Global Handling Framework For Preventing and Responding to Safeguarding Violations Experienced by IRC Clients

PURPOSE

The IRC defines safeguarding as the protection, safety, and dignity of staff and clients. In the context of clients, this includes the exploitation and abuse of adults or children, including physical, verbal, emotional, mental, economic, and sexual exploitation and abuse, who are or could be clients of IRC - by its staff, contractors, partners, sub-grantees, vendors, or other associates. This Handing Framework specifically applies to those who are or could be clients of IRC, both adults and children.

This Handling Framework was developed to ensure that IRC offices can take immediate and appropriate action to address safeguarding violations. It supports local offices – both RAI and CRRD – to ensure that contextualized and localized measures are in place before incidents occur, as well as to support the prevention of such incidents.

All IRC offices should use this Handling Framework to develop a Standard Operating Procedure (SOP) that works for their operating environment, in a language that is understood by their staff.[1] This document sets out minimum standards for preventing and responding to safeguarding violations in ways that meet the IRC's core values, policies, and which are survivor-centered. How this is implemented may look practically different depending on local laws and locally available support services.

This Handling Framework applies to both adults and children, who experience abuse and exploitation by IRC staff. Where specific measures or actions vary for children, this will be highlighted in boxes throughout the text. Unless otherwise noted, measures and actions remain the same for adults and children.

> This document applies equally to RAI and CRRD. Although RAI operating environments may be able to rely on more developed, local mechanisms, these offices still must ensure that reporting and response processes and protocols are clear and that strong preventative action is in place.

Where the IRC is leading a consortia or if partners do not have appropriate response mechanisms and protocols in place, the IRC can share this Handling Framework and its local SOP with partners, and may include partners in IRC's safeguarding protocols until the partner can establish their own.

This Handling Framework includes the following sections:

I. Prevention and preparedness
   i. Communication
   ii. Training
II. Reporting
III. Report escalation and investigation process
IV. Response and support services
V. Learning and reflection

PREVENTION AND PREPAREDNESS

Awareness and understanding about the existence and contents of the Handling Framework, as well as localized SOPs or other documentation created regarding the safeguarding of clients, are essential elements for the prevention of safeguarding violations. The IRC expects leadership in all offices to send a message to staff about the type of behaviours that are

[1] A template SOP can be found https://rescue.box.com/s/9xujls8skyqjrhe9gkcoq3xah9obj8jz .

acceptable and unacceptable, as well as the actions to be taken when there are violations of IRC's safeguarding policy directive or suite.[2] It further ensures the readiness to provide timely and appropriate responses when incidents occur.

Communication

Communication is about setting the tone we want staff, including incentive, occassional, contract, or day workers, volunteers, partners, vendors, other associates, and clients to respect. It is about setting expectations and boundaries, in a clear, concise, and understandable manner; it establishes what is and what is not acceptable behavior. Use the following minimum standards to guide your office's approach to communicating clearly about safeguarding at the IRC:

- Establish Safeguarding Leads for your location
    - This does not have to be a technical staff, but should be individuals most suited for the role. The tasks of the leads are to support the roll-out of safeguarding activities, like the development of a SOP for responding to safeguarding violations against clients. Annex 1 sets out a proposed TOR for such leads.
    - Always ensure that at least one Lead on Safeguarding is a woman, which contributes to the creation of a safe entry point for female staff and clients to report, seek support, and influence safeguarding measures and messaging.
    - Where possible, appoint multiple Safeguarding Leads and include a mix of genders, representing different locations, eg. capital and field sites.
    - Appoint leaders from local staff teams as Safeguarding Leads. Having these individuals also sit on the Senior Management Team or other form of local senior manatement or leadership team sends a strong message that their role and safeguarding is taken seriously at the local level.

- Communicate to all staff and clients that there is a Handling Framework, SOP, and contents of the IRC's safeguarding policies, and identify who will deliver these messages ensuring they have enough authority and trust from the targeted audience to have an impact.
    - It is required that local staff, both female and male, be included in the process of developing and communicating the SOP to other staff and clients. This should include the Women at Work groups for CRRD. This is to ensure that local languages and contexts are taken into consideration.
        - It is further required that the intersectionality of these local staff members be considered, beyond just gender, including their ethnicity, religion, or other identifying features that may reflect a broader representation of the diversity of IRC staff in the operating context.
    - It is recommended that existing programming and programming staff be used as an entry point for communicating with clients.
    - It is recommended that simple and clear language be used in the SOP, and that it be written with the view that the drafter may leave the organization, therefore the document must stand on its own without further explanation.
    - Seek support from technical specialists on Safeguarding, Gender Equality (GE), and Violence Prevention and Response Unit (VPRU) as needed, to ensure appropriate communications and consultations are conducted with clients.

- Identify what types of communication methods will be used. A large variety of options exist, including in-person communications, posters, radio spots, and videos, to name just a few.

[2] These safeguarding of clients' policies are: Child Safeguarding Policy; and Beneficiary Protection from Sexual Exploitation and Abuse Policy.

- It is required that both staff and clients are consulted about how they would like to receive communications about safeguarding. The limitations of the local context – for example lack of cell service or languages that are only oral – need to be taken into consideration as well. There is no one right answer to how we communicate in our different contexts, and the important element is not how the message is delivered but how it is received.
- It is required that a gender and age analysis be part of the consideration for different communication methods, and that consultations with such specific groups be conducted to ensure their needs are reflected in the communication methods used.

> Remember: Children and adults with low literacy skills will not be able to understand a poster that is all writing. We may need to be creative and use imagery, cartoons, videos, or other means of communicating our messages.

- Set regular reminders and communications about the Handling Framework, SOP, and other related materials.
  - It is recommended that Safeguarding Leads, supported by other members of senior management, establish routine methods of communicating with all staff about safeguarding of clients. This could be adding discussion topics at senior management or all staff meetings, through quarterly refreshers on different aspects of safeguarding, or through materials made available in the office place. A combination of different methods is likely to be most effective.
  - It is recommended that guidance be sought from technical specialists on Safeguarding, GE, and VPRU as needed, as they have specific skills that can support the development of appropriate communication materials. The Safeguarding Task Force, a working group created in IRC in 2018 and consisting of a cross-section of technical staff and senior leadership in CRRD and RAI, is creating safeguarding communication materials every two months that may also help with this task.

<u>Training</u>

Where communication is about setting tone and behavior, training is about providing staff, including incentive, occassional, contract, or day workers and volunteers, partners, vendors, and other associates with the knowledge and skills to understand acceptable behaviors in more depth. In particular, this tells us *why* the IRC believes some behaviors are acceptable for anyone associated with the organization – like treating clients with respect and dignity – and others – like the use of child labor preventing children from accessing their full educational potential – is not acceptable.

Training is also about providing the knowledge and skills needed to be able to respond in a timely, dignified and survivor-centered manner when individuals do experience safeguarding violations. No one should be expected to instinctively understand how to respond to a survivor. In some of the local offices there may be staff already trained on this topic, making them a valuable resource, but where possible all staff should be trained to be able to respond to a survivor. We never know who might be trusted with a survivor's disclosure, and should all be prepared to step up and support survivors who have the ability to report.

There are three different levels of trainings that are required to be delivered:

1) Everyone should know how to provide an immediate and initial response to a survivor's disclosure, including psychological first aid, referral to a case worker in CRRD or external support service provider in RAI, what and how to document/report, principles of confidentiality, and consent;
2) Leadership and safeguarding leads should be trained on the above, plus be provided with the skills and knowledge to conduct awareness raising and behavior change activities; and
3) Caseworkers should be trained on the above, plus delivery of minimum response services.

- Develop a plan to ensure that staff, including incentive, occassional, contract, or day workers, volunteers, partners, vendors, and other associates have a comprehensive

understanding and been trained on the contents of the Handling Framework and SOP, including routinely training to ensure all individuals associated with the IRC have reminders and refreshers on what is acceptable behaviour.

- An expanded safeguarding training suite is being developed at the HQ-level, for contextualization and implementation at the local-level. It will consist of e-learning modules and Trainer of Trainer training materials designed to gradually build knowledge and skills, and shift behavior change over time. More information on this training suite and its development can be sought from the Director of Safeguarding. The trainings are developed in a manner to speak across contexts, but where necessary further contextualization and translation should be undertaken. Once rolled out, it is required that this training is being delivered to all staff in all locations.
- It is recommended that, where possible, funding be requested for continuing capacity building – such as internal on-going staff capacity building – as well as other safeguarding and integrity related activities, for staff, including incentive, occassional, contract, or day workers, volunteers, partners, vendors, and other associates on safeguarding. There are currently indications that funding may be granted on an individual grant level where it is for such specific activities, and where it can be directly linked with programmatic necessity.
- Seek support from technical specialists on Safeguarding, GE, and VPRU, as needed, for adapting or delivering training materials.

REPORTING

For IRC clients, the ability to report to the organization in an appropriate, safe, dignified, confidential, and survivor-centred manner is essential to ensuring that incidents, when they do occur, are captured and addressed. The existence and use of reporting mechanisms will also in the longer-term act as a deterrent for potential perpetrators, as it helps to create an environment of openness and communication.

The reporting channels will vary by operating context, and multiple avenues for reporting should be made available to ensure accessibility for clients of different genders and ages. What is ultimately in place must be what is suitable for the client population, not just what works for the organization.[3] Where IRC Child Protection, Women's Protection and Empowerment (WPE) or Protection and Rule of Law (PRoL) programs are operational, reporting can be encouraged and will likely happen through these existing services. Where these are not operational, or where they are in additional to these, other channels may need to be created. If the IRC is participating in joint or interagency complaint mechanisms, such as those for Beneficiary Protection from Sexual Exploitation and Abuse (PSEA), clients may also report incidents of exploitation or abuse directly through such mechanisms.

- Establish reporting mechanisms that are suitable for your client populations.
  - It is recommended that you conduct an assessment with your client populations to capture their preferred methods of reporting any form of complaint regarding IRC programming, integrity violations, or safeguarding violations.
  - Remember that reporting mechanisms can take different forms and will likely vary even within your operating context: by location, age, religion, ethnic breakdown, and gender. Language and low literacy can be essential factors that need to be taken into account when designing reporting mechanisms. Further, reporting requirements may differ within a single country or city program. Assessments must take into account these differences.

- Develop a plan for roll-out of the reporting mechanisms, and ensure that its existence is regularly communicated to client populations.

[3] Further guidance on client reporting mechanisms can be obtained from leads on the Client Responsiveness Framework or ECU. Current draft of the guidance note, templates, and existing good practices can be found here: https://rescue.box.com/s/645zwce8mr9xhenbqg0z1hky8cwhthvd

- It is required that reporting mechanisms be rolled-out in collaboration and coordination with the client population. This helps to ensure there is trust being developed in the reporting mechanism from the start, and so the client population understand that the system is truly for their use.
- It is required that visualizations, audio, and video (as appropriate and as budget allows) communications about how clients can report are readily available and in means that are culturally appropriate, language specific, and as visual as possible for children and those with low literacy.
- Seek support from technical specialists on Safeguarding, GE, VPRU, and Monitoring Evaulation and Learning (MEAL) as needed, to ensure that the reporting mechanisms meet good practices and the needs of the targeted populations.

- Develop a monitoring system on the use of the reporting system and ensure that it remains suitable for the needs of the client population.
  - It is required that regular feedback sessions are held with client populations to collect reports and test the effectiveness of the reporting system.
  - It is recommended that MEAL and programmatic staff participate in the longer-term monitoring of reporting mechanisms, as they already have direct and routine contact with clients. Responisbility for its management and existence lies within senior management at the local level.

REPORT ESCALATION AND INVESTIGATION PROCESS

Being able to collect reports in a manner that protects the confidentiality and safety of the person reporting, in a survivor-centered manner, is imperative if the IRC wants to create an environment where clients feel comfortable coming forward about IRC staff misconduct. It is important to recognize that in some of the contexts where the IRC operates there are significant risks associated with the community or the wider family being aware that a vulnerable individual has a safeguarding violation.

> Remember: There are mandatory reporting requirements when safeguarding violations involve children.

Reporting is an area where there are pronounced differences for adults, adolescents, and younger children. When children report, the confidentiality of their reports needs to be balanced with acting in the best interest of the child. Children should be at all times accompanied by a caregiver[4] during the reporting and investigation process. Questioning of children must be particularly sensitive, so that we do not cause further harm. In CRRD, where at all possible, Child Protection Technical staff should be included in the process of questioning children, either to advise on the best methods or participate in the questioning. For RAI, this may require use of external resources.

When making a report, IRC staff members should seek the following information: what happened; when and where the alleged incident took place; and who was involved. It is never acceptable to suggest that reporters may be lying or making up the details of their allegation. When receiving a report, we ask appropriate survivor-centered questions, believe the reporter, and then communicate the information to ECU for investigation.

[4] Caregiver is a term used to describe the person who is exercising day-to-day care for a child. He or she is a parent, relative, family friend or other guardian; it does not necessarily imply legal responsibility.

Consent[5] and confidentiality[6] are essential elements of the dignity and care that we give to survivors who report to IRC, and must be adhered to at all times. IRC uses a survivor-centered approach. Consult the *IRC Guidelines for a Survivor-Centered Approach to Reporting Safeguarding Misconduct* for further details.

In circumstances where the alleged perpetrator is not an IRC staff member, the IRC may report within an existing inter-agency mechanisms or to local law enforcement for further investigation and action. Such referrals are only considered when individuals (survivors, staff, and witnesses) would not be exposed to any safety risk or harm.

- Communicate to IRC staff, incentive, occassional, contract, or day workers, volunteers, partners, vendors, or other associates about how to receive and escalate reported or sRAIected incidents of safeguarding violations against clients.
    - It is required that how to escalate reports be an integral part of the communications and training section of how the IRC approaches safeguarding at the local level, adapted for each local context.
    - Remember that reporting should follow our *Global Reporting Guidelines* and *IRC Guidelines for a Survivor-Centered Approach to Reporting Safeguarding Misconduct*. Additional guidance on how to receive and escalate reports about safeguarding violations against children can be found at Annex 2 of the Handling Framework.
    - Seek support from technical specialists on Safeguarding, Investigations, GE, and VPRU as needed, to ensure that a survivor-centered approach is taken with all clients who report.

- Develop an information management protocol to ensure that all requests by the investigations team, as well as necessary communications to alleged perpetrators, survivors, and donors, are handled with sensitivity and as a priority.
    - It is required that responsibility for such communications be set in advance by senior management, and adapted as necessary based on specific circumstances and needs of individuals such as survivors.
    - It is required that an analysis of local laws as they relate to the reporting and accountability of different forms of sexual violence be determined in advance of reports, so that timely and survivor-centered recommendations can be made.
    - It is recommended that the local Safeguarding Leads play an essential part in such communications and follow-up.

RESPONSE AND SUPPORT SERVICES

When violent safeguarding violations occur, IRC requires that offices be equipped to provide quality, gender- and age-appropriate services, and that medical care be available within 72 hours[7] alongside the other minimum response services as outlined below.

In CRRD offices that have existing Health, Child Protection and/or WPE programming, these sectors should be the leads in ensuring quality response services, in line with best practice and programming standards. This will include four broad categories: safety; medical; psychosocial;

[5] In IRC, consent is defined as 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 know about and understand the services being offered and be legally able to give their consent. To ensure consent is "informed", service providers must provide the following information to the survivor: 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; what will happen as you work with her/him; benefits and risks of services; that she/he has the right to decline or refuse any part of services; and limits to confidentiality.

[6] In IRC, confidentiality is defined as ethical principle that is associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files. Maintaining confidentiality means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.

[7] Earlier than 72 hours is ideal, and in some contexts, including RAI, immediate services may be available.

and, in some cases, legal services. The minimum standards for each of these services, for the establishment of clear referral pathways, and for how we deliver these services are detailed further in Annex 3.

It is important to note here that delivery of response and support services will require in each specific safeguarding case the appointment of a Child Protection or WPE case worker, who will make sure the survivor receives immediate support services as needed. Where such roles do not exist, IRC has a duty to ensure that alternative methods of seeking support services and clearly established referral pathways, in line with our minimum standards, are operational.

For RAI, the local avilability of support services may make referrals considerably easier. Nonetheless, it is important that these services reflect the minimum standards set out in Annex 3, which while created specifically to address the service gaps in many of our CRRD country programs, does establish a clear standard in line with good practices. Even in RAI, we still require that safety; medical; psychosocial; and, in some cases, legal services be made available, and that clear referral pathways are established in advance.

- Develop an overview or plan that demonstrates appropriate services are or will be available before a safeguarding violation occurs.
    - It is required that the IRC's CRRD Rapid Service Mapping Tool or similar mapping tools be used. When there is changes in the operating context, the services assessment should be re-done to ensure that services are available when survivors and their supporters need to access them.
    - For CRRD:
        - It is required that where there are no existing IRC Child Protection, Health or WPE services, and no external services close enough or not of sufficient quality, plans are put in place to bring in-house expertise and/or strengthen the capacity of external service providers.
        - It is required that caseworkers are pre-identified to work with survivors of safeguarding violations; these would be existing Child Protection or WPE staff, other IRC staff where there are no Child Protection and WPE program, or external service providers. In case of other IRC staff or external service providers, they will need to be provided with appropriate training.
        - It is recommended that, where possible, the referral pathway also include information on actors not affiliated with IRC, in the event a survivor who has made an allegation against IRC is not comfortable receiving services from the organization. It should be left to the surivovr to decide which of the organization or services that are avilable that they are must comfortable accessing support from.
    - For RAI:
        - This will typically involve referrals to external services. While there may be an assumption that services available in the US would be sufficient quality to meet our needs, it is still important to reflect on things such as the languages offered by the service and whether they have experience dealing with refugees in trauma.
    - It is recommended that local offices ensure IRC staff, incentive, occassional, contract, or day workers, and volunteers are also given access to different forms of support services if they have received a report about a safeguarding violation, or if they otherwise supported those affected by safeguarding violations.
    - Seek support from Health, Child Protection, and/or WPE technical advisors to guide the identification and establishment of responsive services.

LEARNING AND REFLECTION PROCESS

After all safeguarding violations are reported, a learning process must be undertaken to capture lessons and remaining gaps. This can and may involve further contextualization to our responses, or reflecting on our survivor-centered approach. It may also include

recommendations from the ECU post investigation. Where it is safe to do so, input from client populations on how the IRC can better respond to safeguarding violations should be collected.

Action plans must be created based on the information collected and implemented to address any identified issues. Learning from errors, even if they are inadvertent, is an essential piece to improving as an organization.

- Develop a plan for a routine lessons learned and reflection process after a safeguarding violation has been reported and investigated.
    - It is recommended that senior management lead on such a process. This should include the Safeguarding Leads.
    - It is recommended that feedback from local technical staff and clients be included in the learning and reflection process.
    - It is recommended that senior management establish mechanisms to ensure that this is a meaningful process.

Checklist

PREVENTION AND PREPARDNESS

- Each local office ensure that at least two members of senior management are appointed as Safeguarding Leads.
- IRC staff, incentive, occassional, contract, or day workers, volunteers, partners, vendors, and other associates must have a comprehensive understanding of the relevant Behavior Protocols and localized SOP.
- IRC clients – adults and children – have a comprehensive understanding of the relevant Behavior Protocols and localized SOP, contextualized and translated for their level of literacy and understanding.
- Senior management regularly communicates to staff about the existence and contents of the SOP and relevant Behavior Protocols.
- IRC staff, incentive, occassional, contract, or day workers, and volunteers have access to and receive regular updated trainings regarding safeguarding.

REPORTING

- Assessment of client populations is conducted to capture their preferred methods of reporting any form of complaint regarding the IRC programming, integrity violations, or safeguarding violations.
- Existing reporting mechanisms through protection programming are reinforced and new reporting mechanisms are designed and rolled-out in line with the differing needs identified in the client population assessment.
- Visualizations, audio, and video (as appropriate and as budget allows) communications about how clients can report are readily available and in means that are culturally appropriate.
- Regular feedback sessions are held with client populations to collect reports and test the effectiveness of the reporting system.

REPORT ESCALATION AND INVESTIGATION PROCESS

- The IRC staff, incentive, occassional, contract, or day workers, volunteers, partners, vendors, or other associates know how to escalate reported or sRAIected incidents of safeguarding violations against clients, as per the *Global Reporting Guidelines*.
- A survivor-centred means of responding to clients is understood and adhered to. This includes mandatory reporting of any allegations involving children.
- Cooperate fully with all requests made by the investigations team, to the best of the abilities of the local team, including communications with the alleged perpetrator and survivor about the outcome of the investigation and actions to be taken.
- Coordinate and communicate with donors, as appropriate, regarding investigations and actions being taken in response to reports of safeguarding violations.
- Local offices must have an information management system and data protection protocols in place.

RESPONSE AND SUPPORT SERVICES

- Local offices must have an up-to-date service mapping in place, including referral pathways and information management protocols that meet minimum standards established by the IRC.
- Local offices must have appointed case workers and have the minimum services in place or be able to refer survivors for case management services which meet minimum quality standards, including plans for bringing in-house capacity or capacity strengthening of external service providers as needed.

LEARNING AND REFLECTION PROCESS

- Lessons learned and remaining gaps are captured by senior management after a report of a safeguarding violation.
- Local offices implement recommendations made by ECU, technical staff, clients, or other essential individuals.

Annex 1

Proposed TOR for Safeguarding Leads

Purpose:

Appointing Safeguarding Leads is required of local offices in order to ensure consistency and progress for safeguarding activities. This is not meant to be a full-time role. Leads will act as a point of contact for inquires on safeguarding activities, feed into contextualization of safeguarding activities, and, as required, assist in the roll-out or distribution of safeguarding guidance, templates, trainings, or other materials.

The appointment of Safeguarding Leads does not reduce or eliminate the requirement of local senior management to take ownership and responsibility for the implementation of safeguarding activities.

Main Responsibilities:

These responsibilities can be shared between Safeguarding Leads, and may shift over time:

- Act as a point of contact for the Safeguarding Task Force, Director of Safeguarding, or other individuals for updates and information on safeguarding activities locally;
- Act as a point of contact for local program staff for questions or support on safeguarding policies and activities at country and/or global level;
- Participate in the contextualization and localization of safeguarding guidance, templates, trainings, or other materials, as necessary; and
- Assist in the roll-out or distribution of safeguarding guidance, templates, trainings, or other materials, as necessary.

Percentage of Time:

Recommended percentage of their time is 5%-10%.

Requirements for the local office:

At least one lead must be a women, and in all cases gender-balance should be the goal. Unless otherwise not possible, leads should be local staff members and represent the diverity of local populations.

Qualities:

Good Safeguarding Leads should possess the following:

- Strong communication skills;
- Empathy and compassion for survivors;
- Understanding of confidentiality;
- Base level of knowledge on safeguarding;
- Commitment and passion for ensuring the safeguarding of clients and staff; and
- Trusted by staff and clients.

Annex 2

Tips and information for speaking to child survivors of safeguarding violations

Any approach to interacting with child survivors must take into consideration cultural and social norms that may affect re-traumatization of clients from such a variety of background.

See attached PPT[8] that provides extensive and detailed information and guidance on the following:

- Understanding Child Abuse – slides 1-15. These slides provide definitions of the various forms of child abuse; a note on perpetration; an overview of common signs of abuse
- Understanding Disclosure – slides 16-21. These slides provide information about disclosure; impact on caregivers; the required child-friendly attitudes and service provider beliefs
- Understanding Guiding Principles and key issues – slides 22-37. These slides give an overview of the key guiding principles and the key issues of mandatory reporting, confidentiality protocols and ensuring the best interest of the child
- Understanding the Importance of Good Communication with Child Survivors –slides 38-81. These slides provide information on establishing a helping relationship; best practices for communication; use of non-verbal techniques; sample scripts; guidelines for interviewing children of different ages and children with disabilities; what to do when do not talk or deny abuse
- Understanding Case Management – slides 82-146: These slides provide information and guidance on the steps of case management including introduction & engagement, intake & assessment, case action planning, case plan implementation, case follow up, and case closure
- Understanding Psychosocial Interventions for Children – slides 147-152: These slides provide information on providing healing education, relaxation training, coping skills and problem solving

Shorter guidance materials, including trainings on how to receive and escalate reports of safeguarding violations, whether received from colleagues, adult or child clients, are under development and expected to be shared across IRC in June/July 2019.

[8] This is taken from: the Interagency Guidelines for Case Management and Child Protection http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf and Caring for Child Survivors of Sexual Abuse https://gbvresponders.org/response/caring-child-survivors/

Annex 3

This Annex was specifically created for an CRRD audience, in recognition that the gaps in services for CRRD operating contexts are vastly different than that of RAI. For the purposes of RAI, please refer only to the minimum services section.

Minimum Care and Services Response for Survivors of Safeguarding[9] Violations
In addition to adequate reporting and investigation mechanisms, the IRC is committed to providing a minimum standard of care and services to support a survivor's recovery.[10] This document sets out the **minimum standards for care and response services for individuals experiencing all forms of abuse and exploitation** (physical, emotional, sexual) at the hands of IRC staff, incentive, occassional, contract, or day workers, volunteers, partners, vendors, and other associates. This will ensure the provision of timely and appropriate support to the survivor that is also responsive to age, developmental stage, and gender.

<u>What</u> is the minimum care and service response that IRC needs to make sure survivors receive?
Upon self-disclosure by the survivor, third person report (with consent of the survivor for adults and older adolescents capable of making their own decisions), or direct observation of abuse (with consent of the survivor for adults and older adolescents), the survivor must immediately be appointed a **case worker[11]** who will make sure the survivor receives immediate care and services as needed, and engage in a **light-touch case management[12]** process.

The case worker is the person who directly interacts with the survivor to ensure the survivor receives the necessary care and services. Trained caseworkers typically sit within existing Child Protection and Women's Protection and Empowerment (WPE) program teams. Wherever possible, the minimum response standards should be provided through those existing teams and program structures, as they have the expertise and experience in this area and will often be the default entry point for reporting. In locations where the IRC is working but does not have Child Protection or WPE presence or programming, IRC leadership will need to identify other options for ensuring that we meet minimum response standards (see below table on how we meet the minimum standards for further detail).

The case workers' interaction with the survivor should be guided by the following **guiding principles** that also inform decision making on services, and ensures overall quality of care and that are in line with interagency humanitarian guidelines:

For women and adolescent girl survivors[13]	For child survivors[14]	For adult male survivors[15]
Survivor centered	Promote the best interests of the child	Survivor centered
Right to safety	Ensure the safety of the child	Right to safety
Right to confidentiality	Comfort the child	Right to confidentiality

[9] This includes Sexual Abuse and Exploitation and Child Safeguarding
[10] Interagency Guidelines for Case Management and Child Protection http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf, Caring for Child Survivors of Sexual Abuse https://gbvresponders.org/response/caring-child-survivors/; and Interagency Gender-Based Violence Case Management guidelines https://gbvresponders.org/response/gbv-case-management/
[11] The case worker, typically a psychosocial or social worker, in a case who maintains responsible for the survivor's care from case start to case closure. This should be an appropriately trained and supervised worker. For IRC, this would typically be a Child Protection or Women's Protection and Empowerment case worker.
[12] A structured process of helping the survivor through direct social-work type support. It involves a psychosocial or social service actor taking responsibility for making sure the survivor is informed, that issues facing the survivor are addressed, and providing the survivor with emotional support throughout the process.
[13] GBV AOR Minimum Standards (forthcoming) and Interagency GBV Case Management guidelines https://gbvresponders.org/response/gbv-case-management/
[14] Interagency Guidelines for Case Management and Child Protection http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf and Caring for Child Survivors of Sexual Abuse https://gbvresponders.org/response/caring-child-survivors/
[15] IRC Male Sexual Assault Survivors Guidance; WHO Clinical Management of Rape Survivors https://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/ and IRC Clinical Care for Sexual Assault Survivors https://gbvresponders.org/response/clinical-care-sexual-assault-survivors/

Right to dignity and self-determination	Ensure appropriate confidentiality	Right to dignity and self-determination
Non-discrimination	Involve the child in decision-making	Non-discrimination
Do no harm	Treat every child fairly and equally	Do no harm
	Strengthen children's resiliencies	

Once a case worker has been appointed to the survivor, the case worker should conduct a light-touch case management process consisting of the following **steps**:

1. Greet and comfort the survivor – this is the case worker's first chance to develop rapport with the survivor (and in the case of child survivors with their caregiver) and begin to develop a trusting relationship. This is essential for the survivor to feel believed and cared for, and the survivor to express her/himself in relation to the experience of abuse as well as wishes on what action to take.

2. Obtain informed consent (and/or assent in the case of child survivors and depending on the age and development stage of the child) – it is essential for the survivor (and in the case of child survivors, their caregiver) to understand what is going to happen, understand the options for care and services and related benefits and risks, and to obtain permission to proceed. Note that for each service referral that will follow, separate consent/assent is required.

3. Conduct the following assessments:
    i. Safety needs, thereby determining whether the survivor is safe: from further harm by the perpetrator; from retaliation from others; and from stigma
    ii. Health needs, thereby determining whether urgent/non-urgent medical treatment/referral is needed
    iii. Psychosocial needs, thereby determining whether the current level of the survivor's functioning is posing medical and/or safety concerns, including self-harm and suicide assessment
    iv. Legal/justice needs, thereby determining whether the survivor (and in the case of child survivors, their caregiver) is interested in pursuing legal action through available justice systems

4. Develop a case action plan based on the main and immediate needs and based on the wishes of the survivor (and in the case of child survivors, their caregiver) in terms of what services will be required.

5. Provide or refer to the required services in the four main areas of assessment with priority needs and minimum services as required in bold:
    i. **Safety and protection** from further abuse
    ii. Clinical health care and treatment
    iii. **Immediate** and longer term **psychosocial support**
    iv. Access to justice

6. Follow up and monitoring to ensure the survivor has received needed services and to assess any improvement in the survivor's situation. Follow-up meetings allow the survivor and the caseworker to "update each other" on actions taken since the first meeting and discuss longer-term needs and care, among other things. Follow-up meetings also provide the opportunity for caseworkers to re-assess the survivor's safety situation.

Minimum services across the four main areas included:

Safety

- **Safety action plan**: If during the assessment it is determined that the survivor is not safe, the case worker should prioritize with the survivor the development of a safety

action plan including a combination of referrals to protection and security agencies, and the development of an individual safety plan

Health

Determining whether medical services are needed is of primary importance in the assessment of survivors who have experienced sexual or physical abuse. The urgency of medical services is determined by the presence of injuries and/or complaints of pain and/or the timing of the assault and/or nature of the assault and/or for evidence collection. If a sexual assault has occurred within the past 120 hours, urgent medical services are needed, since this is within the window of time for the provision of lifesaving treatment. If more than 120 hours have passed, medical services may still be urgent with the presence of injury and pain. **Urgent (e.g. immediate) medical services** may be necessary for:

- Prevention of HIV: The risk of HIV infection can be reduced if a survivor is referred for medical care to receive HIV post-exposure prophylaxis within 3 days (72 hours).
- Prevention of pregnancy: The risk for unwanted pregnancy can be reduced if a survivor is referred for medical care to receive emergency contraception within 5 days (120 hours).
- Medical stabilization/treatment of acute injury or pain: Depending on the severity and nature of the injury (i.e., broken bones, wounds or internal injuries), emergent medical attention may be indicated.
- Evidence collection: If the survivor requests evidence collection for legal purposes, it is important that a medical examination be arranged and recorded as soon as possible (within 48 hours). If the survivor has not bathed or used the toilet, sperm can be collected from the mouth for up to 12 hours and from the vagina for up to 48 hours. If there was no penetration, sperm can be found on the body for up to 6 hours. Injuries should be documented in detail.
- Please note that some serious and life-threatening injuries are not easily detected as they may not be physically visible or associated with pain (i.e., internal bleeding to the stomach or brain, fistula, etc.).

If the person is physically free of injury and pain, the sexual assault occurred more than 120 hours earlier, and/or the nature of the assault did not include physical violence, touching or penetration, medical services may be useful but not urgent. Survivors seeking care more than 120 hours after sexual assault may still require treatment and should not be delayed or discouraged from seeking medical care. Non-urgent medical services may be necessary for:

- Sexually transmitted infections, including chlamydia, gonorrhea and syphilis, should be treated with antibiotics; if left untreated, they may cause chronic illness or infertility.
- Incontinency of urine or stool may indicate severe complications resulting from injury, such as fistula- or rectal-sphincter damage, requiring surgical attention.
- Comprehensive abortion care, depending on the needs and wishes of the survivor[16].

Psychosocial

- **Self-harm and Suicide assessment and/or crisis intervention**: Survivors may experience very serious reactions to the experience of abuse, particularly sexual abuse. It will be critical for the case worker to be watchful for warning signs that a survivor is at risk of self-harm or suicide. Steps to undertake include: assessing current/past self-harm/suicidal thoughts, assessing risk, addressing feelings and providing support, and formulating a safety action plan. If a survivor appears in active crisis, arrange an immediate referral to a health clinic or somewhere safe and supervised
- **Emotional support**: this may happen through the non-judgmental, survivor-centered engagement of the caseworker with the survivor and include the basics of Psychosocial First Aid
- **Providing basic education about abuse**: this helps survivors understands and manage their reactions, and provides them with very specific information about the impact of abuse and the strategies to manage the impact of the abuse

[16] https://rescuenet.rescue.org/Interact/Pages/Section/SubFullOne.aspx?subsection=8528&SearchId=377821

- Assisting survivors with specific problems: if it becomes public knowledge survivors have experienced abuse, harmful consequences are likely. In some settings, child survivors may not be allowed to return to school particularly if they are pregnant as a result of abuse. Unmarried women and adolescent girls may be forcibly married to the perpetrator or have other family settlements imposed on them. Married women face rejection by their family and community and in some contexts honor based killings and harm. Survivors may feel shame about returning to their place of worship or "being seen" in the community generally, or they may have other personal issues. One of the best ways for survivors to heal from abuse is to resume their daily activities, such as attending school or safe spaces, going to the market with someone, and participating in religious and community gatherings. Caseworkers must work with survivors to develop strategies to help them reconnect with their friends, family and community.
- In the case of child survivors, providing counseling to the caregiver and/or other family members. The child survivor is affected by how the people closest to them treat them after abuse. Many parents have strong reactions when learning their child has been abused, especially in the case of sexual abuse. Parents may also have misinformation about abuse which causes them to blame or become angry with their child. If this is happening, caseworkers may need to provide counseling to the family. Counseling should focus on allowing the caregivers to openly (and not in front of the child) share their feelings about the abuse and how this is affecting them and provide caregivers with information, support and education on how to care for themselves and their child.

Legal

The decision to pursue justice is a big one, and survivors (and in the case of child survivors, their caregivers) need to have access to full information to think through such a decision. It is common for survivors/families to take some time to come to a decision. During the initial case action plan, it is perfectly acceptable to present legal options to the survivor and then allow them time to discuss the options.

How do we make sure survivors receive the minimum care and service response?

Minimum Care and Services Actions	**Indicator to measure achievement of minimum standard**	**Activities necessary to achieve minimum standard**	**Verification**
Minimum Care and Services Action #1: Map available services.	Rapid Service Mapping completed every 6 months, including health, GBV and Child Protection services within 2 hours of project site which are assessed to adequately meet needs of survivors	• Contact Health, GBV and Child Protection sectors to access Standard Operating Procedures and referral pathways outlining where local services are available • Conduct a rapid service mapping by interviewing health, GBV and Child Protection service providers using the standard Rapid Service Mapping template • Assess how long it would take a survivor to access these services from the project implementation site. (If it takes over 2 hours the survivor is unlikely to be able to access in a timely or confidential manner and IRC will need to invest in direct service provision – see action #3) • Assess quality of services using xxx. (If services do not meet these criteria, the IRC will need to invest in direct service provision – see action #3). Note that assessing	Mapping available here

		quality requires specialized staff within the team	
Minimum Care and Services Action #2: Appoint a case worker	When incidents occur a case worker is appointed within 24 hours from within the same or most close location	• Where IRC Child Protection and/or WPE programs are operating, existing Child Protection or WPE case workers should be appointed to serve as case worker for survivors of safeguarding incidents from the same or most close location. As a general rule, for child safeguarding cases, appoint Child Protection case workers, for safeguarding violations, appoint WPE case workers. Where these teams/staff members might be implicated, appoint a case worker from the opposite team (ie for child safeguarding, if Child Protection worker is implicated, appoint WPE case worker, and other way around) • Where there are no IRC Child Protection or WPE programs operating, the country team should identify whether other IRC workers from the same or most close location could serve as case worker (eg health or education staff). This should be pre-identified, so these staff can be trained (core concepts, case management and clinical care) accordingly and in advance. In this case, technical support and supervision should be provided by Child Protection or WPE TAs • Where there are no IRC Child Protection or WPE programs operating, and no other IRC workers who could serve as case worker, the mapping should indicate whether which external service provider could be appointed as case worker. This should be pre-identified, so these service providers can be trained (core concepts, case management and clinical care) accordingly and in advance. In this case, technical support and supervision should be provided by Child Protection or WPE TAs	Document that confirms name and date of appointment of case worker for each individual case available on… (without identifiable information about the survivor) Training documentation (eg date, agenda and participant attendance list) for non Child Protection /WPE case workers and/or external service providers available on…
Minimum Care and Services Action #3: Directly provide minimum Safety & Protection, urgent Clinical Health	Safety, health, psychosocial and legal needs assessment completed within 24-36 hours from	• Where IRC's Health, Child Protection and/or WPE programs provide the minimum services in the same or location, or location within acceptable distance, the case worker will ensure the	Document that indicates date of assessment, date and type of service provision and/or referral, and date of

Care and Treatment, and immediate Psychosocial services and/or refer to these services	when case worker was appointed Service provision and/or referral occur within 24 hours from completion of assessments At least one follow-up meeting occurs upon delivery of service and/or referral	survivor receives these services from IRC programs • Where IRC does not provide some or all of these minimum services, or they are not in an acceptable distance to location of the survivor, or the survivor wishes to access external services where available, the mapping should indicate which external minimum services are available, within distance and of quality to which the case worker will refer the survivor • Where IRC does not have Health, Child Protection and/or WPE programs to provide these minimum services currently, and where external minimum services are absent, too far away or of poor quality, the country program needs to bring in and budget for a full-time Child Protection or WPE case worker and/or budget for and conduct capacity strengthening activities for external minimum response providers (eg training, supplies) • Contact Child Protection and WPE program to access Standard Operating Procedures among service providers on referral protocols and information management principles. If these are not in place, or not according to minimum standards, the country programs needs to ensure these are in place and up to standards	follow-up meeting for each individual case available on… (without identifiable information about the survivor) For countries where there are no (or not sufficient) Health, Child Protection or WPE programs, document that outlines country plans and budget for building Child Protection or WPE response and/or other response capacity (eg bringing in trained social worker/ counsellor, funds to transport survivor and accompanying staff to larger city) and/or investment in training and supplies for external capacity strengthening available on… Referral and information management protocols available on…