls and also places additional burden on the hotline organization to protect identifying information.

Collecting non-identifying call data for aggregation and analysis provides valuable insight into how the hotline is functioning, whether it is providing a service that is gaining trust in the community, call volume for different types of issues, risks survivors are facing, and what gaps in services and referrals exist. This information can be useful not only for service improvements but for advocacy, prevention programming, and coordination purposes.

If using PRIMERO/GBVIMS+ for documentation, analysis will be supported through data entered there. For calls that do not proceed to a crisis case management point, it should be agreed which fields will be completed to create call records, or additional logs created for non-survivor calls.

The **documentation system chosen for the hotline should be created in consultation with users of the information**, which could include case managers, hotline supervisors, those designing or monitoring GBV programming, and those who are producing management and donor reports. As the frontline providers, hotline staff can provide feedback on how the documentation system does or does not facilitate service delivery.

Suggestions for consideration when deciding how documentation will be structured include:

- **Starting/ending time** for the call is useful for supervisors to determine whether staff are allowing adequate time for consultation.
 - **Caller type** (survivor, family/friend, perpetrator, caller seeking non-GBV assistance) to understand how to adjust hotline outreach and dissemination.
 - **GBV type or issue** raised (e.g. family disputes, mental health, child custody disputes) is useful to identify trends that may be occurring in the location, so that prevention and response programming can be adjusted to meet needs for awareness raising, communication with communities, service provider readiness and training, etc.
 - Indication of whether a **safety plan** was created is a supervision monitoring point. Innovative safety plan arrangements can also be documented for sharing in group learning sessions.
 - Indication of **verbal informed consent** is a supervision monitoring point.
- Logging the caller location (not address) and the **needs** discussed during the call against the **actual referrals** made will highlight gaps in services (e.g. number of callers who wanted temporary shelter in a location without any safe house).
 - When anonymous callers mention their **age, ethnicity, migrant status**, or request a particular **language**, or flag a **disability**, the information can be captured for statistical purposes, to monitor whether hotline services are reaching diverse populations.
 - Documentation systems can be designed which allow the staff to **categorize the call** at the end. This may assist supervisors in identifying which documentation is relevant for performance monitoring, and assist managers with information about whether the hotline is functioning as planned and reaching the intended users. For example:
 - **Level 1:** Emergency call
 - **Level 2:** GBV counseling and/or referrals provided
 - **Level 3:** Non-GBV issue
 - **Level 4:** Harassment call
 - (continue to customize as needed)
 - It may also be helpful to include a **flag for follow up** actions, if additional information needs to be communicated to other staff in order to ensure the caller receives the assistance discussed.



Source: Women's Aid Organisation, Malaysia



KEY DECISION POINTS FOR CONSIDERATION

- In a context where hotline staff are taking calls at home, what documentation process is safest?
- Is there a precedent, or any reason to anticipate, that hotline call records could be seized for judicial purposes or through extra-judicial action? If so, how will this change what is documented?
- In office or facility settings, will hotline staff document with paper or electronic systems?
- If PRIMERO/GBVIMS+ is in use, how will it be used for hotline calls? What is the “threshold” for considering the call to be a case management activity? Will any other type of documentation be used to capture statistics on non-GBV calls, silent calls, perpetrator calls, etc.?
- Under what circumstances will identifying data be requested and documented? How will this data be encoded?
- If survivors will be connected to case managers or mobile teams for ongoing response, what information is documented on the initial call? What information, in what format, is shared with the case manager/mobile team?
- What non-identifying data will be aggregated and analyzed and for what purpose? Is any data being collected that has no specific intended use?

RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 14: Collection and Use of Survivor Data

Survivor data are managed with survivors' full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

Key Actions Including:

- Identify a safe and ethical information management system in line with globally recognized standards on survivor data management, and dedicate financial and human resources to ensure safe and ethical data collection, analysis and use. If GBV service providers are considering rolling out the Gender-based Violence Information Management System (GBVIMS) or Primero/GBVIMS+, contact the GBVIMS Steering Committee to determine suitability and eligibility
- Train relevant staff (e.g. GBV caseworkers) on safe and ethical data collection, storage, analysis and sharing, including coding systems and safe filing.

Survivors have the right to know what data are being collected and what will be done with them. Data should only be collected with survivors' **informed consent**. Service providers must always assess whether the benefits of data collection outweigh the risks.

Data analysis allows organizations to understand the data collected, extract meaning from it and draw informed conclusions to strengthen GBV programming. Properly analysing quality GBV data can help to: (1) understand the trends and patterns of reported incidents; (2) make informed decisions regarding interventions; (3) plan for future action; and (4) improve the overall effectiveness of GBV service provision and programming at-large.

GBVIMS Steering Committee

Minimum Requirements for GBV Survivor Data Management

- Services (e.g. health or psychosocial support) must be available to GBV survivors if data are to be gathered from them.
- Survivor/incident data must be collected in a way that limits identification, and, if shared for analytical/reporting purposes, must be non-identifiable.

Essential Services Package for Women and Girls Subject to Violence

Module 5, Chapter 2

Section 3.3: Systems for recording and reporting of data

- Obtain consent of victims and survivors before recording personally identifiable information (PII).
- Protect confidentiality and privacy of victims and survivors when collecting, recording and reporting PII.

TOOLS AND RESOURCES

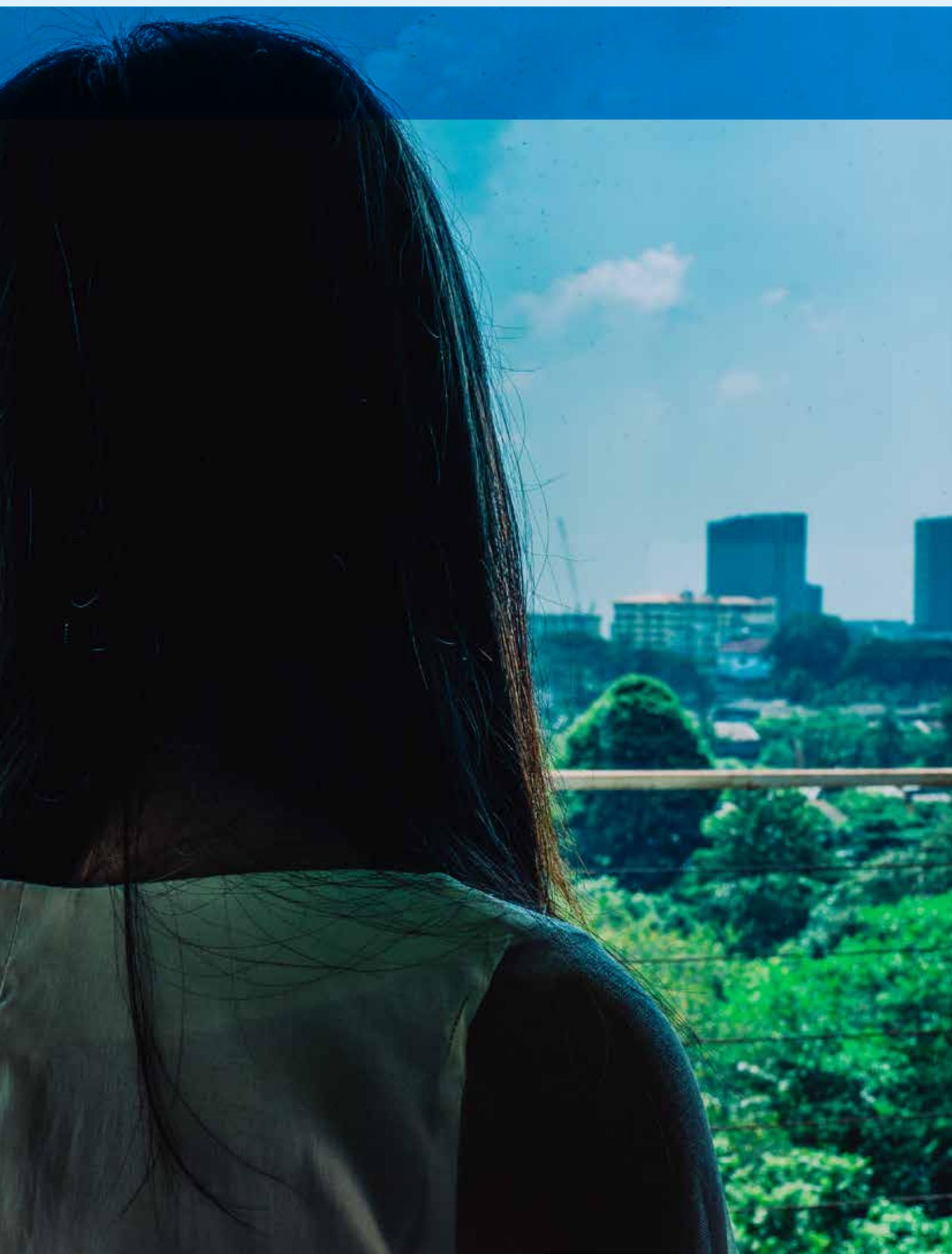
Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slide 17.

GBV AoR Helpdesk (2020) COVID-19 Guidance on Remote GBV Services Focusing on Phone-Based Case Management and Hotlines. Using Primero/GBVIMS+ for Data Collection and Storage for

Phone-based Remote GBV Case Management (pg. 58-60). <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>

GBVIMS (2020). COVID-19 Series/Episode 6: Confidentiality and documentation. <https://soundcloud.com/gbvims>





DISCUSSION

Decisions made in Step 8, Documentation, will determine what data is collected from hotline callers and in what format (paper or electronic, using PRIMERO/GBVIMS+ or other applications). Protection of this data is essential in order to do no harm to survivors, and to uphold GBV guiding principles of confidentiality, respect, and safety.

Whether a hotline call proceeds to crisis or comprehensive case management or not, **any potentially identifying caller information that is collected must be protected.** This requires physical mechanisms (lockable storage, lockable rooms, secure facilities) and/or electronic mechanisms (passwords, encryption). An internal agency policy must be developed to determine who may access hotline logs or data and for what purpose. Levels of data access and reporting should be created to ensure the information shared with donors, media, etc. is not only non-identifying for the individual survivor but does not result in location-specific data that may endanger survivors, communities, or staff.

As mentioned in Step 4 in the referral pathway discussion, **referral partners should agree on a protocol to protect survivor data.** This will apply to the information they receive from the hotline when a survivor is referred, as well as any records they produce or store that contain identifying information. Note that this does not represent a change from how referral practices operate in non-hotline response. However, if arranging referrals by phone results in changes in documentation, all partners should clearly understand these changes and the appropriate revisions should be made to the referral partners agreement.

If the hotline organization is part of a GBV coordination group that shares aggregate-level data under an Information Safety Protocol (ISP), determine whether and how data from the hotline will be reported and in what format. There is the potential for double-counting (if callers are counted at the time of the hotline call but are also referred to in-person mobile/static case management services).

There is also the potential for considerable undercounting of GBV incidents depending on how hotline callers are integrated into overall case management numbers. Determine differences, if any, in how crisis case management calls will be counted compared to comprehensive case management. Consider how the fields of data collected from hotline survivor calls and non-hotline survivor services align so that they can be used in an aggregate analysis of service data.



Source: UNFPA Mongolia

KEY DECISION POINTS FOR CONSIDERATION

- How will the current data protection practices change or expand to include hotline data? Will this affect electronic files, paper files, or both?
- What data backup plans are in place? Are modifications to backup procedures needed for hotline data? If paper files are being kept, what evacuation plans are in place?
- How will hotline data be shared internally to connect survivors to continuing case management?
- What level of hotline data will be shared in reporting to donors, media, etc.?
- Is an Information Sharing Protocol in place with service providers and/or other GBV response agencies? Are any amendments needed to encompass hotline data protection?
- Will hotline data be part of overall GBV case data aggregation (either internally or in situations where data is shared through an ISP) and if so, what threshold of service must be reached during the call to consider it part of GBV case management numbers?
- Do any national laws or policies affect the organization's ability to store and protect caller data? Under what circumstances will data be released?



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RELEVANT STANDARDS

Inter-Agency Minimum Standards for Gender-Based Violence in Emergencies Programming

Standard 14: Collection and Use of Survivor Data

Survivor data are managed with survivors' full informed consent for the purpose of improving service delivery, and are collected, stored, analysed and shared safely and ethically.

Key Actions Including:

- Develop internal protocols to determine how individual-level identifiable data (for referrals) and aggregate-level non-identifiable data (for reporting) will be shared within your organization and with others.
- Procure all items necessary for safe and ethical storage of survivor and incident data, including but not limited to a lockable cabinet, encrypted computer, etc.
- Ensure that a data evacuation plan is in place allocating roles and responsibilities in case of emergency.
- Train relevant staff (e.g., GBV caseworkers) on safe and ethical data collection, storage, analysis and sharing, including coding systems and safe filing
- Develop an information-sharing protocol to share aggregate-level, non-identifiable data for compilation to inform programming, advocacy and reporting

GBVIMS Steering Committee

Minimum Requirements for GBV Survivor Data Management

- Survivor/incident data can only be shared with the informed consent of the client.
- Identifiable case information (i.e., referral forms or, in situations of a case transfer, relevant portions of the case file) are only shared within the context of a referral and with the consent of the survivor.
- Client data must be protected at all times and only shared with those who are authorized.
- Before data are shared, an agreement must be established in collaboration with service providers to determine how data will be shared, protected, used and for what purpose.

Essential Services Package for Women and Girls Subject to Violence

Module 1, Chapter 2

Data Collection and Information Management, p. 16

- Ensure there is a documented and secure system for the collection, recording and storing of all information and data.
- All information about women and girls who are accessing services is stored securely including: client files, legal and medical reports, and safety plans.
- Ensure accurate data collection by supporting staff to understand and use the data collection systems, and providing them adequate time to enter data in data collection systems.
- Ensure data are only shared using agreed protocols between organizations.
- Promote the analysis of data collection to assist in understanding the prevalence of violence, trends in using the essential services, evaluation of existing services and inform prevention measures.

REGIONAL EXAMPLE

Myanmar: Protecting GBV Data in Fragile States



Source: UNFPA Myanmar

In response to the February 2021 military coup and the third wave of the COVID-19 pandemic, which further limited GBV service availability and accessibility in Myanmar, several GBV actors in the country switched their GBV services to helpline/hotline operations so that they could continue providing support to survivors in need remotely. UNFPA's Myanmar Country Office GBV team has been providing ongoing technical and financial support to several civil society organizations, including women's groups and an organization of people with disabilities, in setting up GBV and PSS helplines.

GBV data is particularly sensitive in conflict-affected areas where military and paramilitary groups are involved in GBV perpetration. In this context, UNFPA-supported helplines that do not provide direct case

management services will record data about calls received and the uptake of services in a cloud-based call log template without including any information that could identify the caller or survivor. The call log template includes general, non-identifiable information such as the date and time of the call, length of the call, types of incidents being reported, reasons for the requested assistance and referrals offered.

Helpline operators are advised not to collect any identifiable information from the caller/survivor unless it is absolutely necessary, e.g. for specific referrals. Helpline operators are advised to save the call log template and other relevant documents offline for the case that they lose internet connectivity. They are also encouraged to secure backup copies using tools that are not prone to hacking such as folders on hard drives, flash disks or phone memory cards which can easily be removed from devices and destroyed if need be. Helpline operators are further recommended to make sure that only authorized personnel have access to these documents and to change the password of devices and documents regularly, especially when there is staff turnover.

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slide 18.

Annex 11: GBVIMS. Data Protection Checklist.

GBVIMS. Podcast: Data Protection Principles and Practices.

<https://www.gbvims.com/data-protection/>

DISCUSSION

Monitoring hotline implementation includes checking quality of services and compliance with the policies and protocols established for operation. Some examples of monitoring points:

- Clarity and completeness of documentation
- Identifying information is captured only according to need
- All call documentation filed by end of shift
- Informed consent is obtained
- Appropriate referrals are made
- Referral pathway information is accurate and up to date
- Safety plans are completed for crisis management calls
- Data and files are stored securely
- Administrative logs and records are completed daily
- Staff training records are up to date
- Supervision and mentoring sessions are documented
- Mechanisms for hotline staff feedback are established and response is made regularly

- User feedback (callers, survivors, referral partners, community) is solicited safely and regularly
- Community awareness of hotline existence (and public frame of purpose) is at a satisfactory level

In addition to review of call logs and records, supervisors should conduct ongoing monitoring of staff case management skills (where this is a hotline service), as is done for in-person case management. The Survivor-Centred Case Management Quality Checklist¹¹ is an example of a monitoring tool which can identify gaps and deficiencies so staff re-training can be conducted to ensure hotline service quality is maintained. The Checklist was designed for case management in traditional, onsite contexts but may be adapted for use with hotline staff.

A survivor-centered approach to monitoring remains essential regardless of what modalities are used to provide the services being assessed. Any process established to evaluate hotline service quality through consultation with callers and/or survivors must prioritize the principles of do no harm, safety, informed consent, and confidentiality.

In addition, indicators established to monitor hotline impact and effectiveness must be established and monitored. Rather than day to day functioning, these indicators will measure whether the hotline is achieving the intended results.

- Consider using qualitative indicators that provide insight into the hotline impact e.g. for caller satisfaction: *Did this call help you consider options for what to do next? Did the call affect what you did in your situation, and if so how?*
- Responses to qualitative indicators can also be categorized into a quantitative indicator, e.g.: *75% of callers surveyed stated that their hotline discussion assisted them in planning next steps.*
- Indicators should not report on the number of GBV survivor calls. An alternative is measurement of increase in survivor calls over time: *Number of calls for which referrals were given (this will not be a survivor number since any caller may be referred to a service.)*
- Indicators may be set to reflect community contact that does not typically happen through onsite GBV response facilities: *Number of calls from family or friends seeking information to support survivors.*
- Indicators may be set to reflect whether groups identified as vulnerable are making use of the hotline: *Percentage of calls made by survivors who report being pregnant (which can be given context for data analysis by comparison to the total number of women of reproductive age, and the pregnancy rate per 1,000 WRA in the area).*

KEY DECISION POINTS FOR CONSIDERATION

- What monitoring points will provide useful information for staff skills and performance?
- What monitoring points will support checking quality of documentation?
- How will the quality of services provided to hotline callers be monitored? What methods and protocols could be used to safely and non-invasively request caller feedback?
- What monitoring points will indicate whether appropriate supervision, training and mentoring are occurring?
- How will data storage and protection protocols be monitored?
- How will user feedback be used for monitoring?
- What indicators will meaningfully measure the impact the hotline has for survivors? For the community?
- How will the success of the hotline in reaching specific underserved groups be measured?



Source: UNFPA Viet Nam

RELEVANT STANDARDS

Essential Services Package for Women and Girls Subject to Violence

Module 5, Chapter 3

- Identify purpose, scope, and timeline for monitoring and evaluation
- Focus monitoring and evaluation on the functioning of coordinated response to violence against women and girls
- Develop capacity and resources for monitoring and evaluation
- Include victims/survivors in monitoring and evaluation process

Gender-Based Violence Research, Monitoring, and Evaluation with Refugee and Conflict-Affected Populations

Using a survivor-centered approach for M&E, p. 29

In the course of M&E activities, a survivor should:

- Be treated with dignity and respect at all times
- Not be forced to participate in data collection activities or answer any question that they do not want to
- Be assured of privacy during the data collection process and the confidentiality of their data once given
- Experience a non-judgmental and supportive environment when answering questions
- Be able and encouraged to give feedback on the utility of services provided

TOOLS AND RESOURCES

Annex 1: UNFPA APRO (2020). GBV Hotline Overview Presentation. Slides 19-20.

The Global Women's Institute (2017). Gender-Based Violence Research, Monitoring,

and Evaluation with Refugee and Conflict-Affected Populations: A Manual and Toolkit for Researchers and Practitioners.

<https://globalwomensinstitute.gwu.edu/manuals-toolkits>



Source: UNFPA Indonesia



Source: Rozan Counseling Helpline, Pakistan

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ANNEXES

Annex 1, Annex 1A, and Annex 1B are found in the slide decks accompanying this Guide.

- Annex 2:** Service Mapping Tool (IRC)
- Annex 3:** Focus Group/Key Informant Interview Questions (GBV AoR)
- Annex 4:** Using Mobile Phones to Communicate with Survivors: Policy and Practice Recommendations (NNEDV)
- Annex 5:** Define Hotline Purpose and Scope Worksheet (IFRC)
- Annex 6:** Emergency Flowchart for Hotline Calls (IRC, UNFPA APRO)
- Annex 7:** Remote Support Checklist (UNFPA LACRO/SROC)
- Annex 8:** Self Care for Caregivers (Morarka Leadership Foundation)
- Annex 9:** Terms of Reference for GBV Helpline Specialist (UNFPA LACRO/SROC)
- Annex 10:** Training GBV Caseworkers to Provide Phone Based Services (GBV AoR)
- Annex 11:** Data Protection Checklist (GBVIMS)

ANNEX 2

Service Mapping Tool (IRC)

Source: IRC. <https://gbvresponders.org/emergency-response-preparedness/emergency-response-assessment/>



GBV Assessment Tools

PART 2: SERVICE MAPPING

Note: This tool is for use during interviews with service providers. All sections may apply to some service providers, while for others (i.e., a health clinic) it may only be relevant to focus on one section.

Team: _____

Geographic area: _____

Estimated catchment population: _____

1. Organization: _____

2. Did you provide services before the crisis? Yes No

3. What type of services do you provide to survivors of GBV?

- Health
- Psychosocial / case management
- Legal
- Protection/ security
- Sensitization / prevention

HEALTH

Specific geographic location(s) of service provision:

4. What type of medical personnel work for your organization here?

Nurses: How many? _____

Doctors: How many? _____

Midwives: How many? _____

Gynecologists: How many? _____

Surgeons: How many? _____

Other: How many? _____

5. Do you have GBV focal points? Yes No

If yes, who? _____

6. Have the medical personnel received any specialized training on clinical care for survivors of GBV?

Yes No

If yes, who provided the training? When was the training provided?

7. Have the medical personnel received any specialized training on the provision of care for child survivors of GBV? Yes No

If yes, who provided the training? When was the training provided?

8. Do you have complete post-rape kits available? Yes No

PEP

Emergency contraception

STI medicines / antibiotics

Hepatitis B vaccination

Tetanus vaccination

9. Do you have trained social workers on staff? Yes No

If yes, how many? _____

10. Do they have a safe, confidential space to receive survivors? Yes No

If yes, request to see the space. Is it safe and confidential? Record your observations here:

PSYCHOSOCIAL

Specific geographic location(s) of service provision:

11. What specific services do you provide?

Basic emotional support

Case management

Psychosocial support

Group activities

Other? _____

12. Do you have a safe, confidential space to receive survivors? Yes No

If yes, request to see the space. Is it safe and confidential? Record your observations here:

13. Do you have a woman's center or other dedicated space to facilitate survivors' access? Yes No

If yes, request to see the center. Was the center busy? Was it filled with mostly women? Mostly men? Record your observations here:

14. What specific age groups do your activities serve?

Children

Young adolescents (10-14)

Older adolescents (15-18)

Adult women (18+)

15. Are your psychosocial services provided by:

Trained volunteers

If yes, how many? _____

Partners (NGO, CBO, etc.)

If yes, how many? _____

Staff of your organization

If yes, how many? _____

16. If you work with local NGOs/CBOs, what organizations are they and how many practitioners do they have on staff?

17. What kind of training have your volunteers and social workers received?

SAFETY AND PROTECTION

Specific geographic location(s) of service provision:

18. What specific services do you provide?

- Safety and security planning for survivors
- Safe houses
- Community solutions (i.e., a safe house within the community)
- Patrols
- Others? _____

19. What specific age groups do your activities serve?

- Children
- Young adolescents (10-14)
- Older adolescents (15-18)
- Adult women (18+)

DIFFICULTIES / CHALLENGES

20. What are the significant challenges your organization faces in service provision?

21. Do you turn away women and girls because of a lack of available resources? Yes No

OTHER COMMENTS

CONTACT PERSON FOR THE ORGANIZATION

Name: _____

Telephone: _____

Email: _____

ANNEX 3

Focus Group/Key Informant Interview Questions (GBV AoR)

Source: Rapid Assessment Remote Service Mapping Template, GBV AoR. <https://gbvaor.net/co-ordination-tools-resources>

Focus Group Discussion Online or Survey Sample Questions

1. What technologies do you use to communicate in your everyday life?
2. In an emergency in the current situation, who would you and other people in your community contact first? How would you contact them (phone; email; text message; go to a government facility in person; go to a community location)?
3. Do you or people you know have experience receiving information about health services, or information about other services over the phone or over the internet? For example by SMS or email? What was useful, or not useful, about receiving that information over the phone or internet?
4. Would you feel comfortable reporting or talking about a personal problem over the phone or on-line with a professional counselor or peer? What would make you feel comfortable? What would make you feel uncomfortable or unsafe?
5. How do you protect your privacy when using the phone or internet? Can you speak privately when you need to, or does someone else monitor your phone or computer?
6. When are the best times for service providers to call or contact you by email?

If safe and appropriate to be more direct and ask communities or online survey participants if they would use some of the specific services you have identified in the quick mapping, listing them or rating them on usage. Then, ask for qualitative feedback on why they would or would not use them.

Key Informant Sample Interview Questions

Key informants may include GBV service providers/institutions using remote services, hotline management or operators or others. It may also include interviewing organisations with existing static GBV response capacity to assess if it is feasible for them to consider shifting some staff or resources to remote service delivery. Questions should be adapted to the area of expertise of the informant.

1. What does gender-based violence mean to you? (If they do not seem to know, ask What kinds of incidents of sexual violence or domestic violence between intimate partners do you hear about?)
2. What are the commonly used channels for reporting gender-based violence? From what individuals or organizations do you typically receive reports of sexual violence? (PROBE: victims/survivors, family members, health professionals, etc.)
3. Are the staff who manage contact or receive calls been trained to handle reports of intimate partner violence, sexual violence or other forms of gender-based violence? How long did the training last and who provided it?

4. Are there any Protocols for management of GBV or other protection-related calls and data in place? If so, can you please explain or provide an example.
5. Do you have both male and female operators/hotline staff available? Are persons who call able to request specifically a male or female to speak with?
6. If you receive a report of GBV, to what services are you able to refer people? (police, health, legal, psycho-social, livelihoods, housing/shelter, other). Do you have specific contacts/focal points in those services? How frequently are the contacts updated?
7. How does your organization ensure confidentiality for persons who call/report?
8. What are some of the achievements and challenges your organisation is experiencing, particularly in the context of maintaining services for people in need during the CoVid-19 crisis?



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ANNEX 4

Using Mobile Phones to Communicate with Survivors: Policy and Practice Recommendations (NNEDV)

Source: National Network to End Domestic Violence, Safety Net Project.

https://static1.squarespace.com/static/51dc541ce4b03ebab8c5c88c/t/5d0baeacd7587a00014df2e5/1561046701147/NNEDV_Cell+Phones+Best+Practices+Policies_2019.pdf

Using Mobile Phones to Communicate with Survivors: Policy and Practice Recommendations

Many domestic and sexual violence programs use mobile phones to communicate with survivors. While mobile phones offer convenience, privacy and safety issues need to be thoroughly considered. As with the use of any type of technology, it's important to have clear policies and procedures to outline proper use to maintain privacy for survivors and your program's confidentiality obligations.

Note: This document focuses on advocates' mobile phone use. Read more information on survivors' cell phone safety and privacy in our Survivors' Toolkit.

Purpose of Mobile Phone Use

Consider the reasons advocates within your program would be using mobile phones for work. These reasons will be the foundation to forming policies around advocates' mobile phone use. Some common reasons include being more easily accessible while out of the office, answering hotline calls from home, and texting with survivors if the survivor prefers it.

Read more about texting with survivors in our Digital Services Toolkit.

Not all employees need a mobile phone for their work and advocates who have different roles may need a mobile phone for different reasons. The policy should reflect that. For example, an advocate who travels to meet with survivors may need to make phone calls and send text messages, while an advocate who does community outreach may need to access work email while out of the office.

Recommendations

- Policies should outline the purpose(s) of mobile phone use for work, and have a Mobile Phone Use agreement with each advocate.
- Policies should be clear about expectations of advocates' availability by phone when away from the office and supervisors should regularly check in about work-life balance, boundaries, and signs of vicarious trauma or burnout.

Programs Should Provide the Mobile Phones

While there may be a substantial cost for both devices and voice/data plans, it is best practice for programs to provide mobile phones to advocates rather than ask advocates to use their own personal phones to communicate with survivors.

Risks when Advocates Use their Own Devices

There are serious risks to programs' confidentiality obligations, and potentially survivor safety concerns, when advocates use their own mobile phone to communicate with survivors. If advocates' friends and family members have access to an advocate's phone, they could see survivor information in the contacts, email, or text messages. In addition, if the advocate's phone was part of a family plan, the account holder (which may not be the advocate) could have access to phone records and other details that could include survivor information, breaching confidentiality.

Another risk to advocate's using their own phones is if the phone is lost or stolen, the program may not be able to demand that data on a lost phone be remotely wiped, or if an advocate leaves the program, information on their personal phone will not be accessible to the program.

Benefits for Program-Issued Mobile Phones

Program-issued mobile phones enable programs to better ensure the security of devices, strengthen confidentiality practices, and support healthy work-life balance for advocates. When programs own and manage a mobile phone, they can set up and have control over the phone and accounts associated with it. This includes the data on the device as well as data that is in the connected cloud accounts (Google account for an Android phone and iCloud for an iPhone.)

If a phone is stolen or lost or if a staff person using the phone leaves, the program can easily transfer it to another advocate, or wipe the device. Owning and having control over the mobile devices means that the program will have more security control over the accounts that are connected, apps that can be downloaded, or websites visited from the device.

Devices

Although older cell phones (flip phones or voice only cell phones) are still available, smartphones are widely available. If an advocate is only making phone calls or sending texts, an older cell phone may be more appropriate and safer. However, smartphones may be preferable because advocates can use apps such as maps or the internet. The downside is that smartphones have more privacy risks because of the apps that can be downloaded and the cloud-based accounts that are connected to the phone. Consider why staff would need a mobile phone and provide the type of mobile phone that would be most appropriate. If advocates are using smartphones, develop policies and agreements that address security and privacy risks.

Phone Security

Mobile phones should be set up by knowledgeable IT staff for enhanced security and should be checked by IT staff on a regular basis. The checkup should include needed updates, a scan for malware, a check of all installed apps, and any other security concerns. Additionally, you may consider implementing the following basic security measures:

- Passcodes - All phones should require a passcode, password, biometric factor, or other security measure to unlock the phone. Do not use the same passcode for every program phone, but supervisors or IT staff should always be able to unlock the phone in case an advocate cannot. All phones should automatically lock after a short time when not being used.
- Antivirus and anti-malware apps - All phones should have antivirus or antimalware software or apps installed and updated regularly.

- Remote wiping - Programs should have the ability to remotely wipe the content of a phone that is lost or stolen.
- Parental controls - Programs should exercise caution when considering installing or enabling features that permit controlling or monitoring of the phone. These features should always be used with the advocate's informed consent and respect to privacy. Smartphones and Cloud-Based Accounts Most smartphones require an account to be connected to the phone. Generally, iPhones require an iCloud account and Android phones require a Google account. Depending on the type of phone, the manufacturer may also offer an account for the phone to offer different apps, manage security features, or store additional data. While phones connected to a cloud account may back up information from the phone by default, it is best that any personal information about a survivor not be backed up. This may mean turning off syncing of most services and apps.

Recommendations

- Do not use the same cloud account on more than one phone. Doing this will connect all the phones to one account, which means that some information, such as contacts or messages, could be shared among the phones.
- Minimize the amount of information synced to cloud accounts, particularly information regarding survivors. Most smartphones and apps allow users to determine which data, if any, is synced to the cloud or other connected devices. Check for and purge any survivor data from the backup regularly. Also check to make sure that updates to operating systems or apps have not reset these settings.
- Limit who has access to the cloud's account logs and information. Cloud accounts can reveal personal information about the user of the device, including the location of the phone and even messages sent through the phone.

Location Services and Apps

Phones should not have location sharing or tracking turned on without informed consent of the advocate. Some programs may want to track the location of a program-issued phone for the safety of the advocate or to locate a lost device. However, location tracking for the purpose of monitoring an advocate's location for employee management purposes is not appropriate. If using location services for apps (such as Maps), advocates should understand the benefits and risks of using location services. Location history could be stored on the device or cloud accounts associated with the device or apps. Keeping location history could violate a survivor's privacy or become a safety issue if the advocate met with the survivor. Advocates might also be targeted by an abusive person and so should have their real-time location information protected.

Recommendations

- Phone location should not be stored in the history of the device and should be turned off or set to a less accurate setting if not needed by the advocate.
- When using location services for apps such as maps or navigation, the location history should not be stored. If this is not possible, it should be deleted regularly.
- Specific locations such as home, survivor meeting places, or work should not be saved to the app or phone.
- Turn off "geotagging" in camera apps, which will prevent the storing of location information in digital photos or videos. Voicemail Some phone systems offer the ability to receive an audio recording or a transcript of the voicemail in an email or text message. This creates a risk of interception or inappropriate access if the email or text is delivered to the mobile phone.

Recommendations

- Avoid automatically forwarding office voicemail to a mobile phone.
- If voicemails are forwarded, delete audio recordings, emails, and text messages of survivors' voicemails messages as soon as they have been listened to.
- Use a secure passcode for voicemail on a mobile phone.

Texting & Messaging Apps

Texting and messaging are other ways programs can use to connect with survivors. Messaging can increase access for some survivors, keep survivors engaged, and can be used to relay information when a survivor isn't able to talk on the phone. Read more about Texting with Survivors in our Digital Services Toolkit.

Recommendation

Delete messages as soon as possible from all devices as well as cloud accounts where messages could be stored. Email Depending on the advocate's role and work needs, they may need to access email while out of the office. Access to work email from a smartphone could create additional confidentiality risks. If access to email on a smartphone is necessary, ensure that confidentiality policies and practices include email on smartphones.

Read more about Emailing with Survivors in our Digital Services Toolkit.

Remote Access to Files & VPN's

If staff need to access files from a phone (or another device such as a tablet or laptop) while away from the office, secure file sharing "cloud" services exist to help manage security. Look for "No-Knowledge" or "Zero-Knowledge" encryption options where the tech company itself cannot see the content of the files because they do not hold the encryption key – only the program does. Also, choose a service that allows you to control user-by-user access to the files so you can add or revoke access at any time. Another option is to use a VPN (Virtual Private Network) from a reputable provider, which will provide a strong layer of security for the data that staff is sending and accessing. Bear in mind that a VPN won't protect the data from access or monitoring while the data is on the phone, but will increase data security while it is in transit.

Read more in our handout, WiFi Safety and Privacy: Tips for Victim Service Agencies and Survivors. Contacts, Call Logs and Text Logs

Minimize the amount of information saved on the phone. Your policies should include deleting information regularly, in most cases as soon as possible.

Recommendations

- Don't save survivor contact information in a mobile phone.
- All incoming and outgoing calls and texts should be purged regularly.
- If the phone has both internal memory and a memory card, save to only one and regularly delete from that. Saving to a memory card offers greater protection since a memory card can be removed and destroyed.
- Before getting rid of a phone or updating the phone to give to a new advocate, reset the phone to factory settings to clear any data that is on the phone.

Calendars

If the calendar on the phone includes appointments with survivors, schedule survivor information in a way that reduces the likelihood of it being identifying. Some calendar programs allow users to create multiple calendars. Consider creating a calendar for only appointments, which can be synced to the phone and then deleted when no longer needed.

Personal Accounts on Work Phones

Smartphones, and the apps installed on them, have the ability to have more than one account configured to it. Staff should not have personal accounts configured to a work phone. Having a personal account on the phone could lead to accidentally mixing survivor information with personal information or accounts. This also protects advocates' privacy, since personal information on a program-issued phone might make that information accessible to the program.

When Advocates Use Their Personal Mobile Phones

While it is our recommendation that programs provide mobile phones to advocates for work purposes, in the rare situation when advocates use their personal mobile phone to communicate with survivors it should be done so with specific consideration to privacy and safety.

Recommendations

- Advocates can use a virtual phone service and voicemail to contact a survivor, allowing the advocate to keep private their phone number.
- Alternatively, an advocate can prevent their number from showing in the receiver's Caller ID by either dialing *67 before dialing the number or turn off "Show My Caller ID" in the smartphone settings.
- Call logs and text message logs related to communication with survivors should be deleted immediately from the advocate's phone. Survivor's contact information should not be saved in the phone or the advocate's account.
- Programs might consider including some of the basic privacy and security practices described above in a Mobile Phone User Agreement.

2019 National Network to End Domestic Violence, Safety Net Project. Supported by US DOJ OVC Grant #2017-VF-GX-K030. Opinions, findings, and conclusions or recommendations expressed are the authors and do not necessarily represent the views of DOJ. We update our materials frequently. Please visit TechSafety.org for the latest version of this and other materials.

ANNEX 5

Define Hotline Purpose and Scope Worksheet (IFRC)

Source: IFRC (2020). *Hotline in a Box*. Available at: <https://communityengagementhub.org/guides-and-tools/hotline-in-a-box/>

Define Your Purpose and Scope

• OUR PRIMARY PURPOSE IS TO:

- Provide updates
- Link to services
- Answer questions
- Deliver services
- _____

What? Describe your main goals

• AND WHO DO WE SERVE?

Who? List your main audiences

• WHAT IS THE SCOPE OF THE CONTACT CENTRE AND WHAT ISSUES OR TOPICS **WILL** IT ADDRESS?

For example: Beneficiary feedback on a food distribution program; maternal health issues

• GIVEN THE SCOPE OF YOUR CONTACT CENTRE, WHAT WILL YOUR CONTACT CENTRE **NOT** ADDRESS?

For example: Request to join the food distribution program; issues related to women's health that are not specifically maternal health

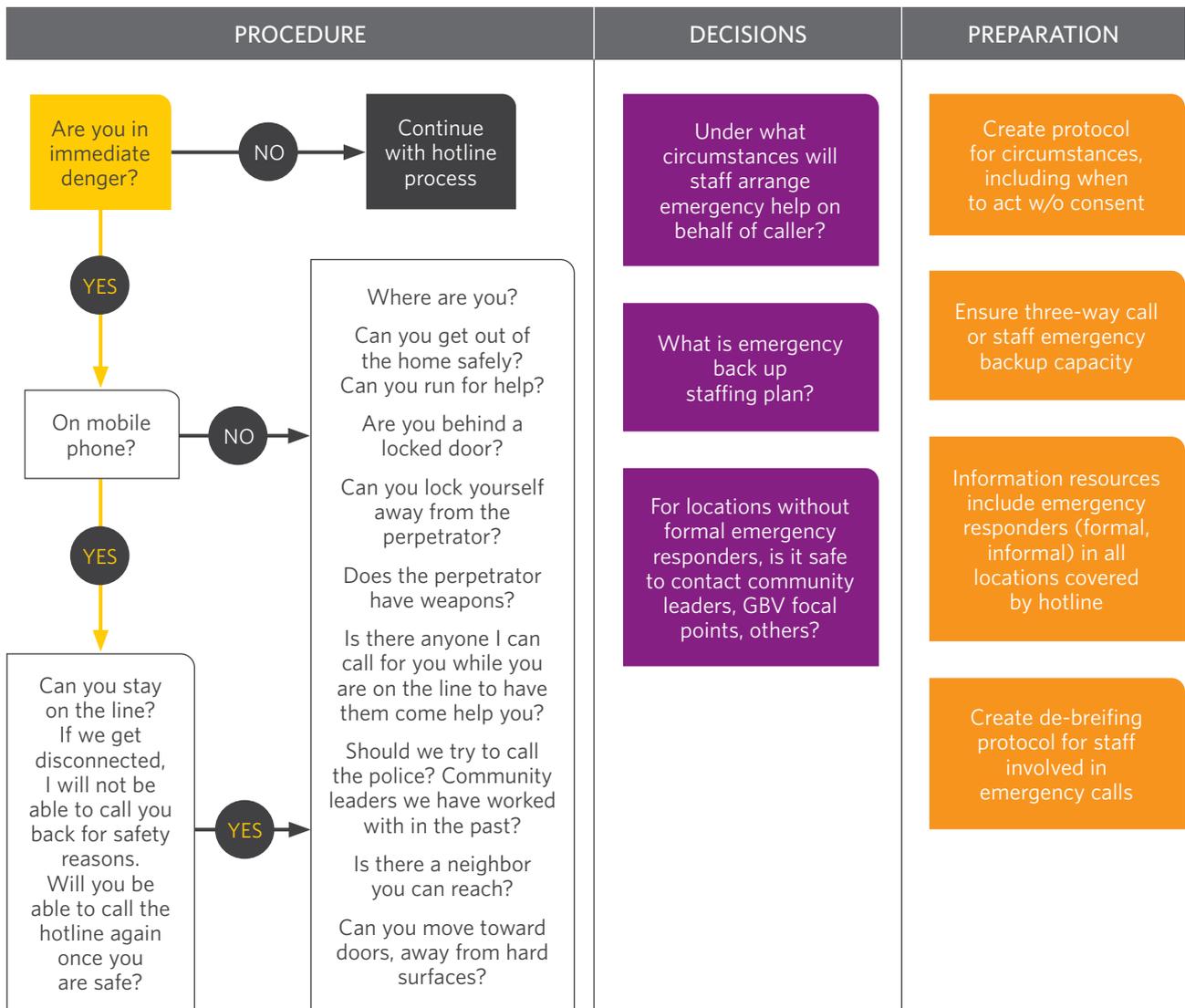
• HOW WILL YOU HANDLE OUT OF SCOPE REQUESTS?

- Provide callers with the phone number or contact details of another service
- Log the issue, but refer it to another service point behind the scenes
- Other: _____

ANNEX 6

Emergency Flowchart for Hotline Calls (IRC, UNFPA APRO)

Source: IRC information. https://gbvresponders.org/wp-content/uploads/2018/10/GBV-Mobile-and-Remote-Service-Delivery-Guidelines_-final.pdf



ANNEX 7

Remote Support Checklist (UNFPA LACRO/SROC)

Source: UNFPA, LACRO/SROC. (2020). Guidelines for the provision of remote psychosocial support services for GBV survivors. https://lac.unfpa.org/sites/default/files/pub-pdf/unfpa_guiavbg_web.pdf

1. Adaptation of guiding principles to remote assistance

ACTION	YES	NO
The organization has established a confidentiality protocol for remote work.		
All service providers/case workers and psychologists have received the instructions and materials necessary to protect survivor's confidentiality during remote work (binders, personal computers, cell phones, appropriate software, etc.).		
The organization's staff has received training in remote empathetic communication techniques.		
The organization has developed new tools or adapted existing ones for the development of survivor's safety plans.		
The organization's staff has received training in support for vulnerable population groups: persons with disabilities, LGTBQ+ persons, and indigenous or Afro-descendant populations.		
If relevant to the context: the organization has services for translation into survivors' native languages.		
All staff members share and know how to implement the principles of the survivor-centered approach.		

2. Adaptation of digital services

ACTION	YES	NO
The organization has consulted the target population about their preferences regarding communication channels.		
The organization has conducted a review of the different digital services available.		
The organization has an IT security consultant.		
The organization's staff has received training in the use of digital services.		
All staff members know the pros and cons of each communication service and how to explain to survivors, in easy-to-understand language, how to use the digital service of their choice.		
The organization has developed a protocol to resume contact with the survivor in case communication is interrupted unexpectedly.		
The organization has equipped its service providers with efficient mechanisms to ensure confidentiality and has provided the necessary support.		
The organization's staff follows a series of minimum standards to ensure confidentiality while delivering services from their homes.		

3. Checklist to make a remote referral

ACTION	YES	NO
I have verified the availability of GBV services in my area during the COVID-19 health crisis through established referral pathways, if in a humanitarian context, or through my own service mapping.		
I am in permanent contact with the different medical, psychosocial, justice and legal counseling services, survivor shelters and emergency contacts (ambulance services, law enforcement, etc.) available in the area during the COVID-19 pandemic, and their contact information is up-to-date.		
I informed the survivor of all the different services available during the COVID-19 pandemic.		
I explained to the survivor the benefits and risks of the different services available during the COVID-19 pandemic, as well as their access requirements.		
Together with the survivor, I identified the potential safety risks associated with access to those services, as well as the corresponding mitigation measures		
I gave the survivor different choices to put her in touch with the service provider, as well as alternatives for support to access those services safely		
I obtained the survivor's informed consent before getting in touch with the service provider of her choice and making the referral		
I have followed the protocols for the secure exchange of survivors' information (use of standard forms, password encryption, persons' non-traceable information, etc.).		
I have considered other choices for the survivor in case she refuses a referral or a referral is not possible due to the lack of services.		
Before referring the survivor to an in-person service, I asked her if she had any COVID-19 symptoms.		
Before referring the survivor to an in-person service, I explained in detail the infection prevention measures she should follow and made sure she understood them.		
I have made sure the survivor accessed the service appropriately and safely.		

4. Checklist for staff support protocols

ACTION	YES	NO
The organization has provided, at least once, information about the problem of stress and its impact on the service providers' health and well-being (by e-mail, through a webinar, etc.).		
The organization has held at least one training session on stress management and self-care during the telecommuting period.		
The organization has made available to its psychologists free (or almost free) clinical psychotherapy services or specialized psychosocial services as part of their benefits through an external service provider.		
During the telecommuting period, the supervisor has incorporated into her clinical supervision process questions and discussions about staff members' well-being.		
During the telecommuting period, the supervisor has called the service providers to monitor their well-being and shared the tools to improve it.		
The organization has implemented and shared information about rules regarding flexible work hours and promotes work-life balance.		
The organization has made recommendations regarding workspaces at home for the delivery of remote psychological support services and how to do it (separation of spaces, privacy, confidentiality policies)		
The organization has expressed, in an explicit and personalized fashion, its gratitude for the service providers' work and acknowledges the value of the work they do.		
The organization has reviewed its self-care policies as a result of the COVID-19 pandemic.		
The supervisor or the human resources department has encouraged service providers to conduct a well-being self-assessment.		
The supervisor or the human resources department has shared with every service provider a self-assessment template and a self-care plan template.		
The supervisor or the human resources department has followed up on the progress of service providers' self-care plans during the telecommuting period.		

ANNEX 8

Self Care for Caregivers (Morarka Leadership Foundation)

Source: Self Care for Caregivers, One Future Collective, Morarka Leadership Foundation Private Limited. Mumbai, India (2019). Available at: <https://onefuturecollective.org/resources/>

Are you facing caregiver stress or burnout?

Experiencing caregiver stress may affect your physical, mental and emotional wellbeing.

Signs of stress or burnout could include:

A. Physical signs

- Changes in sleep patterns
- Loss of appetite
- Feeling sick more often (increased headaches, fever, common cold and cough, gastrointestinal trouble, indigestion)
- Feeling tired often
- Unexplainable changes in weight

B. Emotional signs

- Get irritable easily
- Feeling low, sad often, or crying easily
- Feeling hopeless or helpless
- Getting angry easily
- Not liking the previously fulfilling caregiver responsibilities

C. Psychological signs

- Feeling lost in daily tasks
- Unable to concentrate on tasks or conversations
- Having no thoughts (blinking out) or having a rush of thoughts
- Losing interest in activities that you previously enjoyed
 - Withdrawing from friends, family and relatives

Identifying with even one sign from the above list suggests that your health is in as much trouble as is anyone else's. Getting your own health would help you take better care of the recipient as well.

ANNEX 9

Terms of Reference for GBV Helpline Specialist (UNFPA LACRO/SROC)

Source: Excerpted from Terms of Reference, GBV Helpline Specialist, UNFPA Sub-regional Office for the Caribbean (SROC), Jamaica. Full document available at: https://caribbean.unfpa.org/sites/default/files/vacancies/tor_-_gbv_helpline_specialists.pdf

TERMS OF REFERENCE - GBV HELPLINE SPECIALISTS

Title:	<p>Five (5) GBV Helpline Specialists to support the operationalization of the Bureau of Gender Affairs (BGA) 24/7 hotline/helpline for Survivors of Violence Against Women and Girls, providing First-Line Support, Counselling, Information and Referrals.</p>
Hiring office:	<p>UNFPA Sub-regional Office for the Caribbean (SROC), Jamaica</p>
Purpose of the Consultancy:	<p>Five (5) GBV helpline specialists are needed to alternate in operating a 24/7 helpline for survivors of violence against women and girls, providing first-line support, counselling, information, and referrals.</p>
Scope of Work:	<p>Under the supervision of the Director of the National Shelter Unit of the BGA, and a case manager supervisor, the technical supervision of the shelters' counsellors, and with technical support from UNFPA, the GBV Helpline Specialist will work in coordination with other GBV Helpline Specialists at the BGA to guarantee the provision of quality services 24/7 through the helplines for survivors of VAWG.</p> <p>The consultants will perform the following specific tasks in an inclusive and non-discriminatory manner towards all clients, including members of marginalized populations:</p> <ul style="list-style-type: none"> ● Provide first-line response with the LIVEs approach and according to the Guidelines for the provision of remote psychosocial support services for GBV survivors. ● Assessing the survivors needs and support them in planning for safety, following internal operating procedures and protocols, designed according to the LIVEs approach and the GBV fundamental principles. ● Provide all relevant information and counselling and refer to the shelter's resident counsellor for case management and psychosocial support or to other actors as required. ● Refer to other services of the health sector (including for clinical management of rape, sexual and reproductive health services, specialized mental support), police sector, justice sector and social services sector according to the survivors' needs and wills, considering the validated referral pathway, protocols, MoU, and SOP, and provide appropriate support with a survivor-centred approach.

TERMS OF REFERENCE - GBV HELPLINE SPECIALISTS

Scope of Work:

- In cases where the survivors are at high imminent risk, activate the “Danger to Safety Services” and organize transfer to the appropriate national shelter.
- Accurately obtain and record survivor information for use in identifying services, needs of callers, referrals ensuring confidentiality.
- Maintaining up-to-date Caller Log and GBV Services Registry with appropriate numbers and contact persons.
- Offer information and appropriate referrals to the public as it is necessary. Above all, ensuring information about the service, contacts number and addresses and hours of operation are clearly and accurately communicated in appropriate channels.
- Provide monthly reports on calls received, services and referrals provided and results, with disaggregation of data according to the agreed procedures.
- Attend monthly staff meetings between helpline specialists, social workers of the BGA, counsellors of the shelters, coordinator of the shelter unit and other key stakeholders of the BGA.
- Contribute to the creation of GBV strategies by the BGA and other key stakeholders.
- Contribute to the conception and development of BGA’s Remote GBV Services and educational and promotional materials for the elimination of GBV.

In operating the crisis hotline/helpline, the GBV helpline specialists will ensure that their response **always** follows/adheres to the Human right approach; Survivor Centred Approach; GBV Guiding Principles; Do No Harm Principle; Leave No One Behind Principle (LNOB); The NSAP-GBV Strategic Priorities.

To guarantee that the services are offered in line with the NSAP-GBV and with the Essential Service Package guidelines, the GBV Helpline Specialists in their first three weeks will need to have a thorough knowledge of the following important documents:

- The seven modules of the Essential Service Package guidelines
- The guidelines for Provision of Remote Specialized Psychosocial Support for GBV Survivors developed by UNFPA
- Protocols connecting the hotline to other social services, health, and justice services and with police when requested or necessary.
- Internal operating procedures and protocols
- Any other documents deemed relevant for the position.

These GBV helpline specialists will start operating after receiving training from UNFPA on case management and on remote psychosocial support.

TERMS OF REFERENCE - GBV HELPLINE SPECIALISTS

<p>Location of activities and expected travels:</p>	<p>The five (5) GBV helpline specialists will operate from one of the installations from which the BGA provide these services (BGA office, shelters among others) and/or remotely. The helpline specialists will be provided by the BGA with a proper office space to guarantee confidentiality (silent, safe to speak on the phone with the survivors, and safe to store documents to guarantee confidentiality and safety of the survivors).</p>
<p>Required expertise, qualifications, and competencies:</p>	<p>Specific qualifications, skills and experience include:</p> <ul style="list-style-type: none"> • Minimum of a bachelor's degree in counselling/social work, or certification in counselling or crisis intervention. • Minimum of one-year professional experience working with survivors of gender-based violence. • Strong organizational skills and teamwork skills. • Flexibility, and ability to work on multiple tasks simultaneously. • Ability to maintain confidentiality. • Solid overall computer literacy, including proficiency in various MS Office applications (Word, Excel, Access, etc.) and email/internet. • Excellent oral and written command of English and excellent drafting skills and accuracy and professionalism in document production and editing. • Ability to communicate also in Jamaican creole.
<p>Coordination and reporting mechanism:</p>	<p>The GBV helpline specialists will report to a case management supervisor and to the Director of the National Shelter Unit of the Bureau of Gender Affairs and will receive technical support from UNFPA.</p>
<p>Inputs/services to be provided by UN agency:</p>	<p>BGA and UNFPA will provide documentation and overall guidance that will be critical and relevant for this assignment.</p> <p>The five (5) GBV Helpline Specialists will be provided by the BGA with stationary, a proper office space to guarantee confidentiality, the hotline/helpline numbers and phone stations at the BGA.</p> <p>Any operating cost related to the use of the phone and cell phones, including SIM card, call credit and internet data credit will be covered by the BGA.</p> <p>UNFPA will provide cell phones, headphones and computers with software that guarantee confidentiality to be used exclusively for the hotline/helpline (procured by UNFPA).</p>

ANNEX 10

Training GBV Caseworkers to Provide Phone Based Services (GBV AoR)

Source: COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines. GBV AoR (2020). Available at: <https://gbvaor.net/sites/default/files/2021-01/covid-guidance-on-remote-gbv-services-04012021.pdf>

Training GBV Caseworkers to Provide Phone-based Services

At minimum, training for caseworkers when shifting to phone-based services should cover a review of all of the Standard Operating Procedures noted above. This should include opportunities for staff to engage in roleplay so that they can practice, in real time, how to engage with a client over the phone. If time permits, and if necessary or beneficial, it may also be useful for a supervisor to provide revision sessions on basic GBV issues and concepts. It will also be important to provide training for staff on any new technology or approaches to be used for remote case management. Teams may need to get acquainted with systems used for phone or internet service provision, new apps for data management, etc. (Also see Section VII).

If lockdown means that in-person training is not possible, then staff can be trained over Zoom, with practice calls between supervisors and case workers also conducted over the phone. Training plans should be drawn up as part of the implementation plan for shifting to remote case management and should accommodate the fact that online training must be offered in shorter intervals than in-person training (with two hours per training session as the rule of thumb).

Essential Training for Caseworkers Transitioning to Phone-based Service Delivery

- ✓ Operation of relevant apps to provide remote services (e.g. WhatsApp);
- ✓ 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 client, 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 hotline;
- ✓ Standard call-handling protocols in line with basic case management steps, e.g., introduction, assessment, case and safety planning, referrals, call closure;
- ✓ Managing calls with a minor;
- ✓ Managing calls when clients are at immediate risk and/or when a call is picked up by a perpetrator (See Section IV);
- ✓ Managing calls when clients are distressed or suicidal (See Section IV);
- ✓ Review of updated referral pathways and providing referrals over the phone (See Section V);
- ✓ New data collection and management responsibilities (See Section VI).

ANNEX 11

Data Protection Checklist (GBVIMS)

Source: GBVIMS Data Protection Checklist. Available at: <https://www.gbvims.com/data-protection/>

The checklist below is a starting point to gauge if essential practices are in place in program(s).

DATA PROTECTION MEASURES	IMPLEMENTED
<p>Are survivor records/files stored in a safe location?</p> <ul style="list-style-type: none"> • Is access limited to authorized staff? • Are offices with survivor/beneficiary information* stored in lockable file cabinets or on computers locked when unoccupied? • Are electronic devices with survivor/beneficiary information locked in a safe location? (This includes laptops, external hard drives, USB/flash drives) • Are computers, laptops or programs storing information routinely password protected? 	
<p>Is there a Staff Data Protection Agreement Implemented?</p> <ul style="list-style-type: none"> • Is it signed by staff interacting with information and stored in HR files? (REF: Template in Annex 3) 	
<p>Have staff been trained on confidentiality, informed consent and the process for informed consent?</p> <ul style="list-style-type: none"> • Is consent for information sharing documented? 	
<p>Are staff informed about and comfortable discussing applicable local mandatory reporting mechanisms?</p> <ul style="list-style-type: none"> • Do staff know applicable mandatory reporting and how it's applied in the WPE program (the process and outcomes)? • Have the risks to survivors of mandatory reporting been discussed in the program? 	
<p>Is there a protocol for safe destruction of paper forms (shredding, burning and wetting)?</p> <ul style="list-style-type: none"> • Are staff aware of appropriate times and places to do this? • Is there an emergency protocol in place for safe destruction/transfer of files in case of staff evacuation or imminent security threat? 	
<p>Are electronic case management systems protected?</p> <ul style="list-style-type: none"> • Do electronic case management systems have required user log-in or other graduated access (depending on role)? 	
<p>Do you routinely back-up data?</p> <ul style="list-style-type: none"> • How often? Is it backed up to a safe location? 	
<p>Are survivors informed of their rights in terms of data collection, storage and sharing?</p> <ul style="list-style-type: none"> • The right to request that her story, or any part of her story, not be documented on case forms. • The right to refuse to answer any question they prefer not to. • The right to tell the caseworker when she needs to take a break or slow down. • The right to ask questions or ask for explanations at any time. • The right to request that a different caseworker be assigned to her case. • The right to refuse referrals, without affecting our willingness to continue working with her. • The right to access their personal information and request deletion. 	
<p>Are you aware of applicable data protection laws in the country of operation?</p> <ul style="list-style-type: none"> • What are they? Has this been discussed in the program? 	

If after going through this checklist you determine that your data is not safe or that the data collection or sharing process doesn't follow minimum standards or may have negatively impact on survivors, contact your supervisor.

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