Feasibility and Acceptability of Mobile and Remote Gender-based Violence (GBV) Service Delivery:

A study of innovative approaches to GBV case management in out-of-camp humanitarian settings

BACKGROUND

Gender-based violence (GBV) often escalates during humanitarian emergencies, especially when crises result in displacement.[1] Increasingly, displaced persons are living in host communities or informal settlements, with more than half of the world's displaced people living in urban areas[2]. Furthermore, conflict and disasters exacerbate many forms of GBV, such as sexual violence, intimate partner violence (IPV), and early marriage. Often those populations at greatest risk of GBV reside in areas that are difficult to access, both in terms of distance and security. To address these challenges, the International Rescue Committee (IRC), with support from the U.S. State Department, Bureau of Population, Refugees and Migration (BPRM), and European Civil Protection and Humanitarian Aid Operations (ECHO), has developed guidelines to support the provision of mobile and remote services to survivors of GBV in out-of-camp humanitarian settings. The guidelines recommend approaches and minimum standards for designing and implementing such approaches to service delivery while adhering to best-practice principles.

The guidelines were developed over a two year period (2016-2018), during which IRC implemented pilots of mobile and remote GBV service delivery approaches in Myanmar, Burundi, and Iraq. In partnership with external researchers Leah James PhD, LCSW and Courtney Welton-Mitchell, PhD, LPC, the IRC engaged in research to assess the feasibility and acceptability of these pilots. Together the specific areas targeted for services in each of the three countries are representative of community needs and associated service delivery challenges typically found in out-of-camp humanitarian settings, particularly those resulting from civil conflict.

OVERVIEW OF MOBILE AND REMOTE GBV SERVICE DELIVERY

As part of the project and study, mobile and remote GBV services were piloted in the Northern Shan State of Myanmar, Makamba and Bujumbura provinces in Burundi and Karbala province in Iraq. In each site, IRC established **mobile GBV services** where service providers (mobile teams with caseworkers) move to sites where a population is displaced, residing, or in transit, and cannot be easily reached with static services. IRC also implemented **remote hotline services,** in which GBV services (predominately case management) are provided remotely over a technology platform (i.e. hotline, chat or SMS) rather than in person.

Mobile GBV service delivery

Two types of mobile GBV service delivery were implemented during this pilot.

Short–term rapid GBV response

The short-term rapid response involved the deployment of GBV mobile teams in an emergency to serve survivors who are part of a recently affected by a humanitarian crisis, in transit, or newly displaced. With short term rapid responses, the population will not remain in the site long and the GBV mobile team may visit the site once or a few times within few days to provide crisis response, risk reduction activities and supplies and information about available services.

In **Myanmar**, IRC's GBV short-term rapid response mobile teams have been providing services within an emergency response that targets small groups of people who are displaced on a cyclical basis. This happens when villagers flee to church grounds in response to conflict between the Myanmar Army and other ethnic armed groups. The GBV mobile teams are comprised of:

- IRC GBV staff and local partner staff who speak appropriate local languages
- An IRC health staff member who can provide medications to prevent pregnancy and HIV and referrals for rape survivors within 72 hours.

When at the site, the teams:

- Meet with women and girls in a private space to assess safety concerns and needs
- Address safety and security risks (if appropriate)
- Provide information about services including a hotline for remote GBV services
- Provide dignity kits if required

Displaced villagers usually return to the village of origin within a week. Thus, the team ends support to this displaced group unless an individual follows up through the hotline.

[1] United Nations Secretary General (2017). Report of the Secretary-General on Conflict-Related Sexual Violence. Retrieved from http://www.un.org/en/events/elimination-of-sexual-violence-in-conflict/pdf/1494280398.pdf

[2] European Civil Protection and Humanitarian Aid Operations (2018). Forced displacement: refugees, asylum-seekers and internally displaced people (IDPs) ECHO Factsheet. Retrieved from https://ec.europa.eu/echo/files/aid/countries/factsheets/thematic/refugees_en.pdf

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Mobile GBV response during protracted displacement

View of the road in **Burundi** from a mobile team vehicle.

Additionally, GBV mobile teams deployed to a site (or several sites) in protracted displacement contexts. The teams provided mobile GBV services to agreed-upon locations on a rotational basis (e.g. once a week over months in each site) usually after the acute phase of an emergency has passed. If mobile teams provide a response to several sites, each site requires a unique and tailored intervention appropriate to the context.

In each site, the mobile teams established an entry point for case management through linking case management services in a private space with other non-GBV services. An entry point allows survivors to access case management services confidentially, while appearing to participate in other, non-stigmatized, services so that they do not need to disclose their survivor status to other community members. For example, entry points may be linked to health services or group activities in safe spaces for women and girls. Additionally, community focal points were identified in each mobile site to conduct outreach, support group activities in safe spaces, schedule visits and trainings with the mobile teams, and hold a program phone to manage requests for assistance and referrals to IRC when the team was not on-site.

In protracted sites of displacement in Northern Shan in Myanmar, in Makamba and Bujumbura provinces in Burundi and in Karbala in Iraq, the diagram on the following page represents the model that was used to establish mobile GBV services in each site. Entry points for case management were limited to temporary safe spaces identified in the mobile sites and hotline services. Mobile health services were explored as an entry point in Myanmar- however, the lack of private space (and inability to expand service space on the land where health clinics were established) did not allow for health services and GBV case management to happen simultaneously. Because this model did not allow for the appropriate confidentiality required for GBV services, the program shifted to providing case management either linked to group sessions in temporary safe spaces which were borrowed from the community or through GBV hotlines.

A community hall in Kamenge, Bujumbura served as the entry point for case management in this mobile site. Women and girls from the community organized non-GBV activities. The IRC mobile team visited the site twice a week to raise awareness of GBV and provide case management in the adjoining room. This was one of 4 sites on the weekly rotation of the Bujumbura mobile team.

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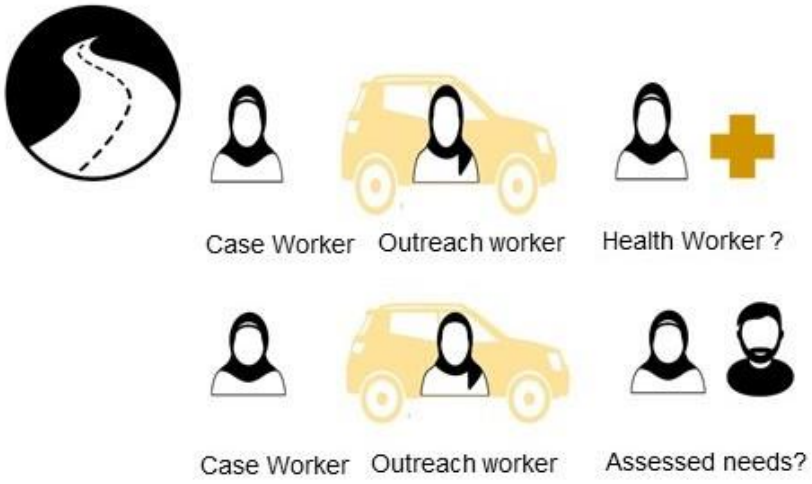
Mobile and Remote Approaches to GBV Service Delivery in Contexts with Protracted Displacement

Mobile Teams

Post coordination and security clearance, **mobile teams travel to target communities** on a set interval or in response to a new emergency displacement. The number and composition of mobile team members and vehicles needed depends on displacement density and population per site, the distance between sites and assessed needs for direct program support.



Establish entry points for case management linked with non-GBV activities in mobile sites

Identify private space and time to link with non-GBV, non-stigmatized group activities for confidential access

Temporary safe spaces for women and girls

- Encourage community ownership of social networking activities
- Individual support and empowerment
- Community risk assessment, safety planning, advocacy and coping skills
- Case management for survivors of GBV.

Alternative entry points linked with available services

- Case management in private rooms linked with non-GBV static services like health clinics or in private spaces created though the use of tents or assembled infrastructure and joint-sectoral deployments
- Requires strong coordination, training, time on site and ethical referral procedures .

Hotlines, training and community outreach

Hotlines and the training of service providers, strong referral pathways and capacity building of community focal points to refer survivors increases access, effectiveness and sustainability when mobile teams are not on site

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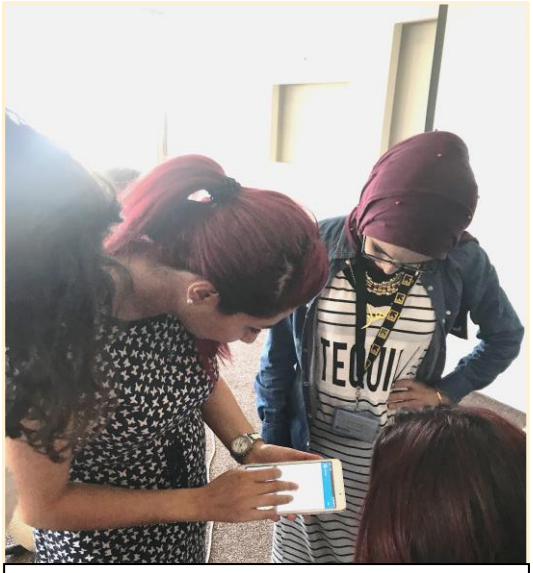
Remote GBV service delivery

With remote GBV service delivery, services are provided over a technology platform (i.e. hotline, chat or SMS) rather than in person. In each country, crisis intervention, referrals, and case management were provided through a hotline. Remote service delivery models can be particularly effective to meet the needs of highly stigmatized populations. Any hotline targeting GBV survivors should cover these essential actions: prioritize safety planning, provide accurate and timely information, support the survivor's ability to cope, provide an opportunity for emotional support and dialogue, increase the caller's understanding of GBV, and provide referral information.

In addition to speaking directly to survivors, hotlines can be used to: 1) retain connection with survivors identified through mobile teams because they potentially allow survivors to access follow-up services when the mobile team is not present, 2) offer support and resources for community focal points and service providers working with survivors; and 3) facilitate community focal point supervision and capacity building as a means to have regular communication and review GBV knowledge and skills.



IRC Iraq team members training on remote GBV services.

In Burundi and **Iraq,** IRC has established a call line for the target beneficiaries covered by mobile programming. This call line benefits the community and survivors while IRC mobile staff are not on site, providing consistent access.

In **Myanmar**, the IRC has established a hotline (a "Call Support Center") with the large target area in Northern Shan State. An information dissemination campaign was conducted in IDP communities and in 10 targeted townships through community focal points. The IRC coordinates with the Department of Social Welfare to receive referrals in Northern Shan State through the hotline. The Call Support Center is also being advertised to government, NGO and civil society health organizations so that they can refer patients to the hotline if a survivor is identified through health services. Further training for health agencies and other referral pathway providers is planned.

The hotlines and "Call Support Center" provide survivors with crisis support, case management, and referrals as well as serves as information lines for family and community members. The lines are also being utilized for remote supervision of community focal points and IDP case workers to provide consistent coverage in mobile sites.

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Technology enhancements

Three innovative technology enhancements were created through and/or utilized in this project to enable supervision of distant staff and safe documentation of data in mobile sites.

The **Primero mobile application** eliminates the need for the use of paper case files in mobile GBV service delivery, thereby increasing safety and security. Primero allows for the maintenance of individual case records as well, and compiles GBVIMS data for safe analysis. The application is specifically developed to respond to mobile settings, providing caseworkers and other frontline staff a safer way to track incidents and document and monitor case management efforts. The Primero application was piloted in Iraq.

A second technology enhancement utilized in this project was **CommCare**, a mobile data collection platform for survey collection. Deploying this platform allows users to better evaluate the services provided through mobile and remote technology-based approaches and the level of client satisfaction. CommCare was used for client satisfaction surveys and case management quality control checklists.

Lastly, **ROSA**, or Remote Offered Skill Building and Assessment application, is a remote supervision and skill-building application that was developed for this project. The application facilitated skill assessment and capacity building for frontline workers and created a community space for peer learning and coaching. The app improves caseworker and community focal point knowledge of GBV and strengthen case management, communication, and survivor-centered attitudes and skills. By having this content available on a mobile device (tablet, smartphone) via an application, staff can access it in settings with low or no connectivity.

STUDY DESIGN AND METHODOLOGY

This study used mixed methods approaches to assess the feasibility and acceptability of mobile GBV service delivery in Myanmar, Burundi, and Iraq. Methods involved structured and open-ended individual interviews with 181 women and girl beneficiaries and 21 IRC staff.

A total of 29 focus group discussions (FGDs) were also held with stakeholders in each country, including adult women and adolescent girls, IRC staff, IRC focal points, non-IRC service providers, community leaders, and adult men (community members). Finally, all participating staff and focal points were invited to take a written survey after their interview or FGD.

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	Myanmar	Burundi	Iraq
Women and girl beneficiary interviews	73	72	36
IRC staff interviews	10	3	8
IRC staff written surveys	27	6	6
Focal point written surveys	10	20	4
Women and girl beneficiary FGDs	0	0	2
Staff FGDs	3	1	1
Focal point FGDs	1	2	1
Non-IRC service providers FGDs	6	2	2
Community leader FGDs	1	2	1
Male community member FGDs	2	2	0

Interview and FGD scripts for all participants were developed through collaboration among research advisor consultants and IRC Women's Protection and Empowerment staff, with input from country program teams and local research team members. Trainings, interviews and focus groups were conducted in staff and participants' preferred languages (Myanmar/Burmese, Jinghpaw, Ta'ang, and English in Myanmar; Kirundi and French in Burundi; Arabic and English in Iraq). All research materials were translated into preferred languages.

KEY FINDINGS

Beneficiaries are satisfied with mobile and remote services, given restraints, and desire more services.

Beneficiaries of group activities across all settings reported general satisfaction with staff warmth and relatability, staff trustworthiness, safety and privacy of the space for group activities and privacy of the space for case management. Beneficiaries in Burundi and Iraq also reported that the hotline was easier logistically than physically accessing services and that it allows for more convenient timing and confidentiality.[3] Though mobile and remote service delivery is intended to increase access in this way, the study demonstrated a clear demand for even more, intensive and consistent services. Beneficiaries cited some challenges with scheduling, transportation, and location as continued barriers to access. Requests for expansion of the number, location and variety of activities were common from both beneficiaries and staff. Additionally, beneficiaries were eager for increased availability of the hotline through longer hours during the week as well as open hours on the weekends. Such expansion of both mobile and remote GBV service delivery would require more staff availability (e.g. to keep the hotline open; to spend more hours at each mobile site; go to more mobile sites) than is typically associated with emergency mobile response.

Group activities and individual interactions with staff that are not about GBV are key for discreet case management.

> *"They know that different people with different problems come to the center, even those who come for singing and dancing"* Adult beneficiary in Burundi

During the interviews, beneficiaries in all three countries were asked whether a woman seen talking individually to a staff member would be perceived as a survivor by the community. In Myanmar, 61% of adult beneficiaries felt she would be seen as a survivor whereas 20% in Burundi and 53% in Iraq said the same. The qualitative response from both staff and beneficiaries illuminates a potential reason why this number is lower in Burundi: community perceptions of the mobile spaces and mobile teams are that they help many types of women, not only survivors. Staff emphasized the role of PSS activities in decreasing stigma about help-seeking from IRC, and increasing confidentiality and safety for those seeking and providing GBV-focused services. A staff member explained, "When the community or the perpetrators see people attending our centers, they think that they are coming for embroidery or basket weaving activities. This also ensures safety for activists. Before the listening centers were set up, perpetrators could threaten our activists."

[3] In Myanmar only two of 61 adult participants and one adolescent reported using the hotline/support call center. Given this small number, participant user experiences are not reported here. However, monitoring data indicators that hotline callers in Myanmar were satisfied with the service.

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> *"There's no one who might think that this is a place for GBV or for case management; we just talk to women there in general and that is the thing that we publish in the community."* IRC Staff, Iraq

To discreetly provide case management, staff in Iraq often ask about other needs to normalize individual interactions with beneficiary women and girls. However, in doing so, it is possible that they raise expectations about aid they can give, thus causing frustration. One adult woman in Iraq said: "they just ask about needs and do not care." These interactions are clearly important to being able to provide more support on more sensitive matters, but humanitarian staff must be careful to not set expectations beyond what they are able to provide.

Services for intimate partner violence are the most common case management request.

Stakeholders identified on-going intimate partner violence (IPV) as the most common type of GBV affecting women and girls in pilot sites. The research study and monitoring data highlighted emergency calls to the hotline during active violence, reports that husbands deny women and girls access to services which require that staff have in-depth knowledge of the dynamics of IPV and how to respond safely. Beneficiaries also continuously requested livelihoods programming in order to be independent from abusive partners.

Community focal points are essential for supporting mobile teams.

Because IRC staff spend less time in each site during a mobile response than they would at a static service point, this service delivery relies heavily on community focal points to support mobile teams when they are off site. During both research and monitoring activities across all three countries, beneficiaries identified community focal points as their entry point to group activities, in-person case management and hotline services. Focal points themselves also indicated that the role has helped them personally by providing them with knowledge about their own safety and access to services.

More supervision and support for all staff and focal points is required.

The study demonstrated the urgent need for a higher level of remote technical supervision and training regarding boundaries and safety. Reports from the beneficiaries, staff, and from focal points themselves, highlighted several safety concerns associated with this pilot: family (typically husbands) of focal points being curious about their work which can compromise the confidentiality and safety of the survivor, staff and focal points travelling throughout the community alone or at night, going to the homes of survivors, and giving survivors shelter in their own homes.

As community focal points are chosen due to their leadership in the community and survivor-centred attitudes, it is understandable that they want to assist survivors to the highest degree possible. However, for active cases of intimate partner violence (IPV) staff or focal points should not be going to the home of the survivor as it can place both the survivor and staff member at risk of harm. This is particularly the case for community focal points who live amongst the community. More emphasis and training needs to be placed on boundaries and self-care with this type of approach. Because management and technical staff are only at the mobile sites for limited amounts of time (approximately one day a week), it is challenging to carry out traditional means of observing focal points work in their environment. Therefore, there is a need to provide additional methods of remote supervision, such as through the hotline or a mobile-based application developed through this project such as ROSA. Initial testing of ROSA has already proven useful according to staff feedback.

> *"Whenever I need to know more about case management I go directly to Rosa app"* IRC Staff, Iraq

Staff in all three countries also raised the issue of stress related to their work. In some cases, this was related to the need for additional staff members and more management supervision, but they also mentioned the need for more opportunities to process their experiences, decompress and practice relaxation exercises.

Misconceptions about service delivery are a barrier to access.

A number of comments throughout the findings highlighted lack of consistency between staff and beneficiary understanding of services and access (e.g., beneficiaries believing there are age caps, that services cost money, etc.) which need to be addressed. This may be particularly important for mobile service delivery because there are often barriers associated with accessing services in the host communities (e.g., fees for services). Beneficiaries may erroneously associate these same barriers with mobile services because they are happening in the same geographical area. It is also possible that staff and focal points do not have a clear understanding of when and how survivors can access services and are therefore unable to respond to beneficiary concerns and encourage access for all survivors. Clarifying these policies and having clear messages will be essential to increasing acceptability of both mobile and remote GBV service delivery.

Referral services for mobile and remote service delivery require increased resources.

GBV actors cannot meet the comprehensive needs of survivors without links to other services including health, legal, protection and security. While service mapping is always important for GBV response, it requires additional staff time and effort for mobile service delivery. Where static services operate in a single space with defined boundaries (such as a refugee camp), mobile teams move to a broad range of sites that do not always have clear borders. In order to provide case management services, mobile teams must map services in each and every site where they operate, meaning that a mobile team going to four sites must do four times the service mapping as a static team. Similarly, because anyone with the phone number can call a hotline, it is difficult to narrow down a specific area in which to map services for remote service delivery. Therefore, to truly be responsive to referral needs, remote teams must map as much of the surrounding area as possible, which requires considerable staff time and effort. It is also important to map which referral partners are accessible via phone in order to connect beneficiaries to services remotely. Additionally, because many of these contexts change regularly with new displacements and responders, there is a need to continually be gathering service information. Creating access to local or government services also requires higher budgets for case management as there are more fees associated with services than in traditional refugee or IDP camp settings. Additionally, voucher systems with referral pathway partners may potentially reduce access barriers for survivors in remote mobile sites.

There is interest in technology-based services, though there are some barriers to access.

Requests for more active hotline hours suggest that beneficiaries are interested and able to access services remotely. However, not all survivors have access to phones. Though focal point networks have been helpful in making phones available to women and girls in the community, some respondents pointed to the need to further build and advertise such systems (e.g., assign more focal points and others as official “phone-holders” for particular areas; increase awareness about where and when phones are available). For locations that do have hotlines available, increased awareness raising about this service is needed. Across contexts, many respondents (beneficiaries and other stakeholders) reported that they were not aware of hotline services. Whereas some programs have utilized creative methods to advertise the hotline (e.g., Facebook (Iraq and Myanmar); brochure distributions (Myanmar), hosting competitions for drawings that communicate about the hotline (Iraq); and discussions in safe spaces (all countries), these methods may reach some populations and not others. Additional methods are needed, e.g., radio ads, awareness raising through partner organizations, passing out information at public events (e.g. sports activities), engaging with more community leaders, and other specific groups of stakeholders.

Participant responses also highlight generally positive reactions to use of tablets, but challenges remain with poor internet/phone service, and negative or mixed cultural reactions to women and girls’ phone/internet use.

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RECOMMENDATIONS FOR MOBILE AND REMOTE GBV SERVICE DELIVERY

The following recommendations for mobile and remote GBV service delivery build on the primary findings from the feasibility and acceptability[4].

Recommendations for practitioners:

Program structure:

- Entry points for case management need to be private, confidential spaces linked with non-GBV related activities or services in order to reduce stigma for survivors seeking help. This also reduces the likelihood that staff and community focal points will only be associated with providing GBV services which promotes their safety in the community. Models include temporary safe spaces for women and girls where group PSS activities and case management are provided as well as case management services that are provided in a private room linked with other sector static or mobile services, for example with health services.
- Mapping of services in each mobile site requires extensive staff time in order to develop thorough referral pathways that are responsive to the changing nature of these contexts. Strengthened coordination and advocacy for support of referral partners are needed. Referral policies and procedures should be clear, documented, phone-based, and updated regularly.
- Improve targeted outreach to vulnerable groups including development of appropriate outreach messages given the cultural context to ensure that male survivors of sexual violence and male and female-identified LGBTI survivors know that services exist.
- Ensure that there are mechanisms to collect routine feedback from beneficiaries, focal points, and community leaders so that the mobile team can adjust to the changing needs of the community and to ensure that beneficiaries are clear on the scope of service provision and how they can access services.
- Facilitate thoughtful expansion of hotline and other technology, with an awareness of challenges regarding both technological limitations, and social norms that may discourage or create risks associated with phone and internet use by women and girls. Consider use of hotline programming for vulnerable groups facing particular stigma regarding help-seeking, such as men, boys, or LGBTI populations.
- Plan for sustainability by including local partners from the outset of programming. Consider mechanisms for systematically shifting ownership of activities and spaces to focal points and community groups, including by empowering community members to develop their own activities and use spaces as they desire. If the plan entails eventual handover to local organizations, engage in ongoing capacity building, including technical trainings and organizational development.

Staffing:

- More staff overall are needed for mobile programming, specifically, dedicated staff are needed for hotline/support call services.
- Staff and community focal point composition should be reflective of the community (e.g., representing ethnic groups and languages of beneficiaries).
- More technical supervision and on-going coaching is required for staff and community focal point, including in-person and through scale-up of remote supervision (e.g., hotlines and web-based case management applications).
- Staff need to be thoroughly trained in dynamics of IPV, times when survivors are at increased risk of violence, safety planning and how to respond to survivors needs given the significant gaps in services that are available in mobile setting, and what the appropriate responses are to ongoing IPV situations from caseworkers, the security sector and other service providers.
- Staff-support and self-care approaches are critical for staff and focal points.

[4] The full study report with detailed results will be published on www.GBVresponders.org

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Community focal point component:

- Clear Memorandum of Understandings (MOUs) and job descriptions for the role of the focal point are needed, especially to clarify boundaries of focal point roles in regard to providing direct services.
- Focal points should be thoroughly trained on outreach strategies and involved in ensuring access for all populations in the context.
- Focal point MOUs, training, and supervision should prioritize confidentiality and safety protocols related to outreach and community engagement.

Financial resources and infrastructure:

- Aim to strike a balance among various priorities (cost, location, service provider and community control) when selecting spaces for mobile service provision.
- Consider budget lines for adequate transportation support for staff, focal points, and beneficiaries (including for those with disabilities), meeting the basic needs of survivors (e.g., emergency food, NFIs), securing safe places for service delivery, set up and maintenance of the hotline, and information communication and technology (ICT) equipment.

Recommendations for researchers and monitoring and evaluation practitioners:

- Include perspectives from non-service using members of the community to better understand the need for and barriers to engagement in mobile and remote services.
- Include perspectives from those experiencing short term displacement.
- Collect information about what kinds of cash programming can support survivors with economic needs and what links to livelihood programming might be feasible and beneficial within mobile programming.
- Conduct further piloting of innovative programming, including remote service provision through technology (such as SMS, chat, etc.), voucher or mobile cash programming associated with case management, and joint sectoral mobile deployments.

Recommendations for policy makers and donors:

- For donors, consideration of staffing and budget needs outlined above is critical.
- Related to the above, consider that host community populations will also access programming especially if GBV services do not exist in host areas (remote or otherwise).
- UN agencies, donors and other stakeholders should prioritize advocacy for stronger referral options.
- Donors should facilitate and require sustainability planning and responsible handover to local partners as appropriate, including sufficient funds for capacity-building.

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For further information, please contact: Amy Neiman (amy.neiman@rescue.org) or Betsy Laird (betsy.laird@rescue.org). Additional information about the IRC's GBV program models, research, and advocacy can be found at: **www.**gbvresponders.org

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