YOUR GUIDE TO **PROTECTION** CASE MANAGEMENT

[Field-Test Version]

UNHCR
The UN Refugee Agency

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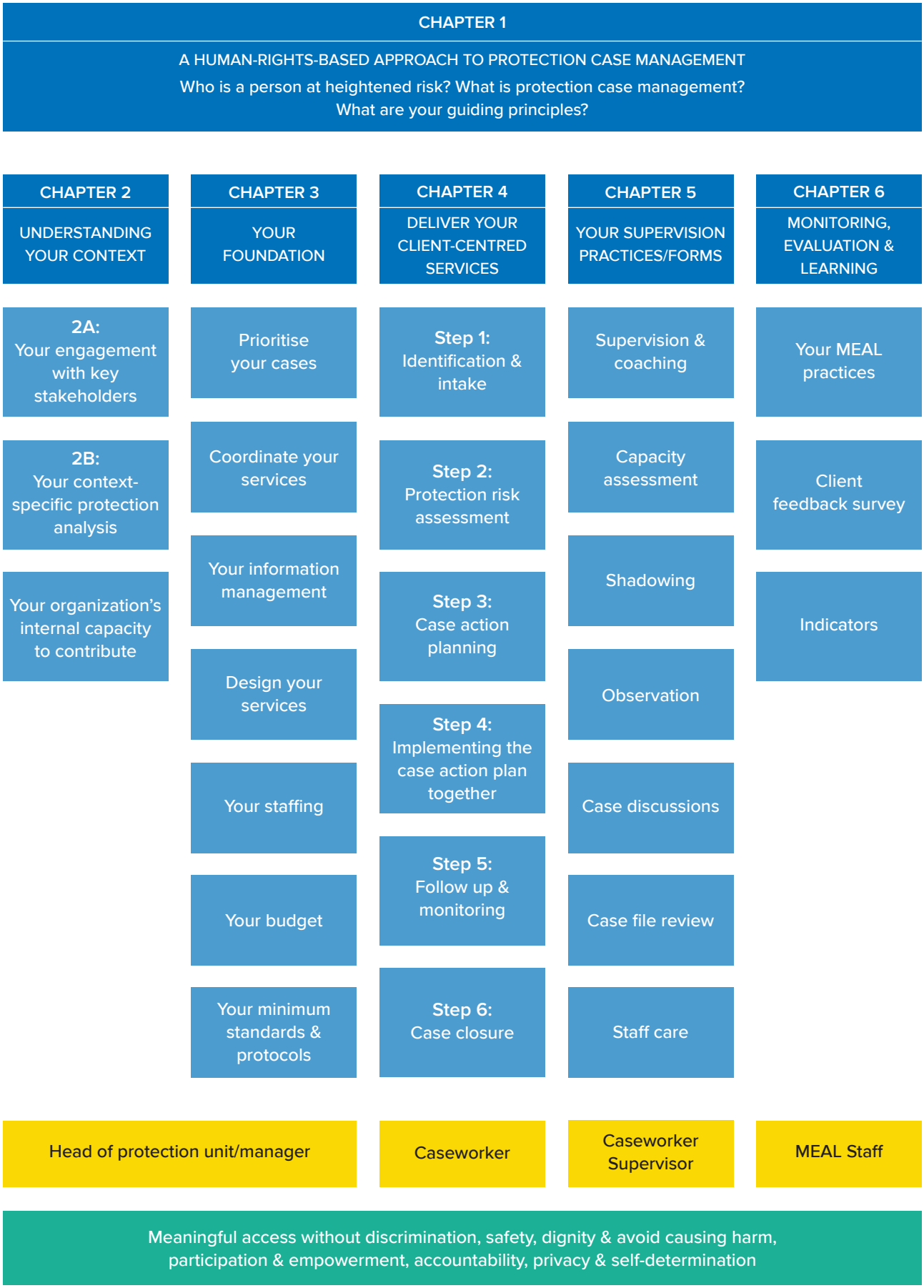
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[1] Child Protection Case Management Supervision Package developed by the Case Management Task Force of the Alliance for Child Protection in Humanitarian Action. Available at: https://alliancecpha.org/en/series-of-child-protection-materials/cm-supervision-coaching-training-package-launch

A FEW KEY TERMS

Accessibility

Accessibility affirms the right of persons with disabilities to enjoy 'access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas'.[2]

Barriers

They are factors in a person's environment that hamper participation and create disability. For persons with disabilities, they limit access to and inclusion in society. Barriers may be attitudinal, environmental or institutional.[3]

Client

An individual who is enrolled in protection case management services.

Enablers

Enablers are measures that remove barriers, or reduce their effects, and improve the resilience or protection of persons with disabilities.[4]

Environment building

Includes any activity aimed at creating or consolidating an environment conducive to full respect for the rights of individuals. Environment building activity aims to change policy, attitudes, beliefs, and behaviour, seeking structural changes in law and attitude.[5]

Environmental risk factors

This represents the source of the risk. It refers to both the threats and barriers in a person's wider environment. These are conditions that are part of the environment (physical, social, economic and environmental processes) and interact with certain characteristics of the individual, to increase their likelihood of experiencing a rights violation.

Human-rights-based approach

A conceptual framework based on international human-rights standards that recognize people as active rights holders who, through active participation, must demand their rights as owed to them by duty bearers in accordance with international and domestic human rights law. It recognizes that every human is entitled to enjoy fundamental human rights, including those who are displaced and/or stateless, but that there are a number of barriers that people may face in realizing them

Client-centred approach

A client-centred approach places a client's rights, experiences and decisions at the centre of the case management relationship. It is rooted in three main concepts: person in the environment, strengths based and trauma informed.

Protective factors

These refer to a combination of all the strengths, attributes, capacities and resources inherent to the person, and also within their community and society, that allow them to manage and reduce risks and strengthen resilience.[6]

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[2] CRPD, Article 9, at: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-9 accessibility.html
[3] IASC, *Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action*, p.9, available at: https://interagencystandingcommittee.org/system/files/iasc_policy_on_protection_in_humanitarian_action.pdf
[4] ibid p.9
[5] IASC, *Policy on Protection in Humanitarian Action*, p.32, available at: https://interagencystandingcommittee.org/system/files/iasc_policy_on_protection_in_humanitarian_action.pdf
[6] Drawn from United Nations Disaster Risk Reduction (UNDRR), *Terminology on Hazards and capacities*, available at: https://www.preventionweb.net/terminology

Protection mainstreaming	The process of incorporating protection principles and promoting meaningful access, safety and dignity in humanitarian aid. Also synonymous with 'safe programming'.
Reasonable accommodation	This requires individuals and institutions to modify their procedures or services (accommodate), where this is necessary and appropriate, either to avoid imposing a disproportionate or undue burden on persons with disabilities or to enable them to exercise their human rights on an equal basis with others.[7]
Resilience	Resilience is the ability to overcome adversity and positively adapt after challenging or difficult experiences. A person's resilience relates not only to their innate strengths and coping capacities, but also to the pattern of risk and protective factors in their social and cultural environments.
Threat	Is the potential for physical or psychological harm with a causal agent
Universal design	This is an approach that advocates for "the design of products, environments, programmes and services … usable by all people, to the greatest extent possible, without the need for adaption or specialized design".

[7] IASC, *Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action*, p.9

INTRODUCTION

WHY IS PROTECTION CASE MANAGEMENT IMPORTANT?

In the context of protracted and acute crises, State, community and family support is often disrupted. This removes important layers of protection from people, leaving them unable to exercise their rights and live in safety and with dignity. People most at risk of rights violations may frequently be less visible to the humanitarian community, may feel stripped of dignity and control, feel fearful or unable to report incidents of violence or discrimination, and require support to build relationships and establish control over their lives. Conventional models of assistance can result in people most at risk falling through the cracks and not receiving the tailored support that they require to recover and rebuild their lives.

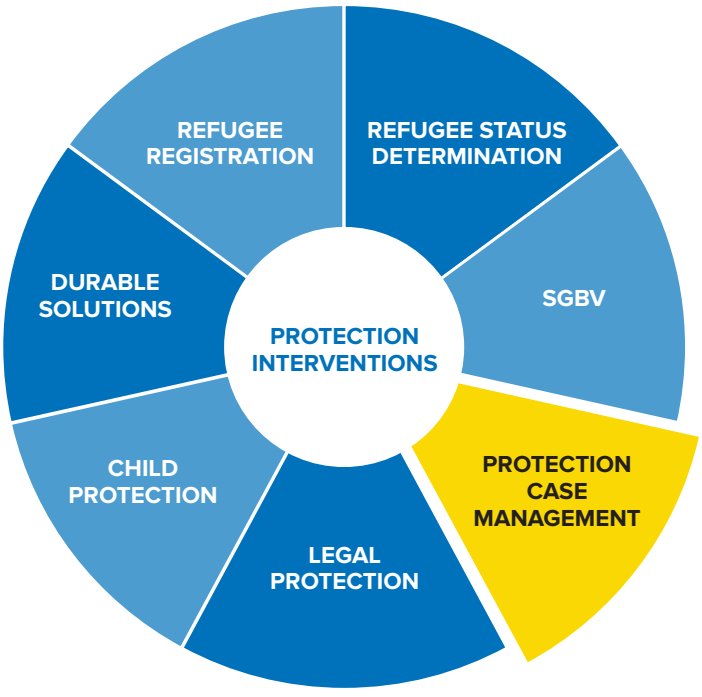
There is growing recognition that case management, a social work model which has been used to support survivors of sexual and gender-based violence and children at risk, can also be effective in supporting people facing other forms of rights violations. Protection case management aims to support people facing challenging social realities as a result of rights violations and help them to find targeted and sustainable solutions.

Protection case management is an integral life-saving protection response for people at heightened risk in emergency and post-emergency, in camp and out of camp, refugee and internal displacement situations. It provides critical support for their recovery, healing and wellbeing, enhancing their own protective capacities and rebuilding social networks in their homes and communities.

Protection case management should be seen as an important step toward achieving UNHCR's mandated commitment to support refugees, internally displaced persons (IDP) and other persons of concern in finding durable solutions by enabling their self-protection and self-reliance mechanisms pending a longer-term solution.[8] It is one of the core components of UNHCRs broader protection response, all of which must be appropriately connected and coordinated.

Local and civil society organisations are key sources of protection and are often the first responders to rights violations in crises. Working with them, as well as providing complementary alternative support to existing systems, will be integral to building sustainable and context-appropriate case management services in line with the New Ways of Working and Localisation agenda.[9]

FIGURE 1: Components of UNHCR case management



[8] As explained in: UNHCR, *Best Interest Principle Guidelines, assessing and determining the best interests of the child*, November 2018, 36, available at: https://www.refworld.org/pdfid/5c18d7254.pdf
[9] The Agenda for Humanity: New Ways of Working and the Grand Bargain: https://agendaforhumanity.org/initiatives/5358.html

WHAT IS THE AIM OF THESE GUIDELINES?

The intention of these guidelines is to help protection case management staff to recognise and to support people at heightened risk of rights violations and who require support to find their own solutions through a process of informed and supported decision-making. These guidelines emphasize the importance that we shift - as a sector and industry - from charity-based models that treat affected populations as people in need of help, to rights-based approaches that recognize affected populations as rights-holders who must be empowered to become active drivers in the realisation of their rights. Through this framework, we work with individuals through a client-centred approach to support their full and effective participation through the case management process.

The objectives of these guidelines are:

- **Guidance:** To provide practical operational guidance for local and international humanitarian staff looking to start up or continue to provide protection case management services, as well as for protection cluster coordinators, head of protection units and donors looking to manage or fund protection case management interventions.

- **Accountability:** To promote accountability across organisations and clusters to adhere to the minimum standards required for quality service provision. This includes promoting a consistent, contextualised and standardised approach to delivering protection case management services.

- **Client-centred:** To promote the design and delivery of services in a collaborative way which encourages the client to guide the direction of the case management process, with a specific focus on the client's strengths and ultimately empowering them to reach their goals.

These guidelines are complementary to and build on the learning from inter-agency standards and guidelines for sexual gender-based violence and child protection case management and are aligned to mental health and psychosocial support case management approaches.

CHAPTER 1: A HUMAN-RIGHTS BASED APPROACH TO PROTECTION CASE MANAGEMENT

We want to set the theoretical background for you in terms of why and what we are doing!

In this chapter, we will look at:

1. Who is a person a heightened risk?
2. What is protection case management?
3. Your guiding principles

Training Modules:

- **Module 1: Your foundation**
- **Module 2: An introduction**
- **Module 3: A client-centred approach**
- **Module 4: Your guiding principles**

1.A: Who is a person at heightened risk?

In times of crisis, threats and barriers to personal safety and dignity that are usually managed by duty bearers, including law enforcement agencies, social service providers or community support structures, are aggravated. This can leave people uprooted, usually with fewer resources, often without documentation and with relied-upon societal, community and family structures disrupted.[10]

Many people, as rights-holders, may find themselves in a position where they are unable to exercise their rights during these situations. The challenge for humanitarians is recognising those individuals who are in situations of *'heightened risk'*, and who require a case management intervention to (re)claim their rights.[11] These people may frequently be less visible, may feel stripped of dignity and control, feel fearful or unable to report incidents of violence or discrimination. They therefore require support to build trust and relationships and establish control over their lives.

(i) RECOGNISING A PERSON AT HEIGHTENED RISK OF A RIGHTS VIOLATION

For the purposes of protection case management, **recognizing a person at heightened risk of a rights violation requires us to understand how someone's protective strengths and capacities can be compromised by risk factors in their wider environment**. This acknowledges that a person's characteristics and circumstances, such as their age, gender, disability and other diversity considerations, can result in risk factors when they *interact with* threats and barriers in their wider environment, placing them in a situation of heightened risk.[12] This also recognizes people as active agents in dealing with difficult situations and the critical role their *protective factors* - their strengths, access to resources and capacities - play in reducing the effect of these *risk factors*.[13]

[10] UN High Commissioner for Refugees (UNHCR), *The personal security of refugees* EC/1993/SCP/CRP.3, 1993, Section 6, Conceptual Framework, available at: https://www.unhcr.org/excom/scip/3ae68cd10/personal-security-refugees.html
[11] UNHCR, *The Heightened Risk Identification Tool User Guide (HRIT*), 2010 (Second Edition) 1, available at: https://www.refworld.org/docid/46f7c0cd2.html
[12] In line with UNHCR, Policy on Age, Gender, Diversity, 2018, available at: https://www.unhcr.org/5aa13c0c7.pdf and UNHCR, *Need to Know Guidance, Working with Persons with Disabilities in Forced Displacement,* 2019, available at: https://www.unhcr.org/4ec3c81c9.pdf
[13] UNHCR, *Best Interest Principle Guidelines, assessing and determining the best interests of the child,* November 2018, 36, available at: https://www.refworld.org/pdfid/5c18d7254.pdf

The greater the number of risk factors that a person faces, the greater their likelihood of experiencing a rights violation. This is because risks have a *cumulative effect* if they are not countered by protective factors.[14] A person's level of risk will also increase if they are more *frequently exposed* to risk factors in their environment, and if they are *more susceptible* to the damaging effects. Certain combinations of risk factors can also intersect to increase a person's risk and create a unique experience of oppression for them. Therefore, to recognise whether a person is at *heightened risk*, we need to understand their wider social environment and their protective factors.[15]

USING THE SOCIO-ECOLOGICAL MODEL TO RECOGNISE RISK AND PROTECTIVE FACTORS

The socio-ecological model illustrates the importance that the wider environment – interpersonal relationships, community and society – plays in a person's protection. It helps us to understand how a person's circumstances both shape and are shaped by their social environment. Starting from the individual up to the socio-cultural level, we can use it to recognise the risk and protective factors for a person in order to determine whether the person is at heightened risk of a rights violation and whether protection case management is the right response for them.

FIGURE 2: Recognising risk and protective factors

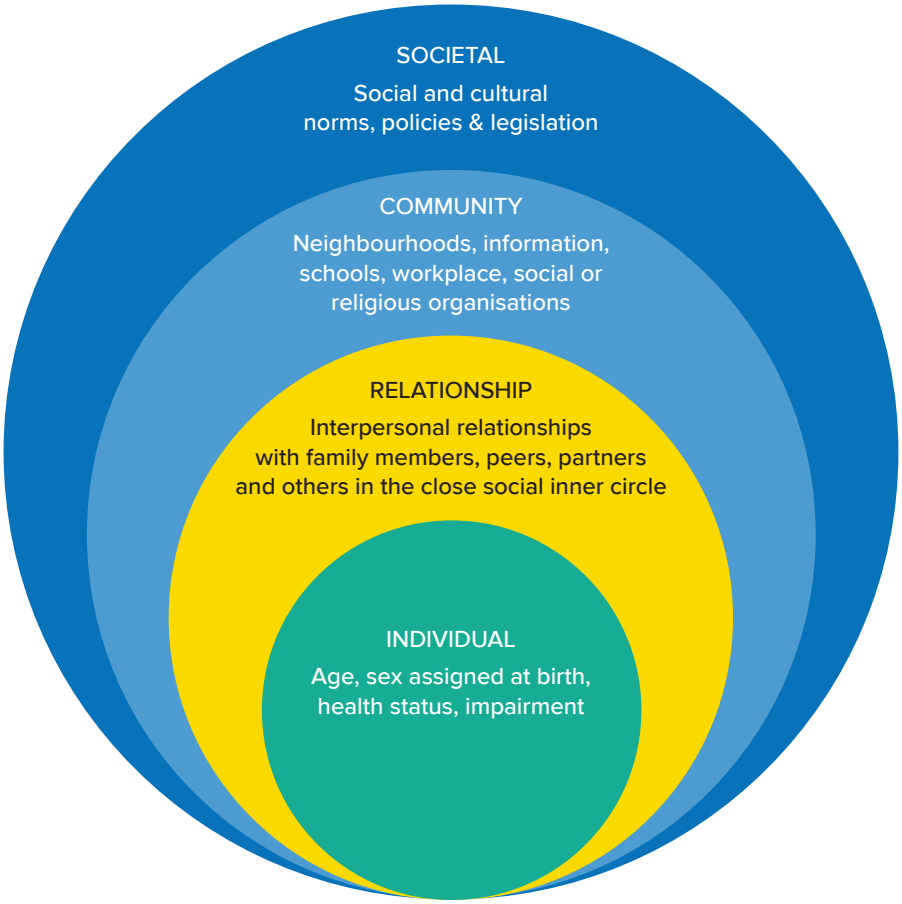
Risk and protective factors

Risk factors: These represent the source of the risk. Whether we refer to these factors as environmental or individual, these are conditions that are part of, and/or determined by, the environment (physical, social, economic and environmental processes) and how that environment interacts with certain characteristics of the individual to increase their likelihood of experiencing a rights violation.

Protective factors: These refer to a combination of all the strengths, attributes, capacities and resources available within a society, community and inherent to the individual that allows them to manage and reduce risks and strengthen resilience.[16]

[14] Ibid.36.
[15] Global Protection Cluster, *Protection Mainstreaming Toolkit*, 2017, 62, available at: https://www.globalprotectioncluster.org/_assets/files/aors/protection_mainstreaming/gpc-pm_toolkit-2017.en.pdf
[16] Drawn from United Nations Disaster Risk Reduction (UNDRR), *Terminology on Hazards and capacities*, available at: https://www.preventionweb.net/terminology

FIGURE 3: The Social Ecological Model (SEM)



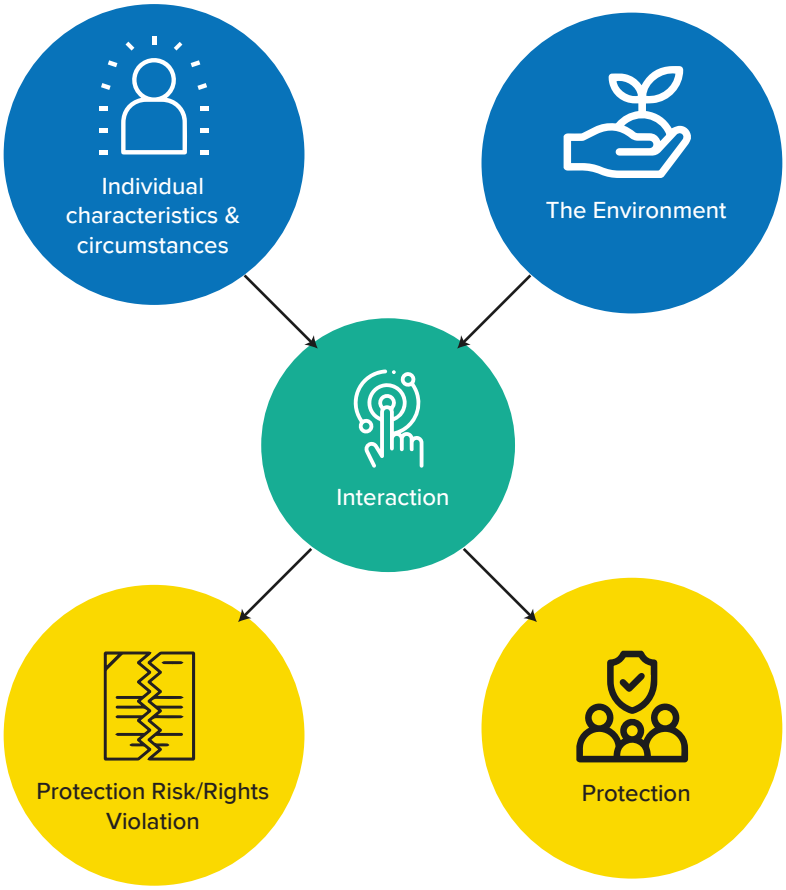
Recognizing risk and protective factors

The individual

Strictly speaking, a person's individual characteristics include their chronological age, sex assigned at birth and their health status, including any impairments. These characteristics intersect with societal and cultural expectations resulting in social constructs, such as age, gender, disability and diversity considerations.[17] When we refer to diversity, we mean that people are diverse in their personalities, experiences, values, beliefs, race, ethnic/tribal/clan backgrounds, religious affiliation, language, sexual orientation and gender identity, literacy/skills to access information or to communicate, history, income, health, legal and displacement status, and so on. Every person carries with them a different number and combination of these factors. To evaluate whether these factors place someone at heightened risk of harm or serve to protect them from harm, we need to look at a person's environment and specifically their inter-personal relationships, and their position in the community, and society. This is because these individual characteristics are not inherently a risk, but they can become a risk factor when they interact with threats and barriers in the environment. For example, in some communities an individual characteristic which could put a person at a higher risk of deprivation of life and physical violence may be albinism. This is because some traditional community healers may believe the body parts of people with albinism have supernatural powers; however, that same person would not face that risk in other environment where that belief is not practiced.[18]

[17] Age, gender and disability are not strictly individual characteristics. They are also social constructs because they draw on how individual characteristics, such as a person's biological age; sex assigned at birth and the presence of impairments, interacts with their environment.
[18] Example from the International Rescue Committee (IRC), Protection Risk Analysis in Tanzania

FIGURE 4: How individuals interact with their wider environment



Relationships

Examining the quality of a person's relationships with other people in their lives, like family members, intimate partners, friends and colleagues, can reveal opportunities for further risk of harm or need for protection. For example, connectivity to relatives and support from friends during trauma can provide protection, whereas family separation, tension between family members or a family history of drug abuse can contribute as factors of risk for physical or psychological violence.

Community

The community is an important layer which surrounds people and families. A community is made up of spaces, such as work, school, sports facilities, markets, community centres and places of worship, where social relationships take place. The characteristics of these places play an important role in enabling or hindering a person's participation and safety, and can range from the attitudes of a community, to the accessibility of the physical environment and to information. For example, new arrivals to a community with a strong level of social connectivity and an accessible environment can help to support them against social isolation and to include them in collective coping strategies. Whereas new arrivals to a densely populated urban area where there is less social interaction, physical barriers and difficulty in accessing information on services can leave people without access to shared approaches to manage the crisis and can result in a breakdown of care, increased reliance on violence and other negative coping strategies.

Society

The final layer of analysis includes the society and culture that surrounds a person, family, and community, influencing their social values, beliefs and affecting people's access to services.[19] Looking at societal factors can help explain the presence or absence of risk or protective factors for people as are an indication of the general level of tolerance or intolerance for discrimination, inequality and violence in a society. For example, societal level discrimination against Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual (LGBTQIA) individuals results in risk factors for these individuals in their communities and households because societal values and understanding influence other layers.

Effective strategies for response work across these layers of influence to reduce risk and strengthen protective factors. Through a context-specific understanding of the environment, its risk and protective factors, this framework can help caseworkers to determine whether a person is a heightened risk of a rights violation, the impact and likelihood of it happening, and whether they should be prioritized for *a sustained case management intervention* to successfully support them to (re) claim their rights and recover.

1.B: What is Protection Case Management?

Protection case management (PCM) is a structured and sustained method for providing responsive and remedial support to a person at heightened risk of a rights violation to help them to manage, and ultimately claim, their rights, leading to their safety, dignity and ensuing resilience.[20] It is an empowering and collaborative process drawing on the strengths of the client, where the client is supported to connect to services needed, to take control of their personal life, to learn new ways of thinking about their situation, and to adopt new behaviours that can help them to recover and respond to new risks.

A client is supported by an assigned caseworker, who provides a safe environment for them and develops a healing relationship built on trust.[21] The caseworker supports the client to assess their situation, and to recognise and strengthen the protective factors in their life. The caseworker informs the client of all the options available and assists them in identifying, and then reaching, personal goals by leveraging their strengths and working with service providers. The caseworker, supported by a supervisor, takes responsibility for linking the client to these services, advocating for actions needed, and following up those actions in a coordinated way.

OUTSIDE THE SCOPE OF OTHER CASE MANAGEMENT STREAMS

Protection case management services support people exposed to heightened risk of a rights violation that goes beyond that experienced by the general population. They support people who fall outside the scope of Sexual and Gender Based Violence (SGBV) and Child Protection (CP) case management services, where these are in place and for which separate inter-agency guidance documents and databases exist. Protection case management services should be seen as complementary to specialised SGBV, CP, mental health and psychosocial support (MHPSS) and legal case management services.[22] Further practical guidance on the division of responsibilities between these case management streams can be found in chapter 3, section B.

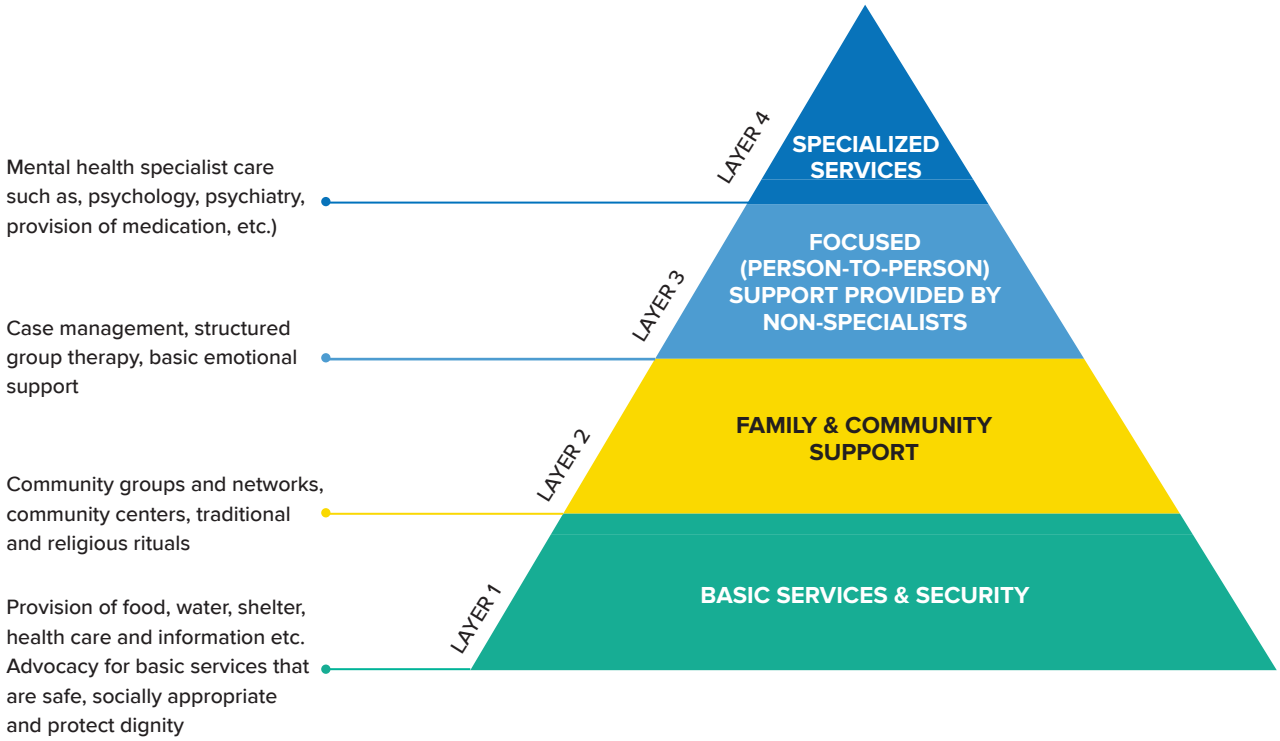
[19] United Nations Children's Fund (UNICEF), *Operational Guidelines on Community-Based Mental Health and Psychosocial Support (MHPSS) in Humanitarian Settings: Three-tiered support for children and families (field test version),* 2018, 19, available at: https://www.unicef.org/sites/default/files/2019-04/Mental-health-and-psychosocial-support-guidelines-2019.pdf

[20] Inter-agency Standing Committee (IASC), *Policy on Protection in Humanitarian Action,* 2016, 'The Egg Model' 31-32, available at: https://interorganisationstandingcommittee.org/protection-priority-global-protection-cluster/documents/iasc-policy-protection-humanitarian-action

[21] Clarity Human Services, *Three Principles for Effective Social Work Case Management,* White Paper, August 2016, 4, available at: http://www.socialserviceworkforce.org/system/files/resource/files/3-Principles-for-Effective-Social-Work-Case-Management.pdf

[22] See Global Child Protection Working Group (CPWG), *Inter-Agency Guidelines for Case Management and Child Protection,* January 2014, available at: http://www.cpcnetwork.org/wp-content/uploads/2014/08/CM_guidelines_ENG_.pdf and Global GBV IMS Steering Committee, *Inter-Agency Gender-Based Violence Case Management Guidelines*, 2017, available at: https://reliefweb.int/report/world/interagency-gender-based-violence-case-management-guidelines and UNHCR, *Best Interest Principle Guidelines, assessing and determining the best interests of the child*, November 2018, 36, available at: https://www.refworld.org/pdfid/5c18d7254.pdf

FIGURE 5: IASC MHPSS Intervention Pyramid



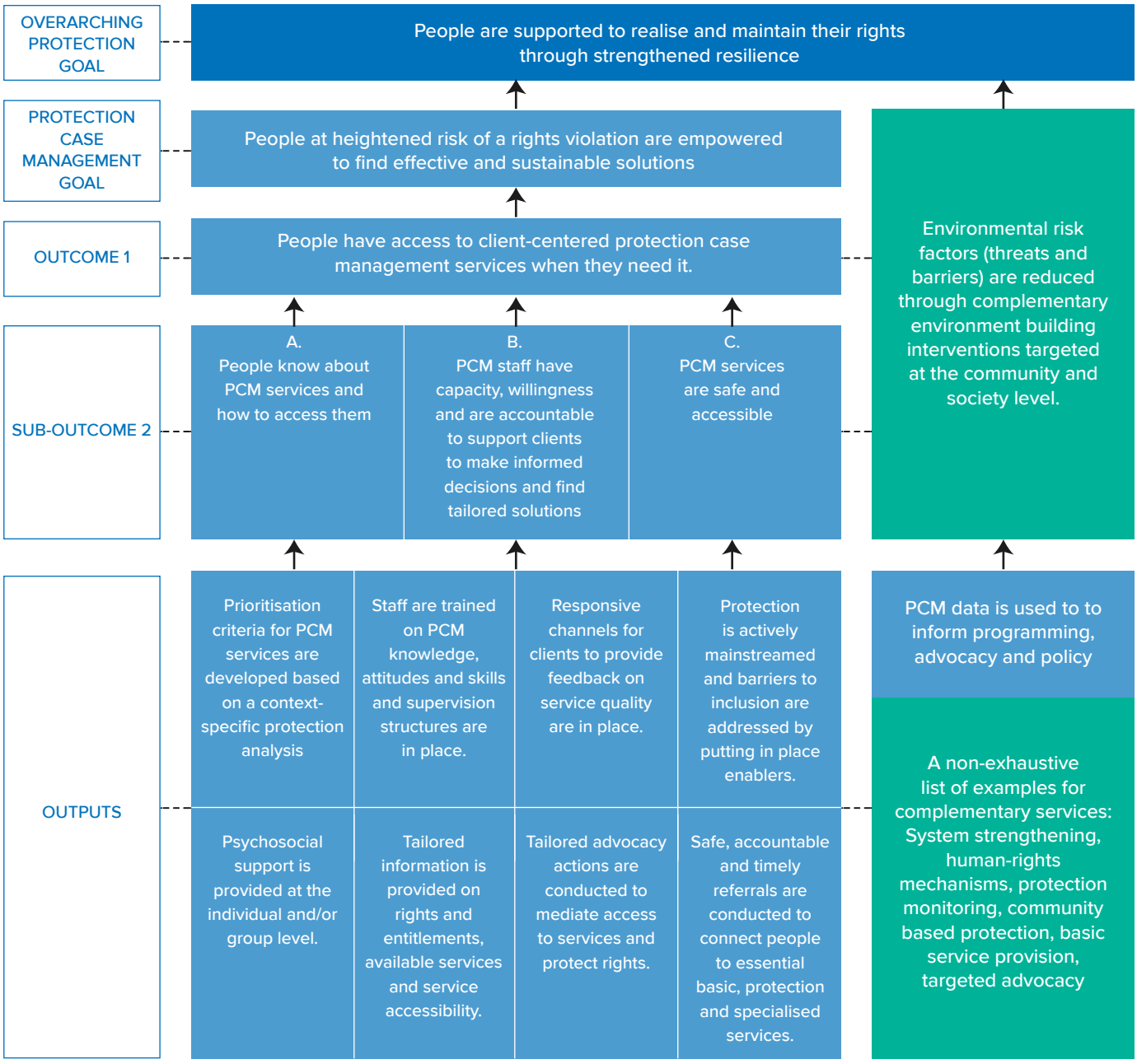
FOCUSED NON-SPECIALISED SUPPORT

As illustrated in the Inter-Agency Standing Committee (IASC) mental health and psychosocial support (MHPSS) intervention pyramid (figure 4), client-centred protection case management can fall under level three as a form of focused non-specialized support for people that can be provided by caseworkers who are trained, but who are not specialists, in MHPSS.[23] Protection case management should support a client's access to other layers of support required to meet their needs, as demonstrated in the pyramid, both through direct service delivery and referrals.

It is important that protection case management services connect with other sector services to allow for functional referrals across the layers of the pyramid. Protection case management services must be coordinated and complemented by a broader package of protection interventions that both straddle these layers of need and address risk factors at different levels of influence, such as the community and society.[24] In turn, protection case management data and information also informs these preventive, remedial and responsive actions.[25]

[23] This is an adaption of the IASC MHPSS intervention pyramid that continues to benefit from application in the field and further discussion among experts. Also note that protection case management can be considered as a level 3 MHPSS intervention when MHPSS is intentionally integrated into the service provision and when staff are trained in MHPSS.
[24] UNICEF, Guidelines on Community Based MHPSS in Humanitarian Settings, 2018, 15
[25] Inter-agency Standing Committee (IASC), *Policy on Protection in Humanitarian Action*, 2016, 'The Egg Model' 31-32, available at: https://interagencystandingcommittee.org/protection-priority-global-protection-cluster/documents/iasc-policy-protection-humanitarian-action

FIGURE 6: Protection case management theory of change



INDICATORS

Outcome 2A: A protection risk analysis Outcome 2B: % of case workers whose attitude score is at least 80% • % of cases that are satisfied with the case management services • % of clients that report their ability to solve problems has increased Outcome 2C: % of clients reporting that actions taken to address barriers were effective • % of planned actions from the protection mainstreaming actions plans implemented

Barriers:
which may influence the programme's effectiveness in achieving its outcomes may include lack of financial and human resources, lack of technical capacity and training, poor supervision, security and safety barriers for clients and staff, poor referral pathways, poor connection to complementary services and poor service coordination, weak protection contextual analysis.

Problem:
During crisis and displacement, state and/or community-based structures to mitigate and respond to environmental risk factors (threats and barriers are often disruptive leading to fewer resources and available support structures, leaving some people at heightened risk of experiencing a rights violation.

1.C: Your Guiding Principles

(i) A CLIENT-CENTRED APPROACH

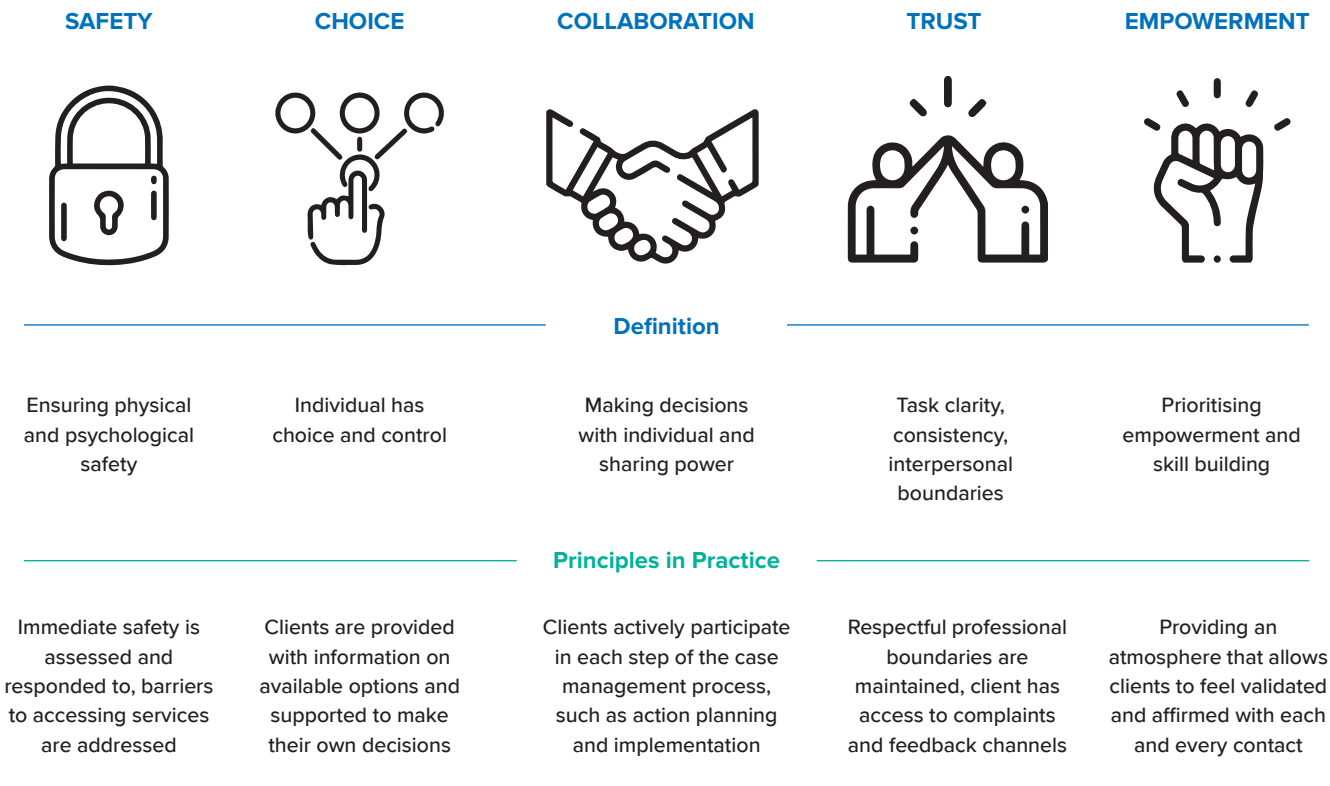
We are seeking to deliver a client-centred service that places a client's rights, experiences and decisions at the centre of a case management relationship that is a space for healing and empowerment. In order to do this, we root our work in three main concepts:[26]

- **Person-in-environment:** This views people as influenced and impacted by the environments in which they live (household, community, society). It asks caseworkers to understand their clients by looking beyond their characteristics and circumstances (biological make-up, behaviours, beliefs etc.) and toward their past and environment. This recognizes that in order to support a client in solving their problems, we need to also work in parallel to effect change in their community and society. Where possible, protection case management should be accompanied by a broader package of prevention and environment-building activities.

- **Strengths-based approach:** This supports caseworkers in focusing on building a person's strengths and capacities instead of focusing solely on their problems. A person's strengths are those inherent to them (education, health, inner resilience), as well as those that stem from their wider environment (relationships, religious community, family networks). This does not deny that people experience problems, but it provides an opportunity for clients to explore their own capacities. It also avoids caseworkers acting as experts in resolving people's problems and thus creating dependency.

- **Trauma-informed:** In times of crisis, people will often have directly or indirectly experienced incidents of violence, displacement and exploitation. A trauma-informed approach realizes the impact these events can have on an individual's access to services and relationships and works to minimize these barriers. **Caseworkers need to avoid re-traumatizing clients during their work**.[27]

FIGURE 7: Trauma Informed Services: Principles In Practice



[26] National Association of Social Workers, *Social Work Case Management Standards*, 2013, available at: https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0

[27] By re-traumatization, we mean any situation or environment that resembles a client's trauma and that can trigger difficult feelings or reactions.

(ii) A HUMAN-RIGHTS APPROACH

A human rights-based approach to protection case management recognizes people as active rights holders who have inherent and inalienable rights, rather than as victims in need of special help. Through the active participation of rights holders, protection case management seeks to support people to activate their response and resilience strategies in order to (re)claim their rights as owed to them by duty-bearers and in accordance with international and domestic human rights law. It recognizes that every human is entitled to enjoy fundamental human rights, including those who are displaced and/or stateless, but that there are a number of barriers that people may face in realizing them.

A context-specific protection analysis underpins your ability to deliver human rights-based services. This requires you to understand what type of violations are present, what their root causes are and who is causing them, as well as who is most at risk of experiencing these violations and why.[28] For more information and resources refer to chapter 2, section B.

YOUR CORE CASE MANAGEMENT PRINCIPLES

Meaningful access without discrimination	Ensure equity and non-discrimination in the delivery of PCM services; accessibility for all individuals must be arranged, considering requirements related to their age, gender, disability and other diversity factors – in proportion to need and by addressing barriers. You must identify **barriers** and put in place **enablers** (measures that remove or reduce barriers and their effects). Some solutions may require changes in infrastructure (and therefore require time), while other solutions can be applied at an individual level for a specific individual who is facing barriers to access.[29] **For example**, ensuring people with a full range of disabilities can Reach, Enter, Circulate and Use community centres may need changes in the built infrastructure (e.g. widening doors, installing permanent ramps); however, lack of access can also be addressed by installing temporary ramps, providing outreach services or meeting in a more accessible place.[30]
Safety, dignity & avoid causing harm	Take actions to ensure the physical and psychological **safety and security** of clients. Prevent and minimize potential for PCM services to cause harm. **For example**, caseworkers should always try to keep clients physically safe first and try to address their other needs second. Services must always be **conflict-sensitive** and not increase community tensions.

[28] Inter-Agency Standing Committee (IASC), *Policy on Protection in Humanitarian Action*, 2016, 6.
[29] IASC, *Guidelines on Inclusion of Persons with Disability in Humanitarian Action*, 2019, 9, available at: https://interagencystandingcommittee.org/iasc-task-team-inclusion-persons-disabilities-humanitarian-action/documents/iasc-guidelines
[30] A location or building is accessible when a person with disabilities can reach it, enter it, circulate from one room or floor to another, and use the services it offers. This is the RECU principle.

Participation & empowerment	Foster the participation and ownership of all the diverse community groups in design, implementation, monitoring and evaluation.[31] Through consultation, active listening, proactively addressing the barriers diverse groups may face, and being open to new ways of working, harness community knowledge and self-protection capacities to shape your services. This will lead to more meaningful and sustainable outcomes for your clients.[32] **For example**, consult groups with security risks, such as LGBTQIA+ individuals, on the safest way to provide PCM services to them. Share your findings in your protection analysis with the community and ask for their opinion on how to address some of the risks and barriers identified.
Accountability	All staff are responsible for their actions and for the results of those actions on clients, their families, and communities. Clients must have routine opportunities to submit **complaints and give feedback**. **For example**, set-up accessible and confidential channels for all clients to provide feedback and receive a response (client feedback surveys, complaint boxes, hotlines). All staff must sign a **code of conduct** and be trained on **safeguarding policies**.
Privacy & self-determination	All people have the right to choose with whom they will/will not share information and the right to remain anonymous. **For example**, **respect confidentiality**, develop **data protection protocols**, and take **informed consent/ assent** at all times. Providing informed consent/assent may require developing forms in accessible formats (such as easy to read), and hiring interpreters in languages, as well as other ways of communication (such as sign language), ensuring that these interpreters have also been trained and have signed a code of conduct that ensures the confidentiality of the information exchanged.

ALWAYS SEEK INFORMED CONSENT/ASSENT

Informed consent is the voluntary and informed agreement of a person above 18 years old. It is a legal responsibility you have to your client that helps to protect their rights. The way we ask for informed consent is central to a client-centred approach because, through it, you support your client in restoring power and control over their lives. It is also a way of building trust and demonstrates your collaborative intention to work with them. To indicate informed consent to taking part in case management services, clients can provide written consent or a thumbprint as a preferred option, but where this is not possible, it can also be given by a clear affirmative action or verbally with written consent being provided at a later date.[33]

[31] UNHCR, *A Community Based Approach in UNHCR Operations*, 2008, 14.
[32] UNICEF, *Guidelines on Community Based MHPSS in Humanitarian Settings*, 2018, 12, available at: https://cms.emergency.unhcr.org/documents/11982/42450/UNHCR,+Manual+on+a+Community-Based+Approach
[33] Ibid. 4.

The informed consent process has three components:

1. Providing all possible information and options to a client in a way they can understand;

2. Determining if they can understand this information and/or their decisions; and,

3. Ensuring that the decisions of the client are voluntary and not coerced by others (e.g. family members, caregivers or people suggesting they will face negative consequences).

You should always assume people aged 18 and above have the capacity to provide informed consent independently. When seeking informed consent, you must always adapt the way you communicate to the communication needs and preferences of the client. Information should be provided in a transparent, easily accessible form, using clear and plain language, and should be communicated through appropriate means (e.g. visual, audio and easy to read) to improve access for persons with visual, hearing and intellectual impairments.[34]

Informed consent must be taken from each person at the beginning and throughout the case management process at each new service or step, specifically:

- **Before beginning the introduction & intake** discussion, to listen to their story and to record their information.

- **After the introduction & intake assessment,** to ask the client whether they agree to be part of the case management process.

- **Before making each referral or taking any other action on behalf of the client, in order to share their** information with a third party to provide services or assistance.[36]

Capacity to consent

Capacity refers to a client's ability to understand the benefits, risks, and alternatives to a proposed service or assistance and to communicate a decision (at a particular point in time). It is specific to a single question and decision and should be documented relative to each decision.[35]

Clients can only give their informed consent when they know what they are agreeing to, so caseworkers will need to provide them with enough information to make an informed decision. You will need to follow these steps:

1. Address barriers to participation

2. Explain the case management process and their rights

3. Explain confidentiality and its limits

4. Explain the risks and potential benefits

5. Ask whether there are any questions

6. Ask for permission to proceed

You can find a scripted explanation of how to seek informed consent in chapter 4, step 1: Introduction & Intake.

[34] UNHCR, *Guidance on the Protection of Personal Data of Persons of Concern to UNHCR*, 2018, section 3.8.1 and 5.2.2, available at: https://www.refworld.org/docid/5b360f4d4.html

[35] Rules governing capacity to consent and need for parental and/or caregiver consent depends on the laws of the country.

[36] GBV IMS Steering Committee, *Inter-agency GBV Case Management Guidelines*, 2017, 54.

For clients who require support with decision-making for informed consent, you should follow these three key steps.

Key actions – Supporting decision-making and self-determination for informed consent

Assume all clients, including those with mental health conditions or intellectual disabilities, have the capacity to make their own decisions. Where there are communication challenges, you can:

1. **Adjust your communication** using a range of methods to convey information in a way that the client can understand – take the time to explain process and concepts. Use simple and clear language, icons, pictorial representation of services or other creative solutions.

2. **Let the client choose any support people** they wish to include who can aid their understanding and communication in the decision-making process.

3. Where, after significant efforts have been made and it is not possible to **determine the will and preferences of an individual**, a best interpretation of the will and preference applies, respecting the rights of the individual and based on an individual's vital or best interests. Only make a decision based on vital or best interests on behalf of the client after all other options have been exhausted.[37]

Further information on this process can be found in Chapter 4, Step 1: Introduction & Intake.

Capacity to consent is not static but can change over time. Situations may arise where consent has been given or refused on a client's behalf. If the client's capacity changes and they become capable of consenting, their decisions would take precedence over any others. Clients may also be able to consent to some elements of the case management process and not others, so it is important to check this at each phase of the process.

Informed assent: During these steps, you can look for the expressed willingness of the client if they face barriers to communication or in providing consent to participate in services. You can use pictures, hand gestures or symbols to ask if someone is willing to participate in an activity or to access a service. Also watch for signs of agitation, anger or distress that may indicate that the client is not happy with something being discussed or an activity that is being undertaken. Informed assent should also be used when taking consent for children.[38]

RESPECT CONFIDENTIALITY

This means not sharing any information with anyone else, including friends or colleagues, without the informed consent/assent of the client. You can maintain confidentiality as you provide services by making sure that you collect, store and share your client's information according to strict data protection policies. This includes only sharing information on a ***need-to-know*** basis to allow your client to access a service or receive support in line with their action plan.

[37] OHCHR, *Convention on the Rights of Persons with Disabilities (CRPD)*, General Comment No.1, 2014, Article 12: Equal recognition before the law (Para 21)
[38] For more information on informed assent for children, including a snapshot table of the guidance, go to the *Inter-agency Guidelines for Case Management and Child Protection*, 2014, 118.

In exceptional circumstances, there are limitations to confidentiality:

- **When decision-making requires interventions that may involve third persons to convey information in accessible ways**, such as when interpretation is required, including sign language interpretation.

- **When mandatory reporting requirements apply** allowing you to override the principle of informed consent. This is where there are indications that a person is planning to take their own life, or planning to harm the safety of others, or where a child is at imminent risk of harm.

What are mandatory reporting requirements?

Many countries have mandatory reporting requirements that require you to report cases of actual or suspected abuse to a relevant government authority without asking the individuals concerned for their informed consent.

These requirements can be challenging for caseworkers, especially when the information has been shared in confidence and could harm their relationship with the client. That is why, where laws exist and function, caseworkers must explain the **limits to confidentiality** to their clients prior to starting case management services and when taking consent for referral.

That said, in some contexts mandatory reporting can further jeopardize your client's **safety and security**. It is good practice to deal with these situations on a case-by-case basis and to consider your client's safety along with the potential legal implications of not reporting. This will help you determine appropriate next steps. Decisions regarding compliance with mandatory reporting laws should be taken at the highest level of an organisation's in-country management for the protection of the client and staff.

Chapter 1: Key tools & resources

Case management guidance:
- Inter-Agency Guidelines for Case Management and Child Protection (Global Protection Working Group)
- Best Interest Principle Guidelines, Assessing and Determining the Best Interests of the Child (UNHCR)
- Inter-Agency Gender-Based Violence Case Management Guidelines (GBV IMS Steering Committee)

Core approaches & principles:
- Age, Gender, Diversity Policy (UNHCR)
- Community-Based Approach (UNHCR)
- IASC Guidelines on Inclusion for Persons with Disabilities (IASC)
- Humanitarian Hands On Tool
- Need to Know Guidance on Working with Persons with Disabilities (UNHCR)

- Guidelines on Community-Based MHPSS (UNICEF)
- Compendium (Global Service Work Alliance)
- UNHCR Protection of Personal Data of Persons of Concern (UNHCR)

CHAPTER 2: UNDERSTAND YOUR CONTEXT

Before setting up your services, make sure you know your context!

In this chapter, we will look at:

1. Your engagement with key stakeholders
2. Your contextual protection analysis
3. Your organisation's internal capacities to contribute safely and effectively

2.A: Your engagement with key stakeholders

(i) BUILDING PARTNERSHIPS

THE ROLE OF GOVERNMENT/AUTHORITIES

States have primary responsibility for social service support. Humanitarian players should be seen as a temporary gap-filler for State systems that are currently unwilling or unable to fulfil this obligation. Considering your eventual withdrawal and transfer of services from the beginning can help shape your planning process and lead to more sustainable and context-appropriate services that 'fit' your context. You may come across existing services or programmes in your context that involve case management or elements of the approach.[39] Wherever possible, you should explore ways to strengthen or complement these existing systems and procedures and not duplicate them.

A first step in doing this is to recognize your role in supporting the primary duty bearer, namely the government responsible for providing protection for people within its territory. Where possible and appropriate, you should look to work in partnership with governments to deliver direct case-management services by strengthening their existing system, and only consider establishing case management services where there are gaps in capacity or resources are low. Even in these situations, you can first look to providing complementary alternative forms of support, such as specialist capacity building and training for existing caseworkers or supervising and developing procedures and protocols.

When trying to develop a functioning working relationship with duty bearers, primarily government bodies, it is essential to avoid seeing them as a single entity. Rather, organisations setting up protection case management services need to understand which bodies may have a positive or negative influence on their work and outcomes with regard to specific human rights violations. This may be the case where a country's military has a poor human rights record, but where the Ministry of Social Affairs/Welfare may be providing effective social work services for displaced and marginalised communities.

[39] Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, 30

BOX 4: Connecting to human rights mechanisms

It is also important to recognise that States may have different responses depending on the type of human rights violation. For example, some States may have a functioning National Human Rights Institution (NHRI), which could provide support in addressing some types of human rights violations.

In some instances, States could also have developed specialized bodies or agencies that address particular violations. For example, for cases of torture, States party to the Optional Protocol for the Convention Against Torture (OPCAT) should have functioning National Preventive Mechanisms (NPMs) against torture that could be a go-to mechanism to help in addressing cases of torture. Similar to the NHRI, referring to the Sub-Committee for the Prevention of Torture (SPT) could be helpful in identifying the status of the NPMs in country, their shortcomings and effectiveness.

In certain contexts, protection case management service providers can create linkages to human rights mechanisms and can in turn contribute to how those mechanisms work. However, engaging with such mechanisms should be done carefully after a risk analysis and be a decision which is made by your senior management team. For more information, please refer to: https://www.ohchr.org/Documents/Issues/WHS/Leaflet.pdf

When operating in situations where the government itself is party to the conflict and has lost control over territories, or where you are under another entity's de-facto authority, there may be tensions between working with and building national capacity and protecting displaced people.[40] In such situations, in accordance with humanitarian principles, you might consider establishing a case management system that is separate from formal government case management services.

This can be justified because protection case management aims to provide responsive and remedial actions to address human rights violations and support people in claiming their rights. This can mean challenging social imbalances that often work in favour of those in power. While this is positive for the person whose rights are restored, at times, it can create a backlash from those whose power is undermined. For example, supporting an individual from a disenfranchised group has the potential to trigger harmful reactions in the community, which can upset fragile social dynamics.

Providing protection case management services in these circumstances can be appropriate but **you must take a *conflict-sensitive* 'do no harm' approach so that your services are designed to support individuals and communities rather than exposing them to *further risk of interpersonal or community violence or conflict***. This requires you to analyse the risks and put in place mitigation measures, where possible, ***with*** local staff and partners who understand the context and may be aware of contextual sensitivities that could lead to negative consequences.[41] If you are unable to mitigate these risks, you may need to re-consider establishing case management services.

For information on the overall country **context and crisis situation, including a country's human rights record, conducting a secondary data review can be helpful. This will be used to inform your protection analysis, and also help you determine whether it is safe to work through the authorities in your area to provide services for persons at heightened risk.** Drawing on local sources of information from civil society often provides a rich basis for understanding conflict dynamics, as well as the histories, cultures and languages of a place. This contextual knowledge will help to attune you to local priorities.[42]

[40] Ibid.31
[41] IRC, *Access to Justice Guidance*, 2019, 18
[42] Humanitarian Policy Group, *Localising humanitarianism: improving effectiveness through inclusive action*, 2015, 3, available at: https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9720.pdf

Human rights record: These sources will provide information on a government's compliance with its human rights obligations, the attitude of duty bearers toward certain violations and whether they are being addressed. These sources can also inform you of the stakeholders who can influence or who are influenced by violations. This will support you during the protection analysis phase.[43]

These sources include:

1. International human rights conventions ratified by the State

2. Periodic reports by treaty bodies[44]

3. UN special rapporteur reports

4. UN periodic review reports related to the country. These are often written by coalitions of local civil society organisations.

5. Reports produced by OHCHR and, if available, from in-country commissions of inquiry

6. Human rights reports from local and international organisations

7. Policy and advocacy briefs including, where present, from the country INGO and NGO forums

General country overview: These sources can provide a situational overview of the country, including pre-and post-crisis trends related to the availability and quality of service provision, the exclusion and marginalisation of certain group(s), socio-economic conditions and the causes of conflict or crisis.

These sources include:

1. Country reports from specialised UN agencies that provide insight into certain themes for example: UNODC on the justice system and security sector, UNDP on the implementation of the Sustainable Development Goals (SDGs), the World Bank on the development situation and indexes, UNICEF on child protection, WHO on the health situation, and UNHCR on the protection environment and refugee situation.

2. Humanitarian country strategy and protection sector strategy

3. Humanitarian Needs Overview (HNO)

4. Humanitarian Response Plan (HRP)

5. Policy and advocacy briefs

6. Sectoral assessments

7. Inter-sector service mappings

[43] This information can feed into a stakeholder analysis tool. For an example please see: DRC, *Protection Analysis Guidance* (annex 2) Stakeholder Analysis Tool

[44] Each convention has its own treaty body, which is responsible for overseeing the implementation of the convention and issuing recommendations to support States in the implementation of their obligations. Some treaty bodies also have the ability to receive individual complaints, known as an individual complaints system. This system can illustrate the judicial capacities of a State, its willingness and ability to address violations.

LOCAL CIVIL SOCIETY

Local partnerships are incredibly important for protection case management services due to the significant role that local organisations and communities play in preventing and responding to protection risks. Protective outcomes from case management services rely on local services and protective structures as a form of risk reduction.

Local organisations and communities are often better placed to engage in casework due to their intricate knowledge of the social and cultural context. This includes their knowledge of the risks they face, their causes and effects, and how best to address them. They are also often at a comparative advantage to international organisations due to their community acceptance and their permanence. To realize the benefits of working with local organisations to deliver effective protection case management services, it is vital that programmes are funded adequately to allow for the recruitment of staff with the necessary expertise and experience, the availability of sufficient and quality training opportunities, and for supervision structures to be in place to support caseworkers that are in line with these guidelines. It will also be important to promote the participation of local organizations in a community of practice through their engagement in country coordination mechanisms.

International agencies looking to establish protection case management services should consider whether opportunities for co-created partnership are possible.[45] Ideal partners are those organisations already working on protection issues and – even better – those advocating on behalf of the most vulnerable in their communities, with long-term goals, legitimacy and access. Where appropriate, you should always include a plan with a mentoring component.[46] Partnerships should promote the principles of equality, transparency, responsibility and complementarity, and be results-oriented.[47]

Before entering any partnership agreement for protection case management services, you must always conduct a due-diligence assessment to make sure that the organization fully complies with and respects humanitarian principles of neutrality, independence, impartiality and non-discrimination so that it is safe for persons at heightened risk to access services.

(ii) COORDINATION

Good coordination involves understanding each responder's role and responsibility, identifying and addressing gaps and complementing each other's services. **Your case management services should be coordinated with and not duplicate other services provided in your area of operation**. Being familiar with your country's humanitarian response and protection strategy will help you to develop services which are part of a defined plan for the country. This will also support your prioritization process.

Knowing what services exist in the community, the extent to which they are functioning, and who has access to them will help you to plan and design your services. For example, if you provide specialized care for survivors of torture, you may need to work closely with the health sector. In some instances, for caseworkers establishing a supportive relationship with clients, making sure necessary services are available will be important for certain types of intervention.

[45] Humanitarian Practice Network managed by HLP, Humanitarian Exchange, Humanitarian Partnerships, 2011, 1. https://reliefweb.int/sites/reliefweb.int/files/resources/Full_Report_936.pdf
[46] IRC, Access to Justice Guidance, 2019, 17.
[47] In 2007, The Global Humanitarian Platform, comprising of UN agencies, the Red Cross/Red Crescent Movement, and NGOs adopted these five principles of partnership. The Charter for Change, led by both national and international NGO to promote locally-led responses, endorsed these principles. More information is available at: https://charter4change.org

The protection sector can support you in filling in these information gaps but if this information is not available, you can also collect it through a **service mapping exercise**, as outlined in chapter 3, section B. The protection sector can also help you to share information as well as connect you to future partners for case coordination and the development of referral pathways to minimize overlap and duplication.[48] For example, where possible, you should draw from the inter-agency protection analysis of the country, which is developed by the protection sector. This will help to inform your own analysis of the context. You can also inform the protection sector prior to conducting any primary data collection for your protection analysis in case they can connect you to agencies with the same information needs. Sharing the type of cases, you will support with the protection sector and other sectors can support the safe referral of these cases to your services.

These questions can guide you as you get to know your operational context and engage with key stakeholders such as community leaders, government departments, service providers, civil society organizations, local NGOs and international agencies.

Key questions on engagement with responders[49]

1. Who are the responders to the crisis?
- a. Civil society
  - i. Local/national NGOs
  - ii. Religious leaders, elders, community leaders, women's groups, youth, volunteers, community based groups, Organisations of persons with disabilities, older persons associations
  - iii. Networks and consortiums
- b. National government (duty-bearers)
- c. UN agencies
- d. INGOs (operational, advocacy)
- e. Armed groups or other actors
- f. Diplomatic missions
- g. Political parties
- h. Private sector
- i. Non-responding stakeholders (who should be considered relevant to the response but are not responding)

2. Is there a pre-existing national social work system in place, community structures and/or other forms of case management support being provided which can be strengthened?

3. Is there tension between working with the government and the protection of clients?

4. Are there access or security challenges?

5. Is a partnership possible?

6. How are those who respond coordinating with each other? (Are local and international organisations equally engaged)

7. What protection services are being provided, where, to whom and how accessible are these? (You can ask the protection sector for a service mapping and safety & accessibility audit)

8. Are there gaps, overlaps or quality challenges in service provision? (Skill, expertise, area of specialty, longevity, newly formed/created)

9. Are services complementary? (You can map responsive, remedial or environment-building activities)

[48] IRC, Gender-based Violence Emergency Preparedness and Response Package, 2012, available at: http://gbvresponders.org/emergency-response-preparedness/

[49] Adapted from Inter-Action, key questions on protection analysis.

2.B: Your context-specific protection analysis

(i) WHAT IS A PROTECTION ANALYSIS?

An evidence-based understanding of your protection environment rests on the strength of your protection analysis. This needs to be done to understand contextual risk and protective factors from the perspective and experience of the community, and to mainstream protection into your services. This is done in partnership with the community to help us understand **the types of violations present, their root causes and causal agents, who is most at risk of experiencing them and why**.[50]

As mentioned in Chapter One, you can think about this in terms of how a person's **individual characteristics and circumstances** *interact with their* **environment** (family, community and society) making them more likely (risk factors) or less likely (protective factors) to experience a rights violation.[51]

Data collection for your protection analysis

You should do this through **a secondary and primary data review**, drawing on data and information collected from existing reports, online documents and previous protection assessments, as well as from existing protection information management sources.[52] **Primary data collection through a protection needs assessment** should only be done if you have information gaps. It should collect data disaggregated by age, gender and disability.

Protection trends captured through protection monitoring activities can be particularly helpful for protection case management teams. This is because protection monitoring is the systematic and regular collection, verification and analysis of information from the community or household. It takes place over an extended period of time within a given location in order to identify changes in the protection environment, including new emerging risks.

(ii) ORGANIZING AND ANALYSING YOUR DATA FOR YOUR PRIORITISATION CRITERIA

Experiences show that arranging a validation workshop to discuss your protection findings with your protection case management team, as well as inviting any colleagues from other case management streams (SGBV, CP, Legal or MHPSS) can notably improve the quality of your analysis. It should be done in a safe and non-judgmental environment where staff can speak openly in analysing the findings shared by the community and through your secondary and primary data review. **A comprehensive analysis of your protection findings can take time, but doing it thoroughly will significantly improve and facilitate your process for developing prioritization criteria for case management. This is the first and crucial step of that process**.

You can use *Annex 1. Key Questions on protection analysis*, to guide a conversation with your team to unpack your protection analysis findings and to organize them **according to the type of violation identified**. For each type of violation, you will need to define the correlated **environmental risk factors, individual risk factors and protective factors**. The protection analysis template illustrates how you can organize this.

You can adapt the template below to include any additional information you will find useful to support you later during the prioritization process.[53]

[50] IASC, *Policy on Protection in Humanitarian Action*, 2016, 6.
[51] The protection risk analysis equation is often used to support the analysis of the protective environment. This equation is: Protection Risk = Threats + Barriers X Vulnerability / Coping Capacity. For more information on this you can refer to: *GPC Protection Mainstreaming Toolkit* 2017, for information on protection analysis methodology, 61. Available at: https://www.globalprotectioncluster.org/_assets/files/aors/protection_mainstreaming/gpc-pm_toolkit-2017.en.pdf
[52] GPC, *PM Toolkit*, 2017, 61.
[53] Adapted from the DRC Guidance on Protection Analysis Template. You can also add columns; a. to capture the likelihood and impact of the risk; b. the stakeholders which have influence in reducing or increasing the risk; c. complementary services which are being done to address the risk in your context. Available at: Protection Analysis Template

Protection analysis template			
Rights violation *What is the specific rights violation people are at risk of?*	**Environmental risk factors (Threats + barriers)** *What factors increase the likelihood of the violation occurring? Include the causal agents and root causes.*	**Individual risk factors (Age, gender, disability, diversity)** *What factors increase the likelihood of the violation occurring?*	**Protective factors** *What factors reduce the likelihood of the violation occurring?*
Denial of liberty due to limited free movement. Risk of arbitrary arrest and detention.	**Barrier:** Strained infrastructure and absence of functioning services leading to negative attitudes toward IDP/refugees. Discriminatory practices toward IDP/refugees by law enforcement. Low accessibility and safety of roads and transportation. **Threat:** Checkpoints manned by security forces Regular raids by security forces	Lack of proof of nationality Undocumented Male Unregistered refugee Arrived in country after April 2019 Unemployment Living in a remote area Difficulties moving, seeing, hearing, etc. Language barrier	Living in an urban area Limited movement Employment Registered with UNHCR (if refugee) Documented

Once you have this information, you are now in a position to know what **violations are prevalent, the root causes and causal agents, and who is most at risk of them and why. You will also know what services already exist to manage these risks and what level they target (society, community, household, individual). However, you still do not know what violations you will address through your case management services. This is the second step of the prioritization process** and will be discussed in chapter 3, section A.

2.C Your organisation's internal capacity to contribute

You will need to assess your organization's internal capacity to strengthen existing mechanisms and/or provide quality protection case management services.[54] This requires a realistic review of your human, financial and security resources to ensure you can safely deliver accessible services that meet minimum standards.

In some contexts, there may already be case management agencies working together to develop agreed on standards of practice. You should make sure you can achieve those standards prior to setting up protection case management. See chapter 3, section G for an overview of protection case management minimum standards.

[54] Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, 33.

These key considerations can help you determine whether your organization has the capacity to provide protection case management services:

Your staff: The number of staff you have and their level of competency to carry out and supervise case management is an important factor when considering your programme's scale, nature and geographic reach. See chapter 3, section E for staffing requirements and considerations. Where your staff have positive attitudes to be able to effectively support the most marginalized in your context.

Your budget: Short grants are not suitable when establishing protection case management services. Grants must be longer than 6-12 months to ensure continuity of services and avoid harm. Protection case management must be adequately resourced, particularly in contexts where there is minimal access to external services for referral. In these situations, you may consider enhancing caseworkers' capacity to deliver mental health and psychosocial support and the availability of protection cash for protection outcomes. Your budget will be influenced by your required mode of service delivery and your operational context. See chapter 3, section F for budget considerations.

Safety and security: Potential unintended consequences can arise when working with persons at heightened risk of a rights violation which can be unsafe for them and for staff, particularly if staff are part of and known to the community. These situations may influence your decision to deliver case management services and/or require you to avoid providing services to a certain group(s). For example, where you are considering providing services for groups which face significant security risks, such as in situations where being LGBTQI is criminalized, it is essential to consult with these groups on whether the provision of case management services is safe, and as to what adjustments could be made to ensure the provision of services is done safely (i.e. alternative locations or timings), as well as consulting with caseworkers on whether they feel safe providing services.

You can conduct a project risk matrix to support your decision on whether it is safe to provide services by considering the safety and security risks and developing measures to mitigate them. An example of a protection case management risk matrix can be found in annex 2. This provides examples of safety and security risks and mitigation measures. It also provides examples of how to mitigate internal constraints to your organisation's capacity. It will need to be adapted to your context.

On the basis of **your engagement with key stakeholders, your context-specific protection analysis** and the assessment of **your organisation's internal capacities** you will be able to consider whether establishing protection case management services is **safe, conflict-sensitive, complementary** and **context-appropriate** and whether you are in a position to deliver them. If you do not consider protection case management to be the best course of action, you can still consider providing complementary alternative services which work to address threats and barriers at community and society level.

Chapter 2: Key tools & resources

Engagement with stakeholders:

- Human Rights Resources by Country (OHCHR)
- Stakeholder Analysis Tool (DRC)
- Do No Harm Assessment / Project Risk Matrix / Conflict-Sensitivity Analysis (IRC)
- GPC Coordination Box (GPC)

Context-specific protection analysis:

- Action Aid Safety in Dignity Tool 7: Protection Equation Analysis
- Protection Information Management Resources (PIM Working Group)
- Participatory Assessment and Guidance (UNHCR)
- Methodology for Protection Analysis (GPC)
- Needs Assessment Handbook (UNHCR)

- Cheat Sheet: Key terms and concepts for protection analysis (inter-action)

Annexes:

- Annex 1: Key questions for protection analysis
- Annex 2: Protection case management risk matrix (combined project & protection matrix)

CHAPTER 3: BUILD YOUR FOUNDATION

Design your services based on your context-specific protection analysis and make sure to mainstream protection!

Training Modules:
- **Module 12: Information management**

In this chapter, we will look at:

1. Your prioritisation
2. Your coordination
3. Information management
4. Design of your services
5. Your staffing
6. Your budget
7. Your minimum standards & protocols

3.A Your prioritisation

(i) CONTEXT-SPECIFIC PRIORITISATION

WHY IS IT IMPORTANT?

When faced with a large caseload where many people are at risk, it is important to prioritize cases based on your context-specific protection analysis. Context-specific prioritisation will support caseworkers in their day-to-day work. It will increase the likelihood of reaching those people in situations of heightened risk and will help to define the scope of your protection case management services so that you can provide quality care. You can then also communicate transparently with community members, service providers and other relevant stakeholders about your work and what protection risks you address. This is essential when providing limited and valuable case management services that target only a limited number of individuals in order not to increase social tension or cause harm through exclusion.

Basing your prioritisation of cases on a regularly updated context-specific protection analysis that focuses on risk and protective factors **will avoid reliance on pre-defined categories of persons with specific needs**. These categories can lead to some group(s) being overlooked and others being viewed as inherently vulnerable. This undermines the empowering process of protection case management. For example, a person with a disability should not automatically be considered to be a potential client for case management as they may not be exposed to heightened risk of a rights violation. This will only be known when you consider their available social, community, household and individual protective factors.

Caseworkers will need to examine risk based on the person's specific individual situation in their context. This means **they will need to assess a person against the full range of all their relevant risk and protective factors**. Having a list of all of these factors which contribute to a violation, can help caseworkers recognise and prioritise cases in a holistic way. This is more effective than establishing defined criteria which select only one or a limited combination of those risk and protective factors considered the most influential.

For example, drawing on the above example from the Protection Risk Analysis template (section 2.B iii) In Lebanon, we can see that **undocumented and unregistered Syrian refugee men** are at greater risk of **arbitrary arrest and detention at checkpoints manned by the authorities**. However, observing whether an individual lives in a remote area or an urban area and whether they cross checkpoints frequently, and whether they entered the country before or after a recent government regulation to give deportation orders to refugees who entered the country after April 2019, will all contribute to the caseworker's assessment of whether the individual is at heightened risk of experiencing a rights violation.

The example below is a section from Prioritisation Reference Form 0. Here, you can see how the information gathered in your protection analysis can be used to support caseworkers in defining specific risks, and to observe correlated risk and protective factors in order to prioritise cases for intake.

THE PRIORITIZATION REFERENCE FORM

This is designed to be a reference for **caseworkers to support the prioritisation and intake of cases**. It comprises of a list of definitions of human right violations, with examples. Under each violation type there is space to include correlated risk and protective factors as identified in your protection analysis. ***This form must always be adapted to your context***.[55]

Key components of the tool:

- **Type of violation/protection risk:** Locate the rights violations you have decided to respond to based on your prioritisation process. Definitions for each violation type are drawn from international sources of law. Where relevant you should add specific national legislation. See the Prioritisation Reference Form 0 for a non-exhaustive list of definitions for rights violations, including *right to life, torture, inhumane, cruel and degrading treatment including violence, right to liberty & freedom of movement, exploitation, access to territory & asylum, denial of family life, access to justice, denial of economic, social and cultural rights, right to nationality, civil status, registration & documentation, denial of other civil and political rights*.

- **Risk and protective factors:** Include correlated risk and protective factors for each violation type as identified in your protection analysis. You should provide details as much as necessary to support caseworkers in analysing an individual's situation.

- **Determination of risk level:** Adapt the determination of risk level to your context. Providing detailed guidance for caseworkers as to how to determine this might be helpful. You can check with the protection sector regarding the risk level used in the country.

- **Outside the scope of protection case management:** Indicate cases which fall outside the scope of protection case management services and require a referral for SGBV, CP, Legal, MHPSS case management or another service.

[55] This tool has been adapted from the IRC Identification Reference Form for caseworkers in IRC protection case management programs and from the UNHCR incident typology list used to report protection incidents.

Deprivation of liberty	
Type of violation(s) *Arbitrary arrest and detention* *Examples:* *- prolonged detention without charge* *- detention of innocent family members* *- failure by authorities to issue ID or travel document resulting in detention* *- detention for housing, land and property disputes*	**Definition** Arbitrary detention is the violation of the right to liberty. It is defined as the arrest and deprivation of liberty of a person outside of the confines of nationally recognized laws or international standards. There are three key grounds to satisfy: 1) The grounds for the arrest are illegal 2) The victim was not informed of the reasons for the arrest 3) The procedural rights of the victim were not respected The victim was not brought before a judge within a reasonable amount of time

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors, causal agents and root causes	Examples of individual age, gender and diversity factors which due to the context can increase individual risk	Examples of protective factors which reduce or mitigate the risk
• *Negative social attitudes toward refugees* • *Checkpoints manned by security forces* • *Regular raids by security forces*	• *Lack of nationality* • ***Undocumented*** • ***Unregistered refugee*** • ***Male*** • *Arrived in country after new regulations came to effect in April 2019* • *Unemployment leading to increased travel* • *Living in a remote area*	• *Living in an urban area due to less checkpoints* • *Employed in neighbourhood* • *Registered with UNHCR* • *Holds documentation*
Outside scope of protection case management requiring referral:	Child Protection: Gender-Based Violence: Legal: MHPSS:	

Examples of: Risk level to determine prioritisation *Adapt for your context.*		
Low risk-level: Probability of a serious risk to individual safety is low. However an intervention to respond to individual specific needs may be required to reduce vulnerability.	**Medium:** Probability of a serious risk to individual safety requiring intervention within a week. Bi-weekly follow-up required by phone and visit. The number of follow-ups will decrease in line with the individuals' needs.	**High:** Serious and imminent risk to individual safety requiring immediate action within a maximum of 48 hours. Depending on the situation, weekly follow-up is required by phone and visit. The number of follow-ups will decrease in line with the individuals' needs.
Example: *The individual was already taken in charge by another organisation. No disclosure of support required, observed, communicated. There is an existing solid community and/or family support network. No obvious use or risk of negative coping strategies. There may be an existing additional need for another type of support not directly related to the protection incident.*	***Example:*** *The individual was already identified by a partner and has received some form of support but this needs to be reinforced. There is fragile existing family and/or community support. There is risk of and/or use of negative coping strategies as a result of the protection incident and/or due to risk of the protection incident. There is no immediate threat to life.*	***Example:*** *Threat to life is identified - suicidal behaviour, health consequences endangering the life of the individual and/or family member(s). There is a physical safety risk. There is absence or a very low level of family and/or community support. The person may live alone. There is visible risk of and/or resort to negative coping strategies. There are multiple protection risk(s) correlated and/or as a consequence.*

HOW TO PRIORITISE YOUR SERVICES?

There are a number of ways to prioritise your protection case management services. If you are analysing your protection analysis findings and doing your prioritisation process in the same workshop, you should plan at least one day for this.

Some key practical steps you can follow are:

- Organise a workshop with your team and invite other protection, **SGBV and CP colleagues already operational in the area to discuss their own approach to prioritising cases, lessons learnt, and their caseloads**. Caseworkers from these teams may frequently recognise persons at heightened risk of certain violations who cannot benefit from their case management services. This can be an opportunity to ensure case management services are complementary with clear divisions discussed between caseloads to support future coordination and safe referrals. This will also provide better outcomes for families or other groups that may need different specialised services.

- **Make sure you have completed a context-specific protection analysis prior to starting your workshop**. This can be organised similarly to the protection analysis template (2.B (iii)), organised by violation type and reflecting identified risk and protective factors.

- Handout and review the protection analysis template together.

- Discuss and agree on **which rights violations in your context are prevalent and which you are in a position – based on your specific means, technical capacities and understanding of your operational context - to address through protection case management services**. To support this discussion, you can use the questions in Annex 3 Key Questions for Prioritisation. You will need to consider what other services are being provided, where you can contribute and complement most effectively, where you are best able to deliver services to an adequate quality of care, the safety and security of your clients and staff, and where you will have maximum impact. Information collected in chapter 2 will help this process.

- For each selected rights violation, **review the correlated risk and protective factors** in your protection analysis template, and consider together and take note of the **most severe and prevalent** in your context.

- For the final step, caseworkers will need to understand how to **prioritise between cases** during prioritisation and intake.

Assessing staff attitudes toward certain group(s) might mean that it is not appropriate for them to provide services due to the risk of re-traumatizing clients. This can help you to prioritise. In these instances, you should work with caseworkers to provide further training and mentorship and re-assess staff attitudes regularly. Some caseworkers may be better placed to provide support to certain groups than others.

HOW TO PRIORITIZE BETWEEN CASES?

- **Prioritisation of cases should be based on the risk level of each case**. Risk factors alone do not indicate the level of risk. For caseworkers to assess the level of risk that the person is in, they must assess the entire situation. You will need to determine whether a case is *low risk, medium risk or high risk*. **We recommend you prioritise medium and high-risk cases for case management only**. The risk level focuses on the urgency with which you need to respond. You can find an example of this in the table above. **Remember to involve the perspective of local staff and the community** when considering what factors make someone more exposed or susceptible to a violation or more protected.

  - **Look at the accumulation of a person's risk factors**, and whether these are counterbalanced by protective factors. Where someone faces multiple risk factors, they are more likely to be at risk of harm. Consider their protective factors and whether these mitigate the extent of risk.

  - **Some risk factors will have greater impact on/susceptibility to the rights violation occurring**. This means that some individual risk factors in certain contexts can lead to more harm than others. For example, an intellectual disability may make someone more susceptible to exploitation in a discriminatory context. We should consider the impact or severity of risk factors over the immediate, short, medium and long term. For example, emotional abuse might have lower impact in the short and medium term but over the long term can be extremely damaging. Including considerations for this in the tool can be helpful.

  - **Some risk factors will lead to greater exposure to the probability of a rights violation occurring.** This means that some individual risk factors put a person in the presence of an environmental risk more often. For example, if an undocumented man crosses a checkpoint in Iraq daily, this may raise his likelihood of being arbitrarily arrested compared to an undocumented man who crosses the checkpoint every month.

- **Examining the cases where your services can be most effective** can help you to prioritise. In some instances, a protection case management approach may not benefit the client.

Once you start to provide protection case management services, aggregated information from your own caseload, as well as protection monitoring and other information channels you have access to, will help you to **adjust and revise as you go along**.

Protection environments in humanitarian and protracted crisis are not static, so it is important to regularly update your protection analysis and review your prioritisation of cases accordingly. This should be done routinely but also in response to changes in your context, including new policies or procedures, outbreaks of violence, changes to the economic situation, etc.

3.B Your coordination

(i) COORDINATION WITH OTHER CASE MANAGEMENT TEAMS

You will need to work closely with other case management teams (internal or external) through a comprehensive and safe referral system to ensure that people are referred to the correct case management service and that all of clients' specialized service needs are met.

The table shows common areas of responsibility between the different case management streams; however, this may vary depending on your context and organisation:

Case management services
Refugee protection case management: In refugee contexts, all refugees that are registered/enrolled by the State/UNHCR are considered to be a part of UNHCR refugee protection case management. Refugee protection case management includes access to refugee registration, refugee status determination, and identification of durable solutions. It also includes more specialised case management interventions such as SGBV, Legal, Protection and CP case management, including assessing and determining the best interests of the child. The ultimate goal is to find long-term durable solutions to refugee displacement.
Child protection case management (CP CM): In principle, anyone under the age of 18 meeting the targeting criteria defined by the CP Case Management programme in place in the country. This includes assessing and determining the best interests for a child in coordination with UNHCR.
Sexual and gender-based violence case management (SGBV CM): Female SGBV survivors, vulnerable women and girls at-risk of SGBV and male survivors of sexual violence. It is encouraged that male survivors of sexual violence be provided with services by SGBV case management providers however this will depend on the context. GBV classifications per the IASC GBV IMS are sexual violence, intimate partner violence, family violence, early forced marriage, abuse and exploitation, denial of resources/humanitarian aid and harmful traditional practices.
Protection case management (PCM): Persons who have experienced or who are exposed to heightened risk of a rights violation going beyond those of the affected population. This service primarily supports adults that are not at risk of sexual or gender-based violence.[56] Clients in protection case management may require referral for specialised legal and MHPSS services but will remain under the responsibility of the PCM caseworker. Discussions on prioritisation of cases for protection case management are best agreed on in coordination with the various case management teams.
Mental health and psychosocial support case management (MHPSS CM): Clients with protection risks specifically linked to their mental health and psychosocial wellbeing. These are people who may have mental health conditions and who require specialised MHPSS services, usually with a treatment plan to support their day-to-day functioning.
Legal case management (LCM): This is a specialised service to support a person through the life cycle of a legal case. It can range from simpler/less resource-intensive assistance (i.e. filling out/submitting a legal form) to more complex and time-intensive legal counselling and legal representation. It provides prevention and response to protection risks linked to legal issues, including protection from reprisals, and concerns both the immediate and longer term.[57]

[56] There may be instances where an adolescent turning 18 years old may be receiving child protection case management services and may continue to require case management. In these situations, child protection and protection case management service providers will need to coordinate to decide the best course of action.
[57] IRC, Access to Justice Guidance, 2019, 40.

Each of these case management streams requires specialised knowledge and expertise. **A client should not be enrolled in two different case management programs at the same time**. **A client should only have one primary caseworker**. When working with people at heightened risk of a rights violation it may take time for caseworkers to build a trusting and healing relationship with clients. This relationship between caseworker and client is central to the case management process. While a client will receive additional services and support from other sectors (e.g. GBV, Legal, Health, etc.) as part of their case action plan, only their primary caseworker will coordinate and follow up on those services, ensuring they are received and reviewing the case action plan until case closure.

However, sometimes overlap can still happen. For instance, when a single woman journalist with children is at risk of arbitrary detention (protection issue) is enrolled in protection case management services and then found to be a survivor of sexual violence after her enrolment (GBV issue). **In such situations, it can be good practice to hold a case conference and for the case management team most technically appropriate to assume primary responsibility for the case**, in line with the aforementioned divisions of responsibility (i.e. an SGBV caseworker should take the lead in cases involving SGBV survivors). **However, you must ask the client what their preference is. Often it will be the caseworker that has the ongoing relationship with the client who remains the main caseworker (so the person does not need to relive/tell their story several times) but coordinates closely with the other case management team to ensure appropriate services are in place to respond to the risk the client is exposed to.**

We recognize that practices around case coordination vary in each country. No matter who is providing the primary case management response, teams should coordinate and ensure that case management responses avoid causing harm. You must develop safe referral pathways between case management streams and case workers must know the prioritisation criteria for them to allow for the safe and timely referral of cases that require attention from another team within or outside your organisation.

Male survivors of sexual violence

GBV case management service providers often do provide services for **male survivors of sexual violence**. For safety reasons, these clients must be supported outside spaces that are safe for women such as a health facility or other community space. GBV case management teams should lead case management service provision where possible to ensure adult male sexual assault survivors have safe access to services. The GBV sub-sector may have specific referral pathways in place for male survivors of sexual violence and LGBTQI individuals.

Where your caseworker identifies an individual whose needs straddle the areas of responsibility between the different case management teams, you should hold a discussion with the relevant case management team at the earliest stage of contact with the individual. This is known as case conferencing.

CASE CONFERENCES

These are multi-sector or inter-agency case planning meetings for complex cases. This helps to provide multi-sectoral services to meet the various needs of a case. It can be used as a forum to make formal decisions around the vital/best interest of an individual when this arises as a last resort option. In refugee settings, UNHCR usually leads such procedures. These meetings should be documented and should be limited to the presence of as few people as possible to respect client confidentiality. In some but not all meetings, clients can attend but provisions should be made to ensure their active role and opinions feed into any decisions made.[58]

People often use case coordination terminology interchangeably so it is easy to get mixed up between different types of case coordination meetings.[59] We hope this table helps to clarify this for you.

Case conferencing	Case action planning	Case review meeting/ Group supervision
For formal decision-making to develop or to review a case plan. Usually for complex cases which require multi-sector approach. Can include the presence of the client and others, with their consent and facilitated carefully. Participation of external actors is usually included.	To develop a case action plan as part of the case management step. Required for all cases. Involves the client as well as anyone else they wish to be present (family/carers). Not usually with the involvement of other players.	A group supervision practice to review a case file for the purposes of learning and to check quality of care. Within an organisation between caseworkers, supervisors and managers only. Usually a case is discussed anonymously.

REFERRAL PATHWAY

Where there is more than one protection case management organisation delivering services in your area or country, it is important to map areas of responsibility between agencies. This is usually determined by agencies' capacities, resources, and the types of cases for which they provide services, including the accessibility requirements that the client may have. Having a safe referral pathway in place will avoid a person being referred to different organisations and spoken to by many people without getting the right information and support. It is usually the role of the protection sector to lead this agreement between agencies so that you can reach out to them for this information and include your services in the pathway. You will also want to reach out to SGBV and CP case management teams for their referral pathways so that you can add these to your service mapping.

(ii) DEVELOP AND MAINTAIN YOUR SERVICE MAPPING

Connecting clients to services is a key component of case management and it is facilitated by an accurate and up-to-date mapping of services. Caseworkers are sources of information on available services and should serve as entry points to refer clients to the services and assistance they need.

An up-to-date and accurate service mapping is essential for safe, accountable and timely referrals. You will need to regularly update this at least every one to three months, depending on the rate of staff turnover in your area. A service mapping should contain information about the available services in your area, their quality and how you can connect clients to them safely. It has proven useful to have service mappings and referral pathways online so that changes can be updated as and when they happen, especially in large operations with frequent staff turnover.

[58] Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, p. 67
[59] Ibid. p66

The following information should be included:

- **Who** is the service provider?
- **What service** do they provide?
- **Where** do they provide the service?
- **When** do they operate? Explain opening/closing times and indicate their project end date.
- **Eligibility requirements** for the service, including services relevant for at-risk populations in the context.
- **Capacity for intake** to help to determine which service provider to refer to.
- **Referral protocols:** Explain how the receiving organisation wishes to receive the referral, i.e. through a password-protected inter-agency referral form.
- **Additional information or documentation needed** to access the service: This helps caseworkers to gather all the documents that must be sent with the referral to speed up the response. For example, if a birth certificate is required to enrol in school.
- **Expected time frame for response**. This indicates the expected response time of the receiving organisation to a referral. This helps caseworkers to inform clients when they can expect a response from the service provider.
- **Data protection protocols** that are in place. This will help caseworkers to explain to clients how their information will be collected, stored and shared for the purposes of informed consent.
- **Contact details for the service provider**. There should be a primary and secondary focal point for each service (name, e-mail and phone number for high-risk referrals). It is a useful practice to assign contact e-mails and phone numbers to a function rather than to a specific staff member so that the right person can be contacted regardless of staff turnover.
- **Safety and accessibility**: Mapping risks and the accessibility of services, including physical accessibility and the accessibility of the information provided at the centre, and the capacities to accommodate clients with accessibility requirements (e.g. sign language interpretation) will help caseworkers to provide their clients with sufficient information to make an informed decision to be referred to the service, including whether the caseworker should accompany them to support access.

Safe, accountable and timely referrals can only work if there is mutual understanding between service providers. This means ensuring that all service providers understand the steps of the referral process and that there are common expectations as to the roles and responsibilities of referring and receiving agencies. This should also include how received information is safely documented and stored. This is usually outlined in a referral minimum standard guidance.

Before trying to collect this information yourself, you can ask the protection coordination group or other protection agencies whether they have a service mapping or a referral minimum standard already in place. If this information does not exist, you can you can use these tools to help you:

- Annex 4 Service Mapping: Service Information Collection Form to collect information about the service

- Annex 5 Service Mapping: Service Accessibility Audit to assess the quality of the service including whether any barriers exist for clients to access the service that caseworkers should be aware of. Guidance on the use of this tool is provided within the form.

It is also common for other organisational staff and community focal points to encounter people who may benefit from protection case management services. You will need to explain the services you offer and the type of cases you support. This can be an opportunity to introduce them to and/or provide refresher training for them on the referral minimum standard so that they know how to safely and accountably connect people to your services.

3.C Information management

(i) DOCUMENTING CLIENT DATA

Case management forms are a critical way to document services being provided. This is a standard practice in the field of social work and critical to having a solid foundation from which to make data-driven decisions. There are standardized forms that have been created by protection players for us in various settings. These forms have gone through a review process, and are the suggested starting point for developing and/or harmonizing case management forms.

If your programme will use digital documentation, you will need to determine what platform best suits your needs and context. A data platform should aid in managing your caseload and facilitating case management documentation. You can explore existing databases in use in your organization or context, or conduct a technical software requirements collection, which can be as simple as identifying the features and functionality needed in a system and comparing that to existing or custom options to determine a way forward.[60] Whether you decide to use a database with electronic forms or a spreadsheet with paper forms, you will need to ensure it is properly maintained by information management staff. These staff should be integrated into the case management team and trained on data protection and confidentiality.

Information shared by a client should, as far as possible, be treated as their data and where possible caseworkers should facilitate the client's access to their documentation on request. Therefore, caseworkers should try to use the same words as the clients when documenting meetings and discussions. This can be a helpful method for caseworkers to monitor the progress made by their client and recognise new problems. Case notes should be based on fact and professionally substantiated judgment rather than bias, with caseworkers refraining from using dismissive or offensive language.[61]

[60] In some contexts UNHCR uses the online ProGres Version 4 database. Access to the database for UNHCR partners can be granted where suitable and appropriate, which can be useful for undertaking joint case management.
[61] Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, 44

(ii) PROTECTING CLIENT DATA

Data protection is the act of protecting personal or sensitive information in terms of how it is documented, stored and shared. A significant amount of information is captured about clients through the course of the case management process. This is because caseworkers, on behalf of their clients, need to document their client's personal protection data, what they have discussed with the client and keep track of the steps they take so they are held accountable.

Policies, protocols and practices on data protection are essential to our work because unprotected data or its unauthorized access or sharing can endanger your client and jeopardise your programme. You will need to establish data protection protocols and have staff sign a data protection agreement if you are to carry out protection case management services.

The minimum standard data protection in annex 6 provides a data protection checklist, a staff data protection agreement and a sample data protection protocol including the handling of data in emergency situations such as evacuations.

(iii) INFORMATION SHARING

In many contexts, there are a number of organisations working together to provide services to persons with heightened protection risks. This can necessitate sharing information about cases and using referral forms. As discussed, the players involved in a referral pathway need to agree on what client information should be shared, when and with whom. They must agree how this information will be shared and followed up on - verbally, electronically or by paper - and on appropriate procedures to ensure that the confidentiality of the person at heightened risk is protected at all times. This can be documented in an information sharing protocol.[62]

While the information management system you use will primarily be for supporting the case management process with your client, aggregated data analysis from this system can serve to inform your or others' advocacy and prevention work or help to prioritize interventions and resources.[63] Bear in mind though that sharing this data should only be done after a risk assessment and after you have agreed with other case management service providers how to share it without causing harm. You should never share identifying information such as any client bio-data.

Example: Advocacy in Yemen.
A protection case management team was providing services in an IDP camp in Yemen. Through an aggregated analysis of the trends, the team realized that many of their clients were lacking the same type of medication and this contributing to a number of protection risks for clients with chronic diseases. Through advocacy with key health stakeholders in the camp through the health cluster, and without sharing any of their clients' identifiable information, they were able to influence the type of medication provided through primary health clinics to patients.[64]

[62] Ibid. 34.
[63] GPC PIM Guidance, 2018, available at: http://pim.guide/
[64] Example from an IRC Protection Case Management team in Burundi tailored to an IDP context.

3.D Design your services

(i) MAINSTREAM PROTECTION TO ENSURE SAFETY AND INCLUSION

WHAT IS IT & HOW CAN I DO IT?

Protection mainstreaming looks to incorporate the principles of **meaningful access without discrimination, safety, and dignity and avoid causing harm, participation and empowerment, and accountability** into protection case management services. Protection mainstreaming is not about changing the goals or objectives of your services, but focuses on the way you design, deliver and evaluate them.

You can follow these key steps:

- Use your **context-specific protection analysis** to **identify barriers** that people of different **age, gender, disability and diversity** may face when accessing your protection case management services. Capture this information in your **protection risk matrix** to proactively address these barriers by putting in place mitigation measures **(enablers)**. You can see an example in Annex 2: Protection Case Management Risk Matrix (Combined Project and Protection Matrix).

- Make sure you integrate your agreed mitigation measures into your project work plan or a **protection mainstreaming action plan** so these are implemented.

- **Monitor, evaluate and learn** whether protection has been mainstreamed in your services and the impact of your services on clients. Use MEAL Form 1 Client Feedback Survey to understand your client's opinions and perceptions of the service in terms of safety, dignity, access and participation. Protection mainstreaming indicators can be integrated into your log frame.[65]

For a step by step guide to mainstreaming protection into your services, please refer to the Global Protection Cluster, Protection Mainstreaming Toolkit: http://pim.guide/

Key considerations for mainstreaming protection.

Set up or link to existing accessible complaint and feedback mechanisms for your clients or others to raise concerns, complaints and provide feedback. Consult different age, gender, disability and diversity groups in the community on their preferences for providing feedback and complaints in a safe, confidential and anonymous way. For case management, this is important because your client may find it difficult to access services or to participate in the community. Caseworkers are therefore in a position of power and adequate safeguards must be in place to prevent abuse of that power and to **prevent sexual exploitation and abuse (PSEA)**.[66]

Accessibility/universal design: Design your protection case management services and products to be useable by all people to the greatest extent possible, without the need for further adaption or specialized design. Avoid designing separate spaces and facilities for people with disabilities. If you design your services for persons with disabilities in mind, you will find that you actually benefit a much larger number of people. For example, putting a handrail above the stairs and a ramp in your community centre will increase its safety, decreasing the risk of falls, and can be used just as effectively by a person with a wheelchair or a new parent holding an infant.

[65] Refer to GPC PIM Guidance, 2018, 27, available at: http://pim.guide/
[66] PSEA: The Secretary General Bulletin provides that all forms of Sexual Exploitation and Abuse by UN staff or UN contractor must be reported through established agency reporting mechanisms. Available here in addition to other resources on PSEA: https://emergency.unhcr.org/entry/32428/protection-from-sexual-exploitation-and-abuse-psea

Reasonable accommodation: Make sure to leave some flexibility when you design your budget and services to allow you to provide additional support, where necessary and appropriate, to allow persons with disabilities who face barriers accessing your services on an equal basis to access them. This means actually making plans for situations where, regardless of the accessibility measures you have put in place, an individual with a disability still finds barriers that limit their access. For example, where appropriate, having an agreement with a sign language interpreter to support communication with a client, or having outreach capacity for clients who cannot access the centre, regardless of its accessibility.

Bridging the gap between accessibility and individual adjustments	
Accessibility	**Reasonable accommodation**
Can be implemented in advance	Has to be provided immediately, otherwise there is discrimination
Is a general solution	Is an individual solution
Applies regardless of the need of persons with disabilities to access infrastructures, services or information	Applies from the moment that a person requires access to a non-accessible situation
Is guided by general principles of universal design	Is tailored to the person and designed together with the person concerned
Is ruled by accessibility standards	Is ruled by a proportionality test: is not relevant, available or affordable by the project

In order to achieve accessibility and reasonable accommodation in the design and implementation of your services, you must be aware of the different types of barriers people face when accessing your services. These are examples of **social and attitudinal, information and communication, physical and institutional barriers and corresponding enablers.**[67]

Social and attitudinal barriers and enablers. Social misconceptions, prejudices and unconscious bias against people may generate incorrect assumptions about our clients, limiting our ability to successfully support them and avoid re-traumatization. While this is not always intended, it still poses barriers for people. We can re-think our attitudes by showing respect for difference.

Barriers	Enabler
A person with an intellectual disability is unable to make decisions; others are likely to need to take decisions for them in their best interest.	All people have the right to take decisions on issues which affect them, and most can. Someone with intellectual disabilities may require support to understand and make decisions but that's not always the case. The centre has a protocol for supporting communication in these cases and service providers identified.

[67] These examples have been taken from the IASC, *Guidelines on Inclusion of Persons with Disability in Humanitarian Action*, 2019, 12-15.

Physical barriers and enablers. Buildings and services and the environment itself can pose physical barriers for people when reaching, entering, circulating and using a space. Barriers are likely to be present in the environment already but you need to make sure to avoid creating additional ones unintentionally.

Barriers	Enabler
Mental health and psychosocial group activities can take place in inaccessible community centres (e.g. with stairs and no ramp at the entrance, without an accessible toilet)	Make sure mental health and psychosocial activities are convened in buildings and sites that are accessible and adhere to the *'Reach, Enter, Circulate and Use'* principle.[68] All community centres should be accessible.

Information and communication barriers and enablers. Poor or inadequate communication with clients can pose barriers to them receiving information, making informed decisions and participating in services with you. This can be the case when different languages are spoken, sign language interpretation is not provided or caseworkers do not speak clearly and slowly. For example, speakers of marginalised languages often are denied using their own language. Not speaking or understanding a specific language can impair their rights to receive our services. We must make provision for interpreters to be available in minority languages or for staff to be recruited who can speak these languages to support access.

Barriers	Enabler
Information about the case management process and confidentiality is only provided using one medium of communication, i.e. verbal which prevents full understanding.	Information about the case management process and confidentiality must be provided in multiple accessible formats (oral, sign, easy-to-read language, easy-to-read form). Where necessary, interpreters facilitate understanding and communication.

Institutional barriers and enablers: Policies and processes in many countries and within your organisation can pose barriers for people to access employment or services. For example, call centres may not collect data on disability making it impossible to know how many people with disabilities are requesting your services or have complaints.

Barriers	Enabler
Case management needs assessments and monitoring indicators do not collect data on disabilities making it impossible to know how many persons with disabilities are requesting and using our services and the extent to which they experience risks.	Disability data is captured through the Washington Group Questions in needs assessments and monitoring and evaluation activities. Data is disaggregated and risks are evaluated in detail.[69]

[68] The *RECU principle means that location or building is accessible when all persons can reach it, enter it, circulate from one room or floor to another, and use the services it offers.*

[69] The Washington Group (WG) Short Set is a set of questions designed to identify (in a census or survey format) people with a disability. See Washington Group on Disability Statistics

(ii) YOUR MODE OF SERVICE DELIVERY

Case management services can be provided in a variety of different ways. It is always best to consult with the community when deciding where and how to deliver your services so that everyone who needs to can access services safely and confidentially. One way to do this is to do a safety and accessibility mapping with different groups of people in the community and ask them to identify spaces they consider safe or even protective for them.

In addition to this, here are some pros and cons you can think through when making your decision. These will vary depending on your context.

CENTRE-BASED CASE MANAGEMENT

This can be a centre where a range of activities take place. Case management is provided in a separate and confidential space or room within the centre. This can be in a community centre, health centre or elsewhere. This does not include women's safe spaces.[70]

Pros	Cons
Due to other services being offered in the centre for which many people are accessing, people outside the centre do not know who is receiving case management support. This ensures sessions can take place outside influence from the community and in a confidential and anonymous manner.	In volatile security contexts, it might not be safe, especially if authorities request information about beneficiaries and ask to enter the space
This is often a visible and known space in the community.	More resource-intensive and expensive to maintain and therefore potentially a less sustainable option
The stability of the centre can support community acceptance and allow more time to build trust. It can also allow for opportunities to connect with community-based interventions and get to know the local services in the area.	Risk of attack if case management is seen as a source of social tension or contrary to social norms.
Rooms for case management can easily be made comfortable and private for clients and staff	Centres may be located in unsafe spaces or far from people's homes. This might mean people cannot physically reach the centre
You can store confidential files and have access to computers and the Internet	Where there is fluid population movement, people may not reside long enough in one location
Allows access to a range of people who may choose to seek services	
It allows you to provide case management services for some clients for a longer period of time and to support clients in building up a support network within the centre.	
Can present opportunities for close coordination and effective referrals with the other service providers, for example if a caseworker works in a health centre where there is also a psychologist they can refer to.	

[70] It is essential that female GBV survivors feel safe and comfortable when seeking and accessing services. A key part of GBV case management is to ensure that women feel safe and comfortable. It is therefore essential that men are not inside or hanging around the outside of the centre at any time. This can compromise women feeling safe and it can cause additional harm.

MOBILE-BASED CASE MANAGEMENT

This involves setting up a semi-permanent space identified in the community for a period of time, generally around three to six months. The space can be a room in an already established local community centre, place of worship, or school. It can also be a tent or a container specifically built for this purpose. You can also rent a space.

Pros	Cons
This is often a visible and known space in the community.	Less resource-intensive and expensive to maintain than community centres and therefore more sustainable
Depending on the size and design, it allows other activities to be provided in the centre so those outside do not know who is accessing case management services. This ensures sessions can take place outside influence from the community and in a confidential and autonomous manner.	It can be harder to establish a private and confidential space for case management services depending on the building, tent or container. At a minimum you need to make sure that there is a separate entrance and room for one-on-one sessions.
While not always as comfortable as more centre-based services, you can still make the space comfortable and private for clients and staff	Centres may be located in unsafe spaces or far from people's homes. This might mean people cannot physically reach the centre. You should always consult with the community first.
It can be a sustainable option if you work with the community from the beginning to run the space and hand over to them when you leave the space for recreational activities only. This can maintain a support network for people but it will need resources. The space you set up in will also need to remain. You need to focus on your exit strategy carefully.	It can be harder to store confidential files and to leave computers due to the lack of infrastructure and/or the temporality of the centre. You can consider hiring a temporary guard from the community.
It can support access for those in rural or remote areas who may not be able to reach a centre located in a more populated area.	It can be harder to establish an Internet connection thus requiring the use of offline or paper tools.
	It might not be as comfortable for staff without a functioning kitchen or a space to decompress.
	It can be harder to ensure that those in need of services in the community are aware of the location.
	It may be harder to establish community acceptance and build trust in a short period of time.
	It can raise situations where a client requires case management services for a longer period of time.
	It can be less sustainable option if the space is needed after 6 months, for example school classes re-start or you are unable to continue paying rent once you leave. To avoid this, plan your exit strategy from the start with the community.

HOME-BASED CASE MANAGEMENT

This involves providing services in someone's home. In this option, it will always be important to ask the client if it is safe to do so and where they prefer to meet you and at what time and day.

Pros	Cons
Services are provided to people without additional potential cost on transportation and in a manner which everyone can physically reach.	In some contexts, it may not be appropriate to conduct home visits and it may signal to other community members that someone is receiving a special service. This can prompt discussion among neighbours and can compromise the safety, confidentiality and anonymity of the client.
Requires little to no resources. May require additional money on transportation.	Clients have less access to recreational activities or group psychosocial support sessions.
Through case management services, it can allow clients to build relationships and/or draw on the support from community members (i.e. neighbour to visit weekly), leading to a more sustainable outcome	It is harder to build a community support network for clients who can support them.
It can allow for engagement with the client's family, as appropriate and requested by the client. This can lead to complementary referrals for other family members, for example a female caregiver in need of support.	Depending on where people live, it can be difficult to find a private and confidential space for the client.
Seeing a person's home can provide indications of risk for the caseworker which can strengthen the safety plan	It is harder for those in need to know how and where to reach you. You will need to do more outreach.
Store confidential files and have access to computers/Internet	It can also be harder to reach the most in need who are isolated or have difficulty accessing services. That means there is greater reliance on referrals through other service providers or community members. It will be more important to build referral capacities.
This can be a reasonable accommodation measure to support access for an individual when a centre or a mobile-centre is not accessible.	Unsafe to conduct home visits if the perpetrator of violence is within the home.

(iii) USING CASH/NON-FOOD ITEMS

Cash assistance is one of the tools available to caseworkers to support a client to meet the goals set in their action plan. There is a growing body of evidence that cash assistance as part of protection case management has the potential to contribute to protection outcomes.[71] Cash is recognized as an empowering tool. Its objective is to provide quality care to address a client's risk(s) and support them to recover. It can enable immediate respite from violence or access to response services otherwise inaccessible due to prohibitive costs or limited financial resources. Clients, in coordination with caseworkers, will determine (within the action plan) if cash is an appropriate response to the protection risk.

In order for cash assistance to be provided, it should usually satisfy the **three S's**:

- **Safe:** The cash will not increase risk to the client on receiving the cash assistance.
- **Sustainability:** Cash transfer will be used to meet a specific and non-recurring cost, which arose recently and which the person/household cannot currently meet.
- **Suitability:** Cash will effectively address the client's most urgent needs for protection effectively, or will do so when paired with other services within the client's action plan.

Some examples for how protection cash can be used in protection case management are:

- **Fear for a client's immediate safety:** Transportation costs, rental costs, the cost of immediate basic needs.
- **Removing barriers** to service access or to community participation: Determined based on the need, transport, and equipment cost.

FIGURE 8: Using cash in protection case management

HOW CASH FITS INTO THE PROTECTION CASE MANAGEMENT CYCLE

STEP 1: INTRODUCTION & INTAKE

↓

STEP 2: PROTECTION RISK ASSESSMENT

In the initial assessment, the caseworker focuses on understanding the protection risks the client is facing including their economic and social networks. Here is where the case worker can identify risks that require cash assistance and analyse risks and barriers to accessing cash.

↓

STEP 3: ACTION PLANNING AND SAFETY PLANNING

Based on the identified needs, the caseworker should inform the client about the possibility of cash assistance and plan with the client how they would use cash, how they will cope once cash assistance ends, as well as put in place enablers to address risks and barriers. Discuss the process of receiving cash and obtain the client's consent. Include cash assistance as an "action" in the action plan.

↓

STEP 4: IMPLEMENTATION OF THE ACTION PLAN

The caseworker will ensure that they receive cash assistance and work with the client to remove any barriers to receiving the cash and accessing services. Case workers should work with the client to implement the action plan/ safety plan to mitigate any risk.

↓

STEP 5: FOLLOW UP & MONITORING

Caseworkers should assess a client's safety in the home and community, including any risks associated with the cash referral during each visit with the client. Post Distribution Monitoring should be completed.

↓

STEP 6: CASE CLOSURE

[71] GPC, *Cash and Voucher Assistance for Protection*, 2020

Cash as a modality is not inherently riskier than other forms of assistance. However it is essential that the caseworker and the client know whether there are associated risks and how to mitigate them.[72] If you want to include cash as a tool within protection case management services, be sure to develop a standard operating procedure for how to identify, assess, deliver, monitor and evaluate the provision of cash safely and equitably, including by identifying and addressing potential barriers that certain clients may face to access this type of support (e.g. digital literacy, accessibility of information and distribution points, etc.).

3.E Your Staffing

(i) ATTITUDES, KNOWLEDGE, SKILLS

Some contexts have a professional social-work structure and require certain qualification in order to practice social work; in those instances, caseworkers need the required qualifications. However, this may not be possible in all contexts. When looking to recruit caseworkers in these contexts, qualifications or humanitarian experience should come second to having the right attitude.

People at heightened risk may have intense emotional reactions, they may be indecisive or take sudden decisions, they may be distrustful, they may feel hopeless and they may live in unhygienic or cramped conditions. Through these challenges, caseworkers will need to develop healing relationships with their clients. This has been well tested through the GBV case management practice, where the 'qualities of warmth, respect, genuineness, empathy and acceptance are key helping skills' and are essential when working to build trust and induce hope.[73]

ATTITUDES

As mentioned, protection case management relies on caseworkers building a positive and hopeful relationship with their clients. However, caseworkers have their own beliefs and values shaped by their culture, ethnicity, religion, gender, sexual orientation, socio-economic status and their own personal experiences and history.[74] Therefore, caseworkers must be aware of how these beliefs and values may lead to bias which affects their ability to use professional judgement, to actively listen and interpret information, to accurately document information and to develop positive relationships with their clients and to avoid re-traumatization.

While there is no easy fix, caseworkers and other case management staff need to reflect on and acknowledge their bias, how it influences their actions and when and where it arises.[75] This is essential to overcoming bias.

There are a number of ways to address bias in your programme:

- **Interview stage:** Make sure to integrate questions into your interview to assess the attitude of the interviewee to certain groups in your context which are discriminated against or stigmatized as identified in your protection analysis. This might include negative attitudes against diversity factors such as sexual orientation and gender identity, HIV/AIDS, or disability. Someone with negative attitudes toward these groups should not be recruited to be a caseworker.
- **Orientation stage:** Train caseworkers and other staff on conscious and unconscious bias (e.g. patronizing attitudes, lack of awareness of barriers faced by certain individuals) and provide them with strategies to mitigate it in their work. Caseworkers can be asked to take an attitude scale to assess whether it is safe for them to work with clients.
- **Supervision:** Supervisors work with caseworkers to address bias through their work and to monitor progress through re-using the attitude scale.

[72] Overseas Development Institute (ODI), *Risk and Humanitarian Cash Transfer Programming*, 2015, https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9727.pdf
[73] Chang.V.Scott, S., Decker, C. (2009). Developing Helping Skills: A Step by Step Approach to Competency. Brooks/Cole Cengage Learning: California. 93
[74] Ibid. 93
[75] ACAPS, *Cognitive Bias*, 2016, 7 https://www.acaps.org/sites/acaps/files/resources/files/acaps_technical_brief_cognitive_biases_march_2016.pdf

KNOWLEDGE

Caseworkers knowledge will grow over time through training, supervision and coaching. At a minimum, caseworkers should have knowledge of:

- The international and national legal framework in the country in order to be able to recognise risk of violations.
- Potential risk factors and protective factors for each violation type based on the contextualised prioritisation reference tool.
- Protection case management guiding principles and concepts.
- Core concepts of child protection and gender-based violence and the cases that require referral and are outside the scope of protection case management.
- Basic helping skills and psychological first aid (PFA)
- Information about common mental health conditions (i.e. depression, anxiety, stress), including identifying key signs of stress and trauma.
- Available services, how to access those services and the quality of those services (including the accessibility and attitudes of services providers towards diversity).
- Their steps and tasks through the case management process, including for supervision, monitoring and evaluation.
- Data protection protocols and the information management database.
- Complaint and feedback mechanisms for clients.
- Self-care approaches

SKILLS

Caseworkers must be able to put their knowledge and attitudes to practice through their skills. This takes practice and comes with experience. Caseworkers will need time to develop these skills through training, supervision and peer support.

Caseworkers should be able to:

- Recognise whether a person is at heightened risk of a rights violation, including what type of rights violation and be able to determine the risk level of the case accurately.
- Respond to immediate lifesaving needs and develop safety plans.
- Collect disaggregated data on disability accurately.
- Assess mental health and psychosocial wellbeing.

- Ask for informed consent/assent.
- Identify potential barriers in accessing the physical environment, information and communication, and making reasonable accommodations to support the participation of their client, if needed.
- Communicate without judgement and demonstrate empathy.
- Inform the client about available service and assistance options.
- Maintain a client-centred approach, while assessing and verifying information in instances of referrals for refugee status determination and durable solutions to uphold the quality and appropriateness of the intervention
- Conduct a safe, accountable and timely referral for services.
- Support the client in recognising key issues and developing an action plan.
- Use the Information Management System and safely document and store client data.
- Report incidents of physical, sexual exploitation and violence according to organisation procedures.
- Use psychological first aid skills, including active listening, identifying key signs of stress and responding appropriately.

Case management staff should be equipped with Psychological First Aid skills (PFA).
The goal of Psychological First Aid is to create and sustain an environment of:

1) Safety

2) Calm & Comfort

3) Connectedness

4) Self-Empowerment

5) Hope

PFA is not traditional psychiatric or professional mental health treatment, but rather a strategy to reduce stress reactions by providing additional support to those who have been affected by a traumatic or emergency incident. PFA does not rely on direct services by MHPSS professionals, but rather on skills that most of us already have and skills which all frontline staff should be trained in and able to use when working with individuals. This includes being able to identify key signs of stress and active listening skills. To arrange training sessions on PFA, you can reach out to local and regional MHPSS Working Groups and/or key sectors within your organisation providing MHPSS services, including but not limited to health, protection, education or MHPSS players.

(ii) YOUR STAFFING STRUCTURE

Caseworkers require supervision and the systems they use and/or that monitor their work will need to be adequately staffed.

- A caseworker should not have more than 20-25 cases at any given time. This needs to be monitored closely by supervisors who understand that some cases will require more support depending on client needs or the stage of the case management process.

- Caseworkers should speak the same language as the clients they support whenever possible. When not possible, interpreters should be engaged.

- There should be both male and female caseworkers. Clients might have a preference as to the gender of the caseworker they want to talk to. This should be established as early on in the process as possible.

- Supervisors should oversee not more than 5 to 6 caseworkers to allow for proper support to caseworkers, mentorship and due-diligence checks to happen.[76]

- IMS will need to be supported by an information management assistant or officer.

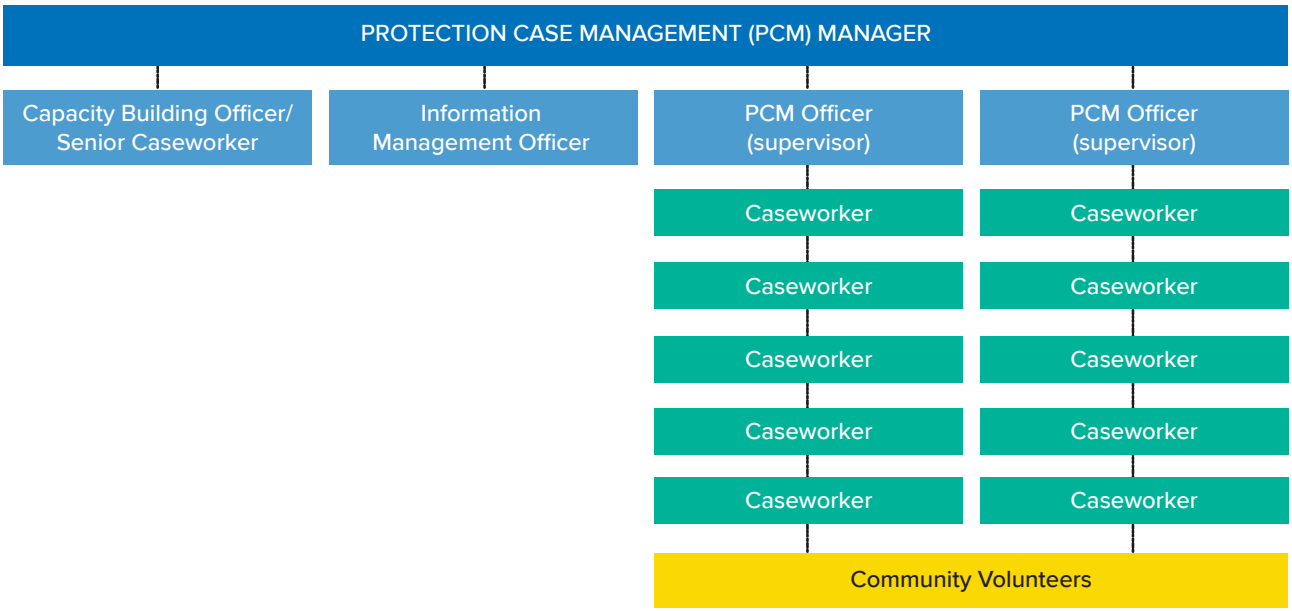
- Ongoing training, learning and capacity building is necessary for staff. It can be helpful to have a capacity building officer, where possible.

Using volunteers to support caseworkers.
There might be some clients who, for a period of time, may require more regular visits by caseworkers, for example, an older person who is unable to care for themselves and without a caregiver may require daily visits. Where safe and appropriate, volunteers from within the community can support caseworkers. In Syria, this was done by connecting with community health outreach volunteers living in the same villages, while in Uganda, focal points were recruited within the case management team to support caseworkers in this way.[77] Volunteers have also played an important role during the delivery of remote case management services that was required in response to the COVID-19 outbreak.

[76] As recognised by established sources for supervision ratio standards, the Child Welfare League of America and the Council on Accreditation, and the Child Protection Supervision and Coaching Package.
[77] Examples shared from the International Rescue Committees Protection Case Management Teams in Uganda and North East Syria.

You can staff your case management services in different ways. This will depend on your resources and your context.

FIGURE 9: Example of a protection case manaegment organogram



Community volunteers can be helpful to support caseworkers in visiting clients who require daily or frequent visits until more sustainable care arrangements are put in place. Similarly, it can be helpful to have a *capacity building officer* who has the experience and technical skills to support the mentorship and training of caseworkers on an ongoing basis. This staff member can also provide safe identification and referral training to other organisations. Please see Annex 7 for Case Management Staff Key Roles and Responsibilities.

3.F Your budget

Quality protection case management services must be adequately resourced. Your budget will be influenced by your mode of service delivery and your operational context. Here are some key budget considerations.

Category	Sub-Category	Reason
Office set-up	Storage cabinets with locks for information management, such as case files. Phone for hotline calls.	Data protection and self-referral purposes
Comfortable, accessible and private space to meet individuals.	Ensure comfortable and private seating for one-on-one meetings that can be accessed by all individuals - comfortable chairs, pillows, carpets, curtains, door locks, adequate lighting outside.	This will depend on your mode of service delivery and your entry point for intake. You may simply set up a room in a community centre or health centre or set up the centre itself as part of your strategy. For community centres, consider having a waiting room with water, toilets and a children space.
Accessibility and universal design See tips for inclusive budgeting below.	Permanent changes in infrastructures and information to ensure access for all. E.g. ramps, handrails, wide entrances for buildings and latrines, adjusting height of door handles.	Ensure no barriers are preventing anyone from fully participating in services.
Reasonable accommodations See tips for inclusive budgeting below.	Interpreter, requisite adaption of infrastructure.	For instances where a client requires additional support to participate in services.
Staff salaries	Caseworkers, supervision officers, case manager, information management officer, community outreach focal points, volunteers, monitoring and evaluation staff.	This will depend on the number and type of your staff in line with your staffing structure. It is recommended to have an IMS Officer to manage your IMS system for case management.
Staff equipment	Computers, tablets, phones, phone costs.	Work phone for caseworkers to contact clients and to be contacted.
Supervision & training	Training venue, training material	Capacity for ongoing training sessions, support and supervision is essential for providing quality services. In contexts where there are limited external services, more emphasis will have to be placed on caseworker capacities and skills to provide direct mental health and support.
Transportation	Vehicle, fuel and maintenance.	For example, for home visits or to support a client in accessing a service.

Communication with communities	Materials and leaflets on services, hotline cards, development of materials in different formats, holding community meetings, complaint boxes, hotline.[78]	For two-way communication with clients. To ensure accessible channels for complaint and feedback. This will depend on consultation with the community.
Information management system	Dependant on your IMS system	For organizations using tablets to collect, store, organize and protect client data.
Cash	Cash amount appropriate to context.	For supporting clients in meeting their protection outcomes, such as for safety or dignity.

Inclusive budgeting tip sheet[79]

What is it? Inclusive budgeting is when costs to address barriers, promote participation, and provide targeted activities for persons with disabilities are incorporated into the budget during planning. You can add lump sums or percentages to budget for these costs either included within other activities or in separate budget rows.

What costs should you factor into inclusive budgeting?

- Physical accessibility
  - Accessibility should be planned in advance and be implemented in time. Standards recommend that to provide for physical accessibility (e.g., in the construction of buildings and WASH facilities), an additional 0.5-1% should be budgeted for.[80]
  - Retrofitting is more expensive! For example, the cost of making a centre latrine accessible is less than 3% of the overall costs of the latrine, and can be less than 1% if planned from the outset.[81]

- Accessible communications
  - Beyond physical accessibility, include in the budget the cost of accessible communications: e.g. publication and dissemination of messages in diverse formats and media accessible to persons with disabilities – subtitles in video announcements, developing information in easy-read/plain language formats, etc.

- Reasonable accommodations
  - In addition to accessibility, you can keep a flexible budget line to provide for reasonable accommodations. Reasonable accommodation is a client measure that benefits a given person who finds barriers to accessing a service; nevertheless, it can have collective benefits: covering costs for personal assistants or sign language interpreters, covering costs for accessible transportation, covering costs for a transportable/temporary ramp can benefit many, providing outreach services if a person with a disability cannot access centre-based interventions, etc.

- Specialized non-food items (NFIs), such as adult-sized diapers, adapted crayons
  - In general, it is recommended in situations where assistive devices can be considered to be part of a reasonable accommodation measure for case management that this is an objective of the case action plan and is accessed in coordination with health service providers and not included as part of a case management budget.

[78] Best practice is to coordinate with other agencies that already have a hotline to avoid setting up multiple hotline numbers for the same service in the same area. This can be confusing for people.

[79] This is adapted from the IRC Inclusive Budget tip sheet which drew from the IASC, *Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action*.

[80] For more information see, Age and Disability Consortium, *Humanitarian Inclusion Standards for Older People and People with Disabilities*, 2018,available at: https://reliefweb.int/sites/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf

[81] For more information see UNICEF, *Including Children with Disabilities in Humanitarian Action*, 2017, available at: http://training.unicef.org/disability/emergencies/index.html

3.G Your minimum standards & protocols

Case management teams need to have clear written protocols regarding the case management process in their programme so that every caseworker and supervisor is following the same steps, using the same forms and following the same procedures. This should be reviewed and updated every 6-12 months. Where possible, your standard operating procedures (SOPs) should be developed in cooperation with the national protection sector. However, where this is not relevant you will need to develop your own.

A protocol should include the following:

- **Guiding principles:** The SOP should be in line with your guiding principles to ensure services are rights based and client centred.

- **Case management procedure:** This briefly outlines the case management steps in the country, making them as practical and specific to your context as possible.

- **Prioritisation of cases:** The risk factors and protective factors to support caseworkers to prioritise cases for intake. This should be based on your contextual protection analysis. Outline how regularly it should be reviewed.

- **Caseload:** The maximum number of cases a caseworker should be handling at one time. The best-practice guidance is between 20-25 cases per week; however, this may vary from location to location. Programmes may have to come up with a system for triaging cases to ensure that they see high-risk cases more regularly. The maximum number of caseworkers to be overseen by a supervisor should be not more than 6.

- **How 'high-risk' cases will be handled:** A high-risk case is usually one in which there is an immediate threat to the client's physical or psychological safety. Supervisors should define with their staff what they will define as a "high-risk" case and what the procedure will be for handling such cases. For example, to whom and when does the caseworker bring such a case to a supervisor's attention? Should they phone the needed service provider directly rather than sending an e-mail? When does the case management supervisor bring it to his/her manager for support?

- **Mandatory reporting:** The protocol should include mandatory reporting procedures and provide detailed guidance on how caseworkers should handle such situations. This includes when they report to the case management supervisor as well as when the supervisor must report this to their manager for support.

- **Case coordination and conferencing:** Clearly mapped areas of responsibility for case management agencies to support referral between case management streams. Established procedures for triggering case conferences for complex cases.

- **Referrals:** Updated version of the service mapping, referral minimum standards, and referral pathways.

- **Risk mitigation matrix:** Include what can be done to mitigate unintended harm and maintain client safety and security.

- **List of forms:** The protocol should include a checklist of the case management forms that a caseworker should be completing at each case management step.

- **Instructions for case filing:** The protocol should also include clear instructions for how digital and paper forms in case files should be organized and how the data should be securely stored.

- **Data protection protocol:** The protocol should outline steps to be taken to collect, store and share information so that it remains safe and confidential.

- **Complaint & feedback, including PSEA protocols:** Contacts and information that can be used to inform clients on how to report complaints and provide feedback.

Your protection case management service should align with the Protection Case Management Minimum Standards Checklist in Annex 8. These standards reflect core practices, approaches and requirements. Prior to delivering services, you can use this checklist to identify gaps in your case management system and to address them. You can also assess an active case management system against these standards and make the necessary adjustments.

Chapter 3: Key tools & resources

Prioritization
- Form 0: Prioritization Reference Tool
- Annex 3 Key Questions for Prioritisation

Service Mapping
- Annex 4: Service Mapping: Service Information Collection Form
- Annex 5: Service Mapping: Service Accessibility Audit

Information Management
- Annex 6: Data Protection Guidance

Protection Mainstreaming
- Protection Mainstreaming Toolkit GPC

Staffing
- Annex 7: Case Management Staff Roles and Responsibilities

SOPs/Minimum Standards
- Annex 8: Protection Case Management Minimum Standard Checklist

CHAPTER 4: DELIVERING YOUR SERVICES

"People are often doing amazingly well, the best they can at the time given the difficulties they face and the known resources available to them. People have survived to this point – certainly, not without pain – but with ideas, will, hopes, skills, and other people, all of which we need to understand and appreciate in order to help. Change can only happen when you collaborate with clients' aspirations, perceptions, and strengths and when you firmly believe in them."[82]

Training Modules:

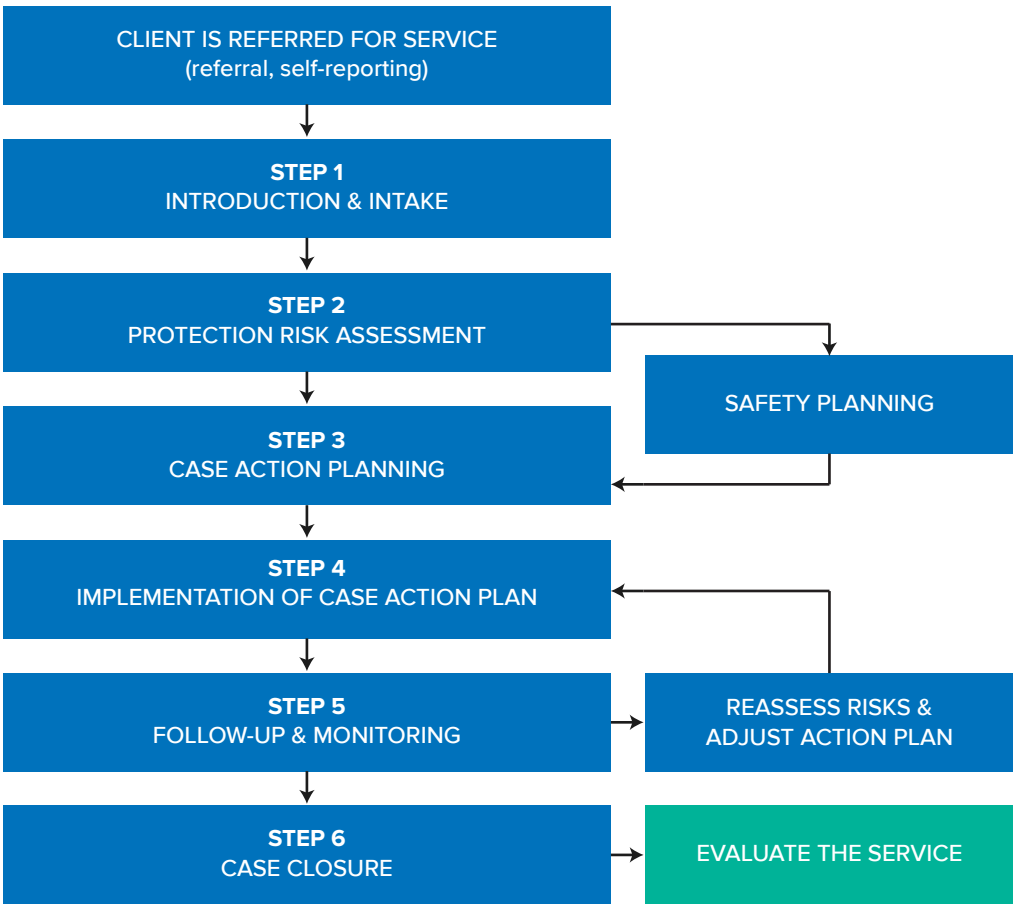
- **Module 5: Overcoming personal bias**
- **Module 6: Psychological first aid & communication skills**
- **Module 7: Step 1: Introduction & intake**
- **Module 8: Step 2: Protection risk assessment**
- **Module 9: Step 3: Case action planning**
- **Module 10: Step 4,5,6 Implementation, follow up & monitoring, case closure**

Overview of case management steps	
Case management step	**Key steps**
The case management process is not linear but flexible according to clients' needs.	
Introduction & intake	1. Introduction 2. Assess immediate safety risks 3. Address barriers to participation in the meeting 4. Begin the process of informed consent/assent 5. Determine whether to open a case file 6. Determine the risk level 7. Ask for permission to proceed
Protection risk assessment	1. Repeat introduction & intake steps 1-4 2. Assess risks and resulting needs 3.Assess protective strengths, capacity, resources and positive influences 4. Re-assess the risk level
Case action planning	1. Repeat introduction & intake steps 1-4 2. Summarize the assessment & check in 3. Define risks together 4. Agree on goals together 5. Agree on actions together 6. Carry out safety planning 7. Get informed consent for referrals 8. Make accompaniment plans 9. Document your case plan 10. Agree when/where to have a follow-up visit 11. Discuss any concerns with your supervisor

[82] Saleebey, D. *Introduction: Beginnings of a Strengths Approach to Practice: The strengths perspective in social work practice*, 1999, New York

Implementing the case action plan	1. Repeat introduction & intake steps 1-4 2. Direct service provision 3. Referral 4. Lead case coordination These steps are not sequential.
Follow up & monitoring	1. Repeat Introduction & intake steps 1-4 2.Follow up with your client & monitor progress 3. Reassess risks and revise your action plan 4. Ask for informed consent for further referrals If necessary, during the follow up stage you may need to develop a safety plan.
Case closure	1. Deciding when to close a case 2. How to document a closed case 3. Case transfer

THE STEPS OF PROTECTION CASE MANAGEMENT



4.A: Preparation is key

(i) CHECKLIST PLAN AND PREPARATIONS

Every time you meet with an individual you need to treat them as someone who may be affected by a traumatic or emergency incident. They may have lost a sense of safety and trust, may suffer from depression or anxiety, and may try to avoid thinking about or discussing any traumatic experiences.

If you are well prepared before you meet with an individual you will be in a better position to establish a rapport with them, manage your expectations of them during the meeting and be ready to address with any difficulties which might arise. It will also help you to manage your own stress levels and reactions.[83]

BEFORE EVERY MEETING YOU SHOULD

■ Familiarise yourself with all the available information you have within the case file and ask yourself questions such as:

- Have I agreed a preferred date, time and location with the client?
- Have I already checked with my client whether any adjustments need to be made so that they can participate in today's meeting and make any decisions needed? This may be supporting their understanding and communication, such as adjusting your communication style or requesting an interpreter or ensuring they can reach, enter, circulate and use the meeting space or referral venue
- What is the purpose of today's meeting?
- How was the client's mental health and psychosocial wellbeing last time we met and how may that have changed?
- Are there any client requests or actions, such as referrals or wanting to have a different gendered caseworker, that I should have followed up on and which need arranging prior to meeting with them?
- What are the client's strengths that I can support the client to build on?
- Is there any specific information that I should share with the client to support them as discussed last meeting?

■ Make sure you always take an up-to-date and accurate service mapping with you, ideally that has information on safety and accessibility, so you can provide the client with full information about the service options available to them and how to access them.

■ Make sure you always take any useful information and awareness materials, including hotline cards or other important contact information, with you in case you need to share this with the client.

■ If, for any reason, you need to have a challenging conversation with the client, make sure you have a flexible plan for your time and think about the best way to approach the subject beforehand.

■ Refresh your memory of healing statements to use with your client.

■ Make sure the client's case file is up to date before you meet with the client.

■ Make sure you have followed through with the client's request for having a male or female caseworker.

[83] UNHCR, *Interview Learning Programme: My Workbook*, 42

Client preference for having a male or female caseworker should be established at the earliest stage possible. If the preferred gender is not available, consider the option of involving a caseworker from SGBV or CP teams of the gender requested by the client to address the immediate needs. If it is impossible to find a colleague from that gender and it is safe to do so, you can postpone the risk assessment phase to a later date after having assessed a client's immediate safety and security, and determined whether they are at heightened risk. You must explain to the client that their case will be transferred to another caseworker of the requested gender for future assessment and follow up.

PREPARE THE PHYSICAL SPACE

- Make sure you have allocated plenty of time in order to avoid rushing the client during the meeting.
- Have any stationary you need in the meeting with you.
- Have properly arranged case file documentation, including any documents you need to get signed such as referral forms or interpreter disclosure forms.
- Take your phone with you but do not interrupt by using your phone (unless for security calls) and do not place it on the table.
- Think through any possible safety or security implications of the meeting space.
- Unless unsafe to do so, make sure you are visibly wearing your staff ID card when you visit
- For a checklist of tips on how to arrange an **inclusive meeting**, see your toolbox at the end of this chapter.[84]

Step 1: Introduction & intake

WHEN & WHY
On initial contact with a potential client. To establish a rapport with the individual and to determine whether to open a case file for case management services. Caseworkers will need to recognise whether someone is at heightened risk and be familiar with their organisation's prioritisation criteria to determine whether case management is the most appropriate intervention for them.

DOCUMENTATION
1. Prioritisation Reference Form 0
2. Introduction & Intake form 1
3. Consent form 2a
4. Easy read consent form 2b

KEY STEPS
1. Introduction
2. Assess immediate safety risks
3. Address barriers to participation in the meeting
4. Begin the process of informed consent/assent
5. Determine whether to open a case file
6. Determine the risk level
7. Ask for permission to proceed

Repeat these steps 1-4 at the beginning of each step.

[84] Light for the World, *Resource Book on Disability Inclusion*, 2007, 65, available at: https://www.light-for-the-world.org/sites/lfdw_org/files/download_files/resource_book_disability_inclusion.pdf

The introduction and intake phase is designed to allow you to have an initial discussion with a potential client to determine whether they face a specific risk and to determine the risk level without asking questions, which the person may be worried or embarrassed to answer before they know you better. A person's age, gender, culture, health condition, trauma experiences and expectations of the future and varying capacities **can affect a person's ability and willingness to recount experiences and to trust you**. Some people may tell you everything, while others may find it harder to open up.[85] Do not pressure the person to answer any questions or provide more detailed answers than they want to. **This initial discussion allows you to respect the person's need to have a sense of control during the process.**

However, there may be situations where the conversation naturally moves into more specific or detailed information, as found in the protection risk assessment form. This may be where:

- You determine the person to be at heightened risk and they are comfortable and forthcoming with providing information;

- You are unsure whether someone faces a specific risk and you find it useful to draw on some of the questions in the protection risk assessment form that are more prescriptive.

In these situations, you may find that you complete all or part of the introduction, intake and protection risk assessment in the same meeting.

Registration staff registering refugees with the State/UNHCR can play an active role in supporting the identification and referral of persons at heightened risk of a rights violation.

This can be a unique opportunity for early identification and appropriate referral of persons at heightened risk of rights violation(s) to protection case management service providers.

- Make sure you have established a safe and private area where you can speak to people confidentially.

- Establish the registration site in a location that allows individuals to reach, enter, circulate and use it.

- Make sure that disability data is captured for individuals using the Washington Group Questions.

- All registration staff should be trained on safe identification and referral and be equipped with an accurate and up-to-date mapping of services and referral pathways for case management;

- All staff should be trained in psychological first aid and how to respond to individuals in immediate crisis situations.

- There should be a balance of both female and male registration staff to support access for women and girls.

- Train receptionists at registration centres/locations on the prioritisation of persons-at heightened risk or who are in emergency situations to fast-track registration processes and to support safe referrals.

- Arrange access to interpreters to support communication for speakers of minority languages, sign language, etc.

For more information, refer to the UNHCR registration handbook available at: UNHCR Registration Handbook

[85] UNHCR, *Interview Learning Programme: My Workbook*, 21

(i) INTRODUCTION

INTRODUCE YOURSELF - SCRIPT TO THE PERSON

My name is _____[insert name]. I am a caseworker for the_____[insert name of organization]'. I am glad that you have contacted us/I received your referral from_____ [insert name of organization].

As agreed, I am with _____ [insert name] who is the interpreter who will help us to communicate. This is the only role of the interpreter. S/he is both impartial and neutral. If you have any questions throughout the interview today, please direct them to me and not to the interpreter.

May I ask how you prefer me to call you? _____. Thank you [insert their name]. I am here to listen to you and to see whether we might be able to support you. Before we start, do you feel safe and comfortable talking to me here or would you prefer us to go to another place?

CREATE A COMFORTABLE, SAFE AND PRIVATE SPACE

Make sure the physical space you are in is private, accessible and comfortable, and that your client can understand and communicate with you. Try to build rapport from the get-go and retain these communication skills through every stage.

Here are some tips:[86]

- **Communicate concern** to your client using empathy and active listening as if the client's feelings are your own.
  - That sounds like it was very challenging, upsetting, frightening for you.
  - You have been through a lot.
  - That must have been a painful experience.

- **Verbal & non-verbal skills** also communicate to the client that you are listening to them.
  - Be sure that your body posture begins and remains open (i.e. avoid crossing your arms or sitting away from the person) and that you are facing the person but remain respectful of local customs.
  - Where culturally appropriate, keep eye contact and mirror the client's language. For example, using any local idioms of distress they might use to convey a sense of understanding and respect for the client's experience.
  - Express similar emotions to theirs by your facial expressions.
  - Use brief verbal indications that you are listening such as 'okay', 'I see'.

- **Praise openness** to help your client feel comfortable talking about personal, difficult or embarrassing topics.
  - Thank you for telling me that.
  - I understand it isn't easy to talk to me. I think it can be helpful for your recovery.
  - You were very courageous sharing those intimate feelings with me.

- **Validating** their problems means letting them know that their reactions are understandable and normal.

[86] World Health Organization (WHO), *Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity*, 2018, 21-24, available at: https://apps.who.intWHO_MSD_MER_16.2_eng.pdf;jsessionid=sequence=1

However, do not tell the client you know what they are going through. It can have the opposite effect to validating their experience.

- You have been through a very difficult experience and it isn't surprising you are feeling this way.
- Many people I have worked with are also feeling this way.
- This is a common reaction a situation like this.

■ **Put aside your personal beliefs and values** by respecting your client's beliefs and values. This means listening to your client without opinion.

■ **Speak in a calm, not loud voice; avoid changes in mood and attitude at any time toward the person.**

■ **Avoid giving advice** by telling your client what to do and not to do. This will undermine your client's ability to manage their own problems.

For tips on how to communicate with persons with disabilities, including persons with visual impairments, speech difficulties, deaf or hard of hearing, physical impairment, intellectual disability, learning difficulty or mental health and psychosocial disabilities, refer to: https://www.light-for-the-world.org

Remember do not focus on your notes or forms. While documentation can be useful to record information, you should set it aside and try not to fill any forms in front of the person or be on your tablet or laptop. You should focus on the person and on providing help. You can complete your forms once back in the office. If you wish to take notes, you should always ask.

(ii) ASSESS IMMEDIATE SAFETY RISKS

AN IMMEDIATE CRISIS SITUATION

If a client appears very upset or with active suicidal thoughts and exhibits out of control behaviour, or appears to be in danger, follow these steps:

1. **Stay calm and reassure the client** that you are grateful they shared this crisis with you and you want to help them. Do not yell, react strongly or get angry with the client. Use your active listening skills.

2. Explain to the client that you would like to talk with your supervisor right now. **Contact your supervisor immediately**. Talk to your supervisor while the client is still with you. **Decide, or agree on a plan BEFORE the client leaves.**

3. If you cannot get in touch with your supervisor and the client does not have someone who can be with them 24/7, **arrange for the client to be referred immediately to the health clinic or somewhere safe and supervised until you can contact your supervisor**. This may require the caseworker to stay with the client if there are no other options.

You can use grounding techniques to calm and reassure the client:
You can say: 'You seem very scared or worried. Let's try to stay in the present. Take a slow deep breath. Relax your shoulders.'

- Ask the client to inhale through the nose and exhale through the mouth. Have the client place their hand on their abdomen and then watch their hands go up and down while the belly expands and contracts.[87]

URGENT MEDICAL SITUATION

For immediate urgent medical needs, such as severe bleeding or extreme pain, take action to get medical help with the individual's verbal consent. This may mean linking the client directly to a health clinic or hospital. For life-saving medical services involving financial cost, make sure to save receipts and invoices for future payment. For lifesaving medical cases, it is always useful to have the national ambulance service or the Red Cross or Red Crescent number to hand.

For cases where someone may put themselves and/or others at risk of harm, emergency referral should be done to the relevant player, depending on the situation. In situations of risk of suicide or self-harm refer to the relevant MHPSS case management services or for specialised MHPSS services, where there are no referrals to local health facilities or other relevant protection services that can be an option. **Make sure not to put the client at further risk by this external referral, for instance in countries where attempted suicide is criminalized, or where referral to a health facility can be harmful.**

(iii) ADDRESS BARRIERS TO PARTICIPATION IN THE MEETING

In situations where it has not been possible to prepare support for your client in advance, you will need to assess any barriers they might face in participating in the session. They may face barriers in their physical environment, if they are unable to reach, enter, circulate and use the location you are meeting in. There may also be information and communication barriers in understanding and communicating with you so that they can provide informed consent. Social and attitudinal barriers may arise if there are any indications on your part, as a caseworker, of discriminatory behaviour towards them due to biases or prejudices. You must address these barriers as soon possible with the client so that you both agree on what reasonable accommodations are required and how you can put them in place to support their full participation.

You will need to agree on how to communicate together when seeking informed consent. For some people, it will be a matter of adjusting your communication style so that they can understand you. But for others, you may need to make some **further adjustments before you proceed with the session and the informed consent process.**[88]

[87] Center for Substance Abuse Treatment, *Trauma-Informed Care in Behavioural Health Services*, 2014, chapter 4, available at: https://www.ncbi.nlm.nih.gov/books/NBK207188/box/part1_ch4.box5/?report=objectonly
[88] Excerpt adapted from the *Inter-Agency GBV Case Management Guidelines for Survivors with Disabilities*, 2017

(iv) BEGIN THE PROCESS OF INFORMED CONSENT/ASSENT

As explained in Chapter One, Your Guiding Principles, the process of asking for informed consent should follow the following steps:

1. Address barriers to providing informed consent by supporting decision-making
2. Explain the case management process and their rights
3. Explain confidentiality and its limits
4. Explain risks and potential benefits
5. Ask whether there are any questions
6. Ask for permission to proceed

STEP 1: ADDRESS BARRIERS TO INFORMED CONSENT BY SUPPORTING DECISION-MAKING

You need to involve your client in this discussion. In situations where communication is challenging, a person cannot lose their right to provide informed consent simply because they face barriers to accessing information and communicating. **You must adjust your way of communicating for your client** to achieve their **meaningful participation** and **meaningful informed consent** to, or refusal of, case management services.[89]

Supporting decision-making for informed consent[90] – script to the person:
'I will do my best to support your participation in this process, particularly so that you feel you can understand and communicate with me well but also so that you easily reach and use the spaces that we meet in.'
In terms of our communication, please feel free to stop me and let me know at any time during our session or following sessions if you need any form of support to understand or communicate with me and what support you need. For example, I can show you a consent form that is easier to read, I can arrange for a sign language interpreter, or if you would like you can also ask a trusted individual to support you to understand or communicate through our conversations and the informed consent process.
Depending on what support you need, it may take me a few days to arrange it, but I will try my best. If I am unable to arrange it for any reason, I will let you know and we can try to arrange another source of support.'

Offer information in the form that the client asks for, or in a form you believe the client will understand (e.g. language they feel comfortable communicating in, sign language, easy to read consent form). **You can watch for any signs that they agree or disagree with the suggestions being made**. For tips on communication with persons with disabilities please see the toolbox at the end of this chapter.[91]

[89] In CRPD, and related General Comment on Article 12, available at: www.ohchr.org/Documents/HRBodies/CRPD/GC/DGCArticle12.doc
[90] Adapted from IRC, Guidance for Focus Group Discussions, *A Scoping Study on Strengthening Accountability & Inclusion of Persons with Disabilities in Humanitarian Action through Client-Responsive Programming*.
[91] Light for the World, *Resource Book on Disability Inclusion*, 2007, 52-56, available at: https://www.light-for-the-world.org/sites/lfdw_org/files/download_files/resource_book_disability_inclusion.pdf

Addressing communication barriers: If you are working with a person with whom you are having difficulty communicating, ask yourself the following key questions:

- *Did you try more than one method of communicating the information? Have you given them time to process this information and ask questions?*
- *Did you allow the client to express her/his preferred way of communicating, and arrange for any reasonable accommodation (e.g. involving simultaneous or sign language interpretation)?*
- *Are you able to determine whether the client understands the information provided and the consequences of any decisions they may make? How did you determine this? (E.g. through questions, discussions, gestures, writing, pictograms, or other forms?)*
- *Have you been able to ensure that the client's decisions are voluntary and not forced or coerced by others? How did you determine this?*
- *Is a caregiver or family member already involved? If so, how? Are they answering the questions you ask without consulting the client?*

If, after reflecting on these questions, your client requires further communication support and/or you are still unsure about your client's capacity to consent independently, you should involve a supervisor to advise whether you need to provide further support.

FURTHER CONSIDERATIONS FOR SUPPORT

You can consider the following two steps in order:[92]

1. **Where safe, involve a trusted support person or interpreter to facilitate understanding and communication with your potential client**. If safe to do so, ask your client for their permission to include someone they trust or an interpreter to facilitate their communication and to enhance their ability to provide or refuse informed consent. You will need to carefully check that the support person does not act *on behalf* of the client but only *supports the process*.[93] Let the client independently identify who they would like to involve, and watch for any signs that they agree or disagree with the suggestions being made.
    - It is good practice for clients to sign a consent form to confirm they agree to the presence of an interpreter in the meeting. You can find examples at the bottom of the Informed Consent Form 2A and the Easy Read Consent Form 2B. Interpreters will need to sign a non-disclosure agreement, which can be found in Form 3 Interpreter Non-Disclosure Agreement, warranting that they will not breach confidentiality. This agreement must be signed by the client and the interpreter.

2. **As a last resort**, you can use the following guiding principles to **evaluate whether the specific decision you are posing to your client is in their vital and best interests.**[94] This means taking a decision *based on the best interpretation of the will and preferences of the client* only where it is *'necessary in order to protect the essential interest for the person's life, integrity, health, dignity or security.'*[95]
    - *Safety:* Does the decision or action protect the client from potential abuse (physical, emotional, psychological, and sexual, etc.)?
    - *Empowerment:* Is the decision or action in line with the best interpretation of the will and preferences of the client?
    - *Cost-benefit analysis:* Do the potential benefits of the decision or action outweigh the potential risks?
    - *Healing:* Does the decision or action promote the client's overall healing, growth and recovery?

[92] Excerpt adapted from the *Inter-Agency GBV Case Management Guidelines for Survivors with Disabilities*, 2017.
[93] Even caregivers are rarely legally permitted to consent to or refuse support on behalf of a client.
[94] UNHCR, *Policy on the Protection of Personal Data of Persons of Concern* to UNHCR, 2018, 17.
[95] Ibid. 14.

Form 9 - Supported consent and best interpretation of will and preference flow chart:
This helps a caseworker to navigate the informed consent process with clients, by helping the caseworker to provide adequate support, and determine when, as a last resort, it may be in the best interest of the client to get consent from a family/caregiver or to take action based on the best interpretation of the will and preferences of the individual. The flow chart helps you to *select the appropriate measure*[96]

CONSIDERATIONS FOR OBTAINING AND DOCUMENTING A CLIENT'S CONSENT

In instances where capacity to consent by the client has been confirmed, ensure that **consent is given voluntarily**; allow sufficient time for the client to understand, consider the information, and ask questions. If the client requests additional information, provide a timely response.

- **Remember:** Consent must be related to a specific proposed case management process. It is given at a particular point in time and in relation to an individual question (consent to a specific aspect(s) of case management) - and should be documented relative to each decision.
- **Remember:** The person obtaining consent should be knowledgeable and well informed about the conditions and proposed services available when entering the case management process.
- **Remember:** Caseworkers should continue to share information, listen to client ideas and opinions, and explain how and why decisions have been made. This interaction will also assist in monitoring changes in capacity over time and with different types of decisions.

Once you have established your client's participation in the session, you can continue with the informed consent process.

STEP 2: EXPLAIN THE CASE MANAGEMENT PROCESS AND THEIR RIGHTS

Explain the case management process, what usually happens at this stage of the process, and what their rights are throughout the process. You can use the image of the protection case management process at the beginning of this chapter to help you explain, if it would be helpful.

For example: script to the person
It is important that you have a clear understanding of what this case management service is. Case management just means that we will talk together about what support you need and I will support you to put in place goals to address these challenges and connect you to the right services.

For us to be able to work together, I will need to ask you about your background and your current situation. In the session today, it would be useful for me to understand a bit more about your situation so that we can see whether our case management services would benefit you and whether we have the right expertise to support you.

[96] Women's Refugee Commission (WRC), IRC, Tool 9: Guidance for GBV Service Providers: Informed Consent Process with Adult Survivors with Disabilities, 2015, available at: https://reliefweb.int/sites/reliefweb.int/files/resources/GBV-disability-Toolkit-all-in-one-book.pdf .

It is important that you know your rights during this process. *At any time during the session and the process, please feel free to:*

- *Not answer my question if you don't want to, and you can always ask me to stop, take a break or slow down*
- *Let me know if you need me to repeat any questions or explain information in more detail*
- *Let me know if you need me to adjust the way I am communicating with you to support you to understand or communicate with me or to make any other adjustments that would allow you to participate fully*
- *If at any time you feel you can work better and talk more easily with someone else other than me of a different gender or for any other reason or you want to work with another organisation, feel free to tell me; this would have no negative consequences*
- *Ask for your information not to be documented, request to see your case files or other case notes.*
- *Refuse referrals to services if you don't want them, and stop the case management process at any time*

STEP 3: EXPLAIN CONFIDENTIALITY AND ITS LIMITS

Emphasize your commitment to confidentiality and that all information shared will be kept strictly confidential. Their data will be stored safely and only the minimum information will be shared after their consent for any services needed. Exceptions where confidentiality must be broken, which are intended to protect them and others, also have to be clearly explained, emphasizing that breaking confidentiality does not automatically mean that authorities will be involved.

Script: Confidentiality & its limits. *Whatever you tell me during this meeting and the whole process will be confidential. This information will stay between us, including any notes I write down during our meeting(s). Any forms or information I collect during our meeting will be stored safely and I am the only person who will be able to access this information. This means that, without your permission, I will not tell anyone what you tell me and only share limited information with service providers for you to receive services only after your consent. We will make sure, as far as possible, that your participation in this process is not known by anyone.*

However, there are a few situations where I may have to speak to someone without asking your permission. If you tell me that you want to hurt yourself, I may have to tell my supervisor or others who could keep you safe. Or if you want to hurt someone else, I may have to tell the relevant authorities to prevent that. And finally, if a UN or humanitarian worker has hurt you, I would need to tell my supervisor and report what this person has done to stop them from hurting anyone else.

Sharing information at these times is meant to keep you safe and get the best help for you. Other than these times, none of your information will be shared without your permission.

STEP 4: EXPLAIN THE RISKS AND POTENTIAL BENEFITS

You will need to explain the risks of participating in protection case management services before intake into case management and before any referrals are made. Risks/benefits to the client as a result of case management services or referrals will need to be tailored to your context and specifically to your client, depending on their situation. Therefore, you may only be fully aware of these after you have heard the client's story. Nevertheless, you should still explain any risks/potential benefits you are aware of prior to hearing your client's story and then further expand on these after your discussion but before asking for consent to proceed with case management services or a referral.

Risk(s):

- Loss of confidentiality, meaning that someone outside of this session could find out what we discussed and your information could be accessed. This might happen if your file was lost or misplaced or there was unauthorised access. *Explain that you will take all possible precautions to keep his/her engagement in this process confidential. Provide details of your data protection protocols.*
- Your anonymity could be compromised if we don't meet in a safe and private place. This is why it is important for you to think carefully about the safest place you would like to meet.
- There may not be the services available of a good quality to manage your client's risks. *Explain that you will make every effort to connect them to those services that do exist.*

Potential benefit(s):

- We will work together to try to identify some solutions to your problem.
- We will provide you with information on the options available to you and work together to help you reach a decision that is the best for you.

STEP 5: ASK WHETHER THERE ARE ANY QUESTIONS

Ask whether they have any questions about the information you have shared, including whether they have understood the case management/referral service and their rights. People may need time to collect their thoughts and think about the information you have shared, especially when thinking about their safety. Do not rush them and make sure you give them enough time to answer you.

STEP 6: ASK FOR PERMISSION TO CONTINUE

If the client has understood the service and their rights in relation to it, ask whether you can proceed to ask them some more questions about their general situation to see whether you are in a position to support them. Ask them for their permission to take notes during the session.

Note: If another service provider has visited the person previously and the client has informed the provider of their situation, in order to avoid clients going through their story again ask whether they want to tell their story again or give consent for you to receive it from the other organisation.

Do you agree to participate in the meeting?	Yes ☐ No ☐
Do I have your consent to document your responses on a tablet/paper?	Yes ☐ No ☐
Do I have your consent to receive your information from the other organization	Yes ☐ No ☐

IF YES: Proceed to ask more questions to determine whether to open a case file
IF NO: Provide information about available services to the person verbally and provide information materials and any relevant hotline numbers should they wish to receive services in the future. If they require a one-off service or advocacy action, then proceed to conduct a quality referral.

(v) DETERMINE WHETHER TO OPEN A CASE FILE

Caseworkers need to determine if the person has experienced/is experiencing or is at immediate risk of experiencing a rights violation. The questions in Part B, Form 1 Introduction & Intake are not intended to be prescriptive and should be used as guidance only.

COLLECT BASIC BIO-DATA

Caseworkers will need to collect demographic data on the person's age, gender and disability. To determine whether someone has a disability, the introduction and intake form has integrated the **Short-Set of Washington Group Questions (WGQ-SS)** on disability. This information does not help with referrals, nor with understanding the type of disability a client has; **it just indicates whether or not they have a disability.**

Collecting data on disability: What are the Washington Group Short-Set of Questions (WGQ-SS) and why use it?
Caseworkers must facilitate the **full and effective participation of persons with disability in our services.** *'People with Disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others'.*

The WGQ short set helps us to identify disability by understanding who has difficulty doing basic universal activities (walking, seeing, hearing, cognition, self-care and communication) and who therefore may be at greater risk of not participating in home and community life. These six questions are non-stigmatizing, do not require medical knowledge and use simple and natural language to refer to disability without using the word 'disability'. That is important because we know that using the word 'disability' can affect the way people respond. They have been used and tested extensively in many countries and contexts.[98] **You must ask these directly to each person.**

You can ask these questions to people over 18 years old. There are additional question sets if you have additional information needs.
The different WGQ data sets:
• **Persons with mental health and psychosocial disabilities:** For better determination of people with mental health and psychosocial disabilities. The Enhanced Short-Set can be integrated into the forms for protection case management.
• **Extended Set:** Extended Set of Questions
The **cause of the disability and the time when the disability occurred** are not captured in the WGQ-SS questions; if this is useful, you can add them using the following example: Fact Sheet- Temporality and Causality

Remember these questions do not identify particular health conditions or impairments **but capture the possible impact of these conditions on a client's functioning. Contextualisation** of the questions or the response categories is not advised and will affect comparability of data.

You must make provision, when you organise your data, to be able to store responses captured through the WGQ and ensure that you are able to properly analyse these questions to produce binary yes or no answers. For more guidance see here: Step by step analysis of the WGQ

[97] UN Convention on the Rights of People with Disabilities and optional protocol (CRPD), Article 1.
[98] From the statement of rationale for the Washington Group general measure on disability, available at: http://www.washingtongroup-disability.com/washington-group-question-sets/short-set-of-disability-questions/

There are 3 key papers outlining the rationale and use of the WGQ:
Short set rationale: Short-Set rationale
Purpose of disability measurement: Purposes of disability measurement page
General discussion of the topic including with official translations, and other question sets can be accessed here: Methodology and Research

How you ask the WGQ-SS matters:
Caseworkers should be trained in and feel comfortable with asking the questions and interviewing persons with disabilities. All respondents should be treated with respect and dignity.

- While the questions are simple, it is essential that the questions are asked exactly as they are written, including response categories.
- Repeat questions if needed without giving further explanation or examples as this will affect the quality of the data.
- Ensure the word disability is never mentioned – especially to introduce the questions, since this may bias the response and affect the quality of data collected.
- Data should not be recorded based on observation or assumptions made about the respondent and whether they can or cannot perform a particular activity, as they are best placed to know their difficulties. For example, if you see a wheelchair do not infer that the person cannot walk as this may not be the case. If the respondent has trouble hearing the questions but responds they do not have difficulty hearing, do not change the answer.

ASSESS WHETHER THE PERSON FACES A SPECIFIC RISK

Caseworkers should use broad, open-ended questions that prompt the client to start telling you the story in general terms. You can always go back for details if appropriate and needed. Let the person take breaks and tolerate silences. This can give them time to manage emotions and organize thoughts.

Tips for asking questions:[99]
Using **TED questions** can help you to encourage the person to think about their situation, reflect and provide you with an overview. They will also give the person concerned a feeling of control and help to avoid triggering traumatic memories:

- **T**ell me more...
- **E**xplain for me...
- **D**escribe what happened...

If you are unable to recognise whether the person is at heightened risk and you need more specific details, you can use **probing questions** to understand more: who, where, when, where, and how. Only ask such questions if the person is forthcoming with information. Make sure to be non-judgmental and neutral when you ask.

- *How come?*
- *For what reason?*

Remember: You may find that you naturally move into the protection risk assessment stage to gain a more comprehensive understanding of your client's risk(s), resources and resilience. You can refer to chapter 4, step 2 Protection Risk Assessment and Protection Risk Assessment Form 4). You will still need to determine the specific violation type and case risk level and ask for informed consent to proceed.

[99] UNHCR, *Interview Learning Programme: My Work Book*, 74

It can be helpful to have a form detailing each violation type with the correlated risk and protective factors in your context. This can help caseworkers to determine what specific risk(s) the client faces and can support context specific prioritization. Refer to Form 0 Prioritization Reference Form for an example.

A helpful technique to close the discussion can be to summarize the person's story in your own words to check that you have understood them and ask for any corrections.

DETERMINE THE RISK LEVEL

Determine the case risk level and flag any case that might require immediate attention. **Medium and high-risk cases should be prioritized for case management service**. You can refer to chapter 3, section A for more information on prioritisation considerations.

Determining the risk level of each client's situation will help caseworkers to prioritize a case appropriately within their broader caseload. It helps to determine the timeframe for intervention, indicates the frequency of visits needed and how frequently the client should be followed up. **Risk level determination is an ongoing process as someone's level of risk will change over time, depending on their circumstances**. Risk levels should be reassessed at all stages of the case management process, from introduction and intake to assessment and at each follow-up visit.

Whenever possible, individuals and households facing specific risks, including barriers, should be empowered and supported to access services and support by themselves. People who are in a position to do this do not require case management services and are considered **low-risk cases**. These clients should still be provided with information on access to available services and assistance, and be supported to decide how to address their problem. This may be through conducting a one-off quality referral or advocacy action or by informing how to access a service themselves.

Example of risk level

Low-risk level: Likelihood of a serious risk to individual safety is low, however an intervention to respond to individual specific needs may be required.	**Medium: Likelihood of a serious risk to individual safety requiring intervention within a week.** Bi-weekly follow-up required by phone and visit. The number of follow-ups will decrease in line with the individuals' needs.	**High: Serious and imminent risk to individual safety requiring immediate action within a maximum of 48 hours.** Depending on the situation, weekly follow-up is required by phone and visit. The number of follow-ups will decrease in line with the individuals' needs.

(vi) ASK FOR PERMISSION TO PROCEED

After you have finished your session with the person and determined whether the person is at heightened risk, you will be in a position to inform the person about the next steps.

- **If the client meets the prioritization threshold for intake into case management services and has fully understood the informed consent process, you must seek their permission to proceed to intake into case management services.**

- Before asking for consent to proceed with protection case management services re-explain the case management process, the person's rights, confidentiality and its limits, and the risks and benefits of the process.
- You should use an Informed Consent Form or an Easy Read Consent Form (Annex: Form 2A Informed Consent, Form 2B Easy Read Consent Form) which the client can sign/thumbprint. Where possible, this form should be kept separate from the rest of the client's case file to ensure adequate separation between the clients identifying information and details about their protection situation. This is especially important when storing data offline.
- Explain the next steps of the process, and agree on another date, time, and location to meet. Provide the client with the relevant hotline/work number and remind them of your name and organization so you can be contacted if needed.

- **If the client does not at this time meet the protection threshold for intake into case management services or if they do not wish to receive case management services for any reason, make sure to** inform them of available services in their area, provide relevant information and awareness materials, including hotline numbers, so they can access services at a later date if they wish. **If they can benefit from a quality referral** for a one-off service or advocacy action, you can ask for their consent to conduct the referral. Remember that people's situations change over time and a person may come back later and require re-assessment of eligibility.

Step 2: Protection Risk Assessment

WHEN & WHY
The protection risk assessment is necessary to gain a comprehensive understanding of the client's risks and resulting needs, resources and resilience, including their family composition, current living situation, etc., and to gather relevant information to be passed to other service providers if needed to facilitate referrals. It is designed to ensure that every client receiving case management services benefits from a consistent approach to evaluating their situation.
A risk assessment should be carried out within two weeks of a client's intake into case management. In some cases, risk assessment may be carried out at the same time as the introduction & intake step.

DOCUMENTATION
1. Protection risk assessment Form

KEY STEPS
1. Repeat steps 1-4 of the introduction & intake step if this meeting takes place at different times. (Introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process for informed consent/assent to proceed)
2. Assess risks and resulting needs
3. Assess protective strengths, capacity, resources and positive influences
4. Re/assess the risk level

The protection risk assessment builds on the information gathered during the introduction and intake step. **You should fill in any information you have already gathered during the intake step into the protection risk assessment to avoid repetition for your client.** The protection risk assessment sets the stage for the entire journey of the case management process. This journey can vary widely depending on the outcome of the assessment and the type of risks and protective factors identified. This process should help you and your client agree on goals and actions for the action plan. This process should be done through a semi-structured interview

asking questions that invite the client to participate. Remember, the protection risk assessment form is there to facilitate the documentation of this information but does not require you to ask every question with the client if they are not relevant.

(i) UNDERSTAND THE CLIENT'S SITUATION

ASSESS RISKS AND RESULTING NEEDS

In all situations, it will be the responsibility of the caseworker during each discussion with the client to assess their immediate safety and to ensure the appropriate ongoing prioritization of the case. Caseworkers should focus on understanding the client's environment and their place within it; who the client is, their potential needs for support and their urgency, as well as recognise positive, protective influences and strengths.

The following key areas should be assessed:

- **The nature of violence:** Is there an immediate risk of, or is the person experiencing, physical or psychological violence. Immediate medical care might be needed in these circumstances, but it is crucial to assess the safety of the client and whether such action might place them at increased risk of harm. If there is neglect, it is important to understand whether the nature of the neglect is intentional or not; is it due to lack of coping-capacity of the caregiver or a lack of available time or resources? If the client refers to a fear of violence, is this fear well founded? **The client should always enjoy the benefit of the doubt as to the likelihood of harm if any doubts remain after the discussion on the well-founded aspect of their fear.**

- **The relationship of the (alleged) perpetrator to the client:** The caseworker should understand the closeness of the relationship between the (alleged) perpetrator and client as this will have implications for immediate safety or longer-term psychological effects. Is the (alleged) perpetrator the partner or caregiver? Is the (alleged) perpetrator affiliated with State or non-State players? What is the (alleged) perpetrator's role in the household/community? What actions (if any) is the (alleged) perpetrator taking with regard to the case (e.g., legal action)? The caseworker must assess the level of influence over and access to the client as part of safety and action planning.

- **Frequency:** If the client has a history of recurring abuse, neglect, or exploitation, focus the assessment on the most recent incident so that you can understand the current needs. This does not mean that it is the most significant incident, but the client should not be asked to recount every incident in the initial interview. Should the client choose to recount a more complete history of the abuse, they should be welcome to do so.

Where your client is at risk of danger, such as killing, kidnapping, abduction, enforced disappearance, physical and emotional abuse and assault and so on, you should do a safety plan with your client to **analyse the risk of harm in their lives and think about how to reduce those risks**.
(Form 6 Safety Planning Form).

- **Housing:** The caseworker needs to understand their client's living situation. Living arrangements may create unique protection risks, such as increased safety risks, exploitation or isolation for the client if they are experiencing violence in the home.

- **Economic situation:** The caseworker needs to understand the economic conditions or requirements of the client to help resolve the protective issues. This includes assessing, if relevant, the extent to which the client can participate in decisions and choices about how money is spent and how much control they have over resources. Lack of control over resources can expose them to unique protection risks, such as neglect and exploitation. These questions should be addressed to the client confidentially, answered from their perspective and not the perspective of the income earner or family decision-maker.

- **Physical Health and mental health status:** The caseworker needs to understand the client's physical and mental health status, as this might shape their experience of harm, impact their relationships within the family and create unique protection risks that may lead to abuse, neglect or discrimination. Importantly, when considering physical and mental health, the two should not be thought of as separate. Poor physical health can lead to an increased risk of developing mental health problems. Similarly, poor mental health can negatively impact on physical health, leading to an increased risk of some conditions. Understanding the client's health situation will also impact any recommendations for required services.

- **Mental health and psychosocial status:** The caseworker should conduct a basic MHPSS assessment to get a better picture of the client's MHPSS status and to determine if a referral needs to be made to a MHPSS service provider as part of case management services. Prior to completing an assessment, it is important for protection caseworkers to review potential assessment options with their supervisor; select the 'best fit' based on the client population, context, and programming goals; complete an adaptation process of the assessment tool; and complete training on the tool prior to implementation. A list of options for MHPSS assessment tools available for review and selection are listed in the table below. Included in protection risk assessment form 4 that accompanies this guidance is the Patient Health Questionnaire-9 (PHQ-9) with minor adaptions.

MHPSS assessment tool	Description	Resource link
PSYCHLOPS	PSYCHLOPS is a short, one-page, mental health outcome measure and can be used during the course of any psychotherapeutic intervention	http://www.psychlops.org.uk/
*Patient health questionaire-9 (PHQ-9)	The PHQ-9 is a multi-purpose instrument for screening, diagnosing, monitoring and measuring the severity of depression	http://www.agencymeddirectors.wa.gov/Files/depressoverview.pdf
WHO Disability assessment schedule 2.0 (WHODAS 2.0)	WHODAS 2.0 was developed through a collaborative international approach with the aim of developing a single generic instrument for assessing health status and disability across different cultures and settings	https://www.who.int/classifications/icf/whodasii/en/
WHO well-being index (WHO-5)	The WHO-5 Well-Being Index is a questionnaire that measures current mental well-being (time frame: the previous two weeks)." Originally developed to assess both positive and negative well-being, this five-question version uses only positively phrased questions to avoid symptom-related language	https://www.psykiatri-regionh.dk/who-5/who-5-questionnaires/Pages/default.aspx

- **Access to services:** The caseworker has to ascertain whether the client is facing any barrier in accessing services and if so, the underlying and root causes of this situation. Is the client facing barriers because the service providers did not design the service in an inclusive way, safety considerations, disability, lack of available services or information about services, stigmatization or because of discrimination? Understanding these issues will be critical in the development of a case management action plan. See Chapter 3, section D for examples of barriers and enablers.

- **Need for legal assistance:** Gaps in knowledge about rights increases vulnerability to rights violations. Access to justice can contribute to a client's recovery and healing process and decrease likelihood of additional risks. If a client is facing barriers in accessing documentation, has experienced or is being accused of a rights violation, the caseworker should assess the client's needs and willingness to receive legal information or assistance. Everyone, even alleged perpetrators, have the right to access legal advice and legal representation. Civil status documentation, such as birth or marriage registration, is key for clients to be able to claim their rights. Caseworkers can facilitate access where clients do not have this documentation or where there are barriers to accessing it.

Access to justice: Considerations for statelessness: The total number of stateless persons worldwide is unknown. They are not considered as nationals by any State under the operation of its law. Statelessness is sometimes referred to as an invisible problem because stateless people often remain unseen and unheard. They often are not allowed to go to school, see a doctor, get a job, open a bank account, buy a house or even get married. Denial of these rights impacts not only the individuals concerned but also society as a whole, because excluding an entire sector of the population can lead to social tensions and significantly impair economic and social development.

Statelessness can be caused by a number of factors such as: discrimination in nationality laws (e.g. racial, religious or gender), conflict between and gaps in nationality laws and State succession. Being undocumented is not the same as being stateless. However, a lack of birth registration can put people at risk of statelessness as a birth certificate provides proof of where a person was born and of parentage – key information needed to establish a nationality. Risks of statelessness can also arise in situations of displacement. For example, in the context of the Syria crisis, the risk of statelessness is increased by a combination of gender discrimination in Syria's nationality law, coupled with a lack of civil documentation amongst the displaced population. For more information see: https://www.unhcr.org/ibelong/wp-content/uploads/UNHCR-Statelessness-2pager-ENG.pdf

ASSESS PROTECTIVE STRENGTHS, CAPACITY, RESOURCES AND POSITIVE INFLUENCES

All clients, their families and communities possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems. Caseworkers and supervisors must work to engage clients and families to play an active role in the case management process. Gathering information on a client's family, social, and spiritual life and strengths can help the caseworker to determine the extent to which a client may have protective and resilience factors that may support their healing and recovery. Do they have positive coping mechanisms? Are family relationships supportive? Are they members of a religious or community group? Is it safe and desirable for the client to rely on these contacts for support in this instance? Are there community members supportive of the client?

- **Strengths-based approach**: One approach to doing this is to have a focused discussion with your client about their strengths. This can lead to opportunities to develop and share skills and make new connections with people. To start this conversation, it has been helpful for caseworkers to focus on three key areas: what has worked for the client before, what does not work for them, and what might work in the present situation?

Areas you can explore:[100]

- **Client's situation, skills, interests**
  - o What are you doing/managing well?
  - o Tell me something you are proud of?
  - o What interests you?
  - o When people say good things about you, what are they likely to say?

- **Support networks, community connections, resources**
  - o Who are the special people you can count on?
  - o What connections do you have in the community?
  - o What role do you play in the lives of people you care about?
  - o Who supports you in your day-to-day life? In what way?
  - o What resources do you have around you to make this easier?
  - o How have you managed to survive this far given all the challenges you have faced?

- **Values, strategies**
  - o What are the things in your life that you really value?
  - o What are your ideas about the current situation?
  - o What has worked for you in the past/what have you tried?
  - o How have you adapted?
  - o What have you learned which could be helpful moving forward?
  - o What's one thing that you could do to take a step forward?
  - o What would you like to get out of our work together?

Caseworkers can list the strengths that are mentioned by their client.[101] See example below:

Individual/interpersonal	Community
• Personal qualities, knowledge and skills, relationships, passions and interests • Health, finances, transport, housing	• Links with neighbours, supportive community groups, shared interest groups, community leaders • Health and social care services, community buildings, religious buildings, schools

This can help the caseworker and the client to consider:

- What strengths (knowledge, experience, expertise) does the client have already and how could these be enhanced?
- What other skills, knowledge, experience or expertise do people directly or indirectly involved in the person's life already have or need to acquire?

Caseworkers should try to have an objective understanding of the client's views so that strengths are not underestimated. For example, someone who has been living with a severely reduced level of mobility for a long time may have become accustomed to the considerable limitations in their day-to-day life. An objective understanding can help to reveal the true impact on the client's wellbeing.

[100] Pulla, *A Strengths-Based Approach in Social Work: A distinct ethical advantage*, 2017
[101] A common approach in social work case management practice. Promoted by the Social Care Institute for Excellence, available at: https://www.scie.org.uk/strengths-based-approaches/videos/concept

Documenting information: Whenever possible, caseworkers should use the exact words of the client when documenting meetings and discussions. This can be an essential method for monitoring progress and recognising potential problems. Caseworkers and their supervisors are responsible for ensuring that all case documents are complete and factual. Caseworkers should be careful to distinguish between facts and professional judgement, ensuring that all professional decisions and recommendations are substantiated and non-judgemental.

(ii) RE/ASSESS THE RISK LEVEL

Refer to Step 1 Introduction & Intake for an explanation of how to determine a client's level of risk. For further support, refer to Form 0 Prioritisation Reference Tool and Chapter 3 Section A on prioritisation.

Step 3: Case Action Planning

WHEN & WHY
A case action plan should be developed, usually within two weeks of the protection risk assessment being completed. This can take a number of sessions with your client. However, action planning is done according to the urgency and complexity of the case.
The objective of this phase is to detail the client's assessed risks and develop specific, time-bound goals with the client to address these risks. This can be through actions or services provided.
If a safety plan is necessary, it should be completed immediately with the client.

DOCUMENTATION
1. Case Action Plan form
2. Informed Consent form
3. Safety Plan Form
4. Referral form

KEY STEPS
1. Repeat steps 1,2,3,4 on the introduction & intake step. (Introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process for informed consent/assent)
2. Summarize the assessment & check in
3. Define risks together
4. Agree on goals together
5. Agree on actions together
6. Carry out safety planning
7. Get informed consent for referrals
8. Make accompaniment plans
9. Document your case plan
10. Agree when/where to have a follow-up visit
11. Discuss any concerns with your supervisor

The case action plan should be based on the comprehensive risk assessment and be consistent with the findings of the assessment, including the client's available strengths and resources. The case action plan should identify the agreed upon actions and steps to be taken to address identified risks and be documented. It should be regularly reviewed during follow up and updated accordingly.

The caseworker must develop the case action plan in partnership with the client so that the client is fully involved in the development of the plan. The client is the *actual* owner of the case action plan. Where the client requests and it is safe and appropriate, the meeting can also include the participation of supportive family members/carers and the caseworker's supervisor for complex cases. However, you must make sure that the client makes the decisions and is not pressured to take actions in any way. Where a client requires a multi-sectoral approach to address their problems, you can also consider calling for a case conference. (See Chapter 3, section B)

Caseworkers should generally avoid giving advice to clients even through it is a very normal reaction. For example, a client who is feeling hopeless and showing signs of depression may find it difficult to make decisions but giving them advice can create a dependency on the caseworker to solve their problems, limiting their ability to manage their own situation in the future and undermining the empowering process of case management. Caseworkers can provide information on the available options and describe the benefits, risks, likely outcomes of each option, but must avoid giving advice based on their personal opinions and beliefs.

(i) DEVELOP YOUR ACTION PLAN

SUMMARISE THE ASSESSMENT AND CHECK IN

Summarise, in your own words, the findings shared by your client during the risk assessment. That should include your client's specific risk(s), resulting needs and their protective capacities. You should check whether the summary is correct with your client and whether there are additional points they wish to add. Then, together you will need to agree on the key risks your client needs to manage.

DEFINE THE RISKS TOGETHER

You will need to define the type of risk/problem your client has. This can be challenging, but it is an important process for the client and will help to establish clear goals. These are two possible options you can use with your clients to support them to do this:

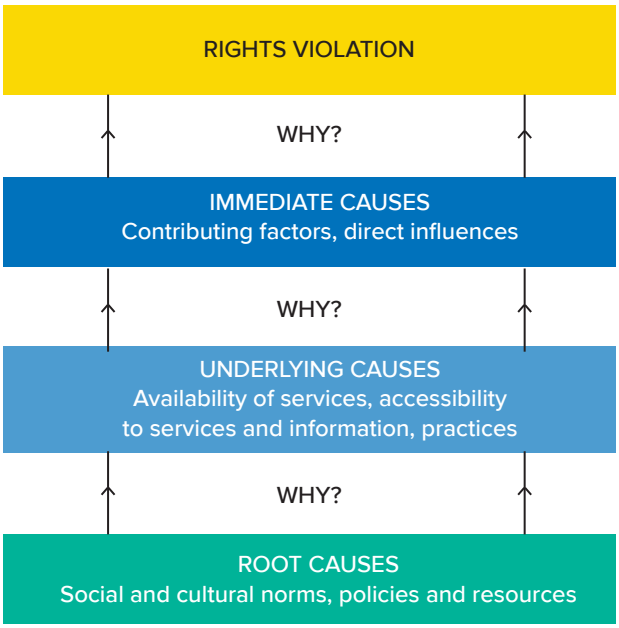
1. Understand which risks are solvable, unsolvable or unimportant.[102] You can **focus your discussion with the client on those risks which are important but also solvable** (i.e. you can influence).[103] **Focus on risks which are important and solvable in your action plan**. Record these with your client, ensuring they are specific and practical. For example, instead of writing problems such as 'feeling worthless' or 'I need to leave the country', you should write problems such as 'the absence of my father's death certificate has prevented me from claiming my property'.

Solvable risks are those which together you can have influence over and reduce, for example reducing your threat of eviction by seeking a written housing contract with the landlord.
Unimportant risks are those which the client does not think are important.
Unsolvable risks are similar to problems which you and client have little control over, for example a Sudanese refugee may be at risk if returning to Sudan and may want the crisis there to end.

[102] Adapted from the WHO, *Problem Management Plus* (PM+), 2018, 47.
[103] Ibid. 47

2. **You can also use the causal problem tree** to discuss with your client the root causes, the underlying causes and the immediate causes of their problem. This can help the client to see how challenges are related, to process them and to focus on what they can change. The main way to do this is to keep asking *'why?'*.[104]

FIGURE 10: Causal problem tree



AGREE ON GOALS TOGETHER

This is the desired goal agreed between the client and the caseworker. The caseworker has the responsibility to present all possible options and consequences to the client, and the client is the primary decision maker in identifying their goals, with the support of the caseworker.

- Asking these questions can help clients define their goal: *How would your life (e.g. daily living) be different if you did not experience this risk/problem? What change to do you want to see?*

The caseworker does have an important role in ensuring that goals identified by the client are:

- **Realistic** (for example, it would rarely be appropriate to list 'resettlement' as a desired outcome). Identified goals must be measurable and achievable. To do this, you can provide them with information on available options, such as services and actions, and the benefits and risks of those options (draw on an up-to-date and accurate service mapping).
- **Ideally helpful in the short as well as the long term**

[104] For a step by step guide see: GPC Protection Mainstreaming Toolkit, 2017, 63

Key considerations for durable solutions

A durable solution is achieved when a durable legal status is obtained that ensures national protection for civil, cultural, economic, political and social rights for the individual.[105] For refugees, key options for durable solutions refer to their local integration in the host country, voluntary repatriation and resettlement to a third country. While for IDPs who do not fall under international protection mechanisms, options for resettlement remain limited.

Identifying durable solutions or complementary pathways will be necessary as part of the case action plan where specific risk factors or protection concerns have been identified. Protection case management staff should be aware of these risk factors and should ideally be able to consider and explain a variety of opportunities simultaneously when explaining available options to the client. Presenting clients with the various options available and appropriate in a given context should be done carefully while managing expectations. Clients should be informed of the procedures, timeframe, assistance, risks and benefits in any given durable solutions process before being asked if they wish to be referred.

In situations where no durable solution options are available and the client is in a temporary arrangement and/or is starting to integrate into their community, this should be maintained and when/if circumstances change this should be reviewed. This may include situations where refugees are unable to return voluntarily, tracing results for family reunification are outstanding or when UNHCR is undertaking discussions with the host government regarding local integration which may take years and where there are no foreseeable changes.[106]

In instances where protection case management teams are supporting an adolescent, identifying solutions or outcomes in their best interests is particularly urgent for those nearing the age of 18 as there are changes to eligibility for protection and assistance services once they reach the legal age of adulthood.[107]

AGREE ON ACTIONS TOGETHER

This is what needs to be done in order to accomplish the goal. This may take a number of sessions to complete but you should continue to support your client to make the decisions themselves. A combination of different actions may be needed, and each should be listed separately.

- **You can break down the overall goal into manageable tasks.** For example, for a man who has a physical disability and wants to find work, this may involve getting information about what work is available, learning about what is needed for different jobs, registering on a vocational training course.

- **Ensure that actions are feasible, and do not expose the client to further risk** (for example, if an action requires the client to travel to another location, discuss risks related to the travel – including barriers, checkpoints and costs – to ensure that the action is feasible).

- **Look to build on and enhance the client's strengths and resources at individual, household and community level.** You can draw on their protective factors to help reduce their risk (i.e. a client who feels socially isolated could be supported to volunteer in their local community centre, where safe to do so a client can ask a family member to remind them to exercise or to walk with them to reduce stress).

[105] UNHCR, *Best Interest Principle Guidelines, assessing and determining the best interests of the child*, November 2018, 71, available at: https://www.refworld.org/pdfid/5c18d7254.pdf
[106] Ibid 72
[107] Ibid 72

- **Responsible:** While the client has ownership over the actions, it is important to break down and name who is responsible for each one. There may be more than one responsible person/organization, but aim to separate responsibilities according to specific tasks wherever possible. The caseworker should always be responsible for a minimum of one action per goal (such as monitor the action plan). If many different players are listed as responsible for tasks related to a single goal (or if a number of goals are interrelated and bring together many different players), a case conference that includes all relevant players may be called for.

- **Agree on a timeframe for actions.** This is the date the action is intended to be completed. It should not be binding, but it can give the client an understanding of the timeframe within which they can expect the action to be completed while also making sure to manage their expectations. For example, if you conduct a referral, you can note down expected response times from the receiving organisation to respond and can explain to the client that these timeframes are an estimate, making sure to keep the client updated on any feedback received or indication of delay.

CARRY OUT SAFETY PLANNING

When necessary, the caseworker should carry out a **safety plan** with the client based on an assessment of their safety and security. Safety planning enables the client to proceed with a pre-determined course of action when their safety is compromised. Once the client has identified potentially dangerous situations, they need to develop an idea of how to react in those situations and to reduce harm.

Carry out safety planning with the client based on a safety planning exercise (either integrated into the protection risk assessment or a separate safety planning form) that helps to gather the information you need to develop a safety plan with your client. This process can be done as part of case action planning using the Case Action Plan Form 5, but you can also have a separate safety plan as needed.

When we do safety planning, it is important that we communicate to the client that the purpose of doing this is to help them **reduce the likelihood of being harmed** or minimize potential harm. We **are not** suggesting that they can control when and where they experience violence.

The key tasks of safety planning are to:

- Help the client identify patterns in the abuse (for example, does it happen it certain places, or at certain times)

- Identify strategies for avoiding situations in which they may be at risk

- Identify safe people and places that the client can go to in an emergency. Work with the client to develop a plan in which they identify people and places they can go to in a crisis and any potential risk and barriers that may arise in trying to access those people or locations.

- Considering barriers that a client could face while trying to escape to protect themselves and seek support is highly important. You should take that into account and assess barriers and enablers with the client.

Safety planning requires a very individualized approach and will look different depending on the type of violation (i.e. risk of abuse, risk of enforced disappearance, suicidal ideations, imminent risk of refoulement) and what options and resources are available to the client. **Usually, there are some coping mechanisms already in place. The key is to find out what is already working for the client and build on it.**

As the client begins to identify potential responses and resources, help them to plan exactly what they would do in each of the threatening situations.

Caseworkers should assess a client's safety during every visit with a client. During follow-up visits, caseworkers should ask specific questions about the client's safety in their home and community and what has changed since the last meeting. Based on the outcome of the safety re-assessment, follow up on safety referrals or make an updated safety plan if necessary.

GET INFORMED CONSENT FOR REFERRALS

As usual caseworkers should always ensure confidentiality, and must **seek permission to share information for each new referral conducted with the client's signature/thumbprint on the referral form** (Form 7 Referral). If referring by phone, do not share confidential information in a public space, and only share information that the other party needs to know to support the provision of services to the client.

To obtain informed consent, caseworkers should explain and discuss with the client:

- The referral process, and what potentially will happen as a result
- The risks and benefits of the intervention (medical treatment, shelter assistance, etc.)
- Their rights, i.e. that they have the right to decline or refuse any part of an intervention provided by the caseworker or the receiving organisation at any time, their right to request the deletion and removal of this information at any time
- Explain what information will be shared with the receiving organisation and how it will be protected applying your data protection protocol.

Remember, if informed consent is not given, do not proceed with the referral. Instead explain how the client can access this service if they change their mind at any time and provide them with any relevant awareness and information materials.

MAKE ACCOMPANIMENT PLANS

For any referrals, the caseworker should make 'accompaniment plans' for when clients want to have someone to go with them to other agencies/service providers as part of the referrals process. Caseworkers should talk this through carefully with clients. In some settings, caseworkers are known in the community and, therefore, even the simple act of a caseworker walking a client to a facility or police station automatically raises the curiosity of others and may inadvertently break confidentiality. Always use strategies that safeguard clients' confidentiality throughout the referral process.

DOCUMENT YOUR CASE ACTION PLAN

Once you and your client have discussed and developed your action plan, you should conduct a final review with the client. It can be helpful for you to show and speak to your supervisor about the case plan.
Once reviewed you and your client can sign the case action plan. You will review and update your case action plan as progress is made and during your follow-up visits. When actions are completed or no longer deemed relevant or feasible, you can complete the 'date completed' column. You should then make sure that you note the justification for this in the follow-up form (i.e. see follow-up form Case Management Form 5-Case Action Plan-Page 198)

If any referrals are required for services/actions, you can use your referral forms (Form 7 Referral Form) and ensure they are filled and signed. For the informed consent process, follow the steps in Step 1.

AGREE WHEN/WHERE TO HAVE A FOLLOW-UP VISIT

The caseworker should discuss with the client the options for a follow-up visit and be very specific about where it will take place and when. When arranging follow-up visits it is important to discuss with the client what barriers could prevent or get in the way of them being able to make a follow-up appointment.

Refer to Step 1 to address barriers to participation. Possible options include:

- Make appointments for the client to come to your centre/facilities
- Meet the client inside another service provider's office if that protects their privacy better
- Visit them at home if this does not compromise safety or confidentiality and is preferred by them

DISCUSS ANY CONCERNS WITH YOUR SUPERVISOR

If issues arise during your action planning regarding urgent safety concerns, be sure to discuss them with your supervisor *before* you close the session with the client.

Step 4: Implementing the case action plan together

WHEN & WHY
Directly after you have completed and endorsed the case action plan. Based on the case action plan, the caseworker works with the client, the family, and the community and service providers (when possible and appropriate) to ensure that the client receives appropriate services and actions as part of the goals in their action plan.
Consent for referrals can be taken during case action planning. Service provision timeframes are set in the case action plan and followed up by the caseworkers and their supervisor.

DOCUMENTATION
1. Form 7 Referral
2. Form 2A Informed Consent
3. Form 2B Easy Read Consent

Repeat the mental health and psychosocial assessment regularly.

KEY STEPS
1. Repeat steps 1,2,3,4 in the introduction & intake step. (Introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process of informed consent/assent)
2. Direct service provision
3. Referral
4. Lead case coordination

These steps are not sequential.

(i) DIRECT SERVICE PROVISION

Direct support provided by the caseworker will depend on the skills, circumstances, programme goals and objectives. Direct support may include mental health and psychosocial support and counselling, direct cash support (to reduce protection risks), working with family members and/or carer, with client consent.

During the case management process, the protection caseworker directly provides psychological first aid through the provision of practical, non-intrusive care and support while assessing needs and concerns; helping clients to address basic needs (for example, food and water, information) by listening to the client (without pressuring clients to talk), comforting clients and providing a calming environment.

Caseworkers will also help the client to connect to information, services and social support networks, protecting them from further harm. **Where there are few options for referral to appropriate service providers, the mental health and psychosocial support provided by the caseworker to the client will be of prime importance and should be provided throughout the case management process.** Similarly, the caseworker can directly support their client in following up on the accompaniment plan for referral (see below) that has been agreed with the client, which might include accompanying the client to service providers.

Provision of mental health and psychosocial support and counselling: Case management is an empowering and client-centred process, which is a mental health and psychosocial intervention in itself, in parallel with on-going care and support provided. Caseworkers can provide emotional support through their non-judgmental, caring manner with the client nurtured through healing statements, active listening and calming techniques. Helping a client to restore their coping strategies, reconnect with friends and community support networks can provide a great source of strength and comfort for a client. Caseworkers can also be trained on the provision of specific individual curricula sessions to support clients in different ways.

(ii) REFERRALS

Where clients are unable to access services themselves, the caseworker will contact the relevant service provider either directly or through their supervisor to ensure that the relevant service is provided in a safe and accountable manner to the client through a quality referral.

Referrals can be made to formal specialised service providers and non-formal structures, such as community-based groups, for necessary services (with consent). This may include referrals to your own organisation's services or externally (e.g. legal, child protection, SGBV, health, shelter, etc.), as long as services are of good quality. The quality of the service you are referring to should be assessed to determine any barriers that need to be addressed prior to referral of the client. (Annex 5: safety and accessibility audit)

Referrals often work best when the caseworkers are familiar with the services offered and the staff providing them; caseworkers should continually educate themselves about relevant services and service providers, and develop strong working relationships with referral agencies.

Service Mapping: Caseworkers should have access to a regularly updated and accurate mapping of services at all times when meeting a client. (See Chapter 3, section B)

The receiving organisation of the referral is responsible for providing the specific service, while case management agencies maintain overall responsibility for follow up with the client and service provider to ensure quality assistance is provided and risks are mitigated.

If informed consent was not asked for during the action planning phase, caseworkers must **seek permission to share information for each new referral conducted using the referral form** (Form 7 Referral).

(iii) LEAD CASE CONFERENCING

A key role of a caseworker is to coordinate any care and services received by the client, acting as a liaison between the client and service providers, advocating for timely and quality care and working with service providers to reduce barriers for the client's access.

Caseworkers are responsible for following-up referrals to make sure that services are provided in a timely manner. The caseworker, when necessary and appropriate, can organize a meeting with the **main actors and service providers that are involved in the case plan to discuss the action plan and find short-term and/or long-term solutions.** This procedure is best reserved for **complex cases and often when a client's needs are not being met in a timely or appropriate way** and when a joint response is critical. Note that the client (and their family members) does not usually attend. These meetings provide an opportunity to review activities, establish progress and barriers, map roles and responsibilities, look for solutions and adjust current service plans as needed.

Step 5: Follow up & monitoring

WHEN & WHY
Follow up & monitoring is undertaken from the time the case action plan is agreed until case closure or transfer. The frequency of follow-up visits will depend on risk level/urgency of the case.
The objective of this phase is to review progress towards the goals outlined in the case action plan, as well as the continuing relevance of the action plan itself.
Case review meetings with supervisors and other relevant meetings should also be documented in this phase. Every significant interaction with the client should be documented in the case follow up form.

DOCUMENTATION
1. Follow up & Monitoring Form
2. Consent Form
3. Referral Form

KEY STEPS
1. Repeat steps 1-4 in the introduction & intake step (Introduction, assess immediate safety risks, address barriers to participation in the meeting, start the process of informed consent/assent)
2. Follow up with your client and monitor progress
3. Reassess risks and revise your action plan
4. Ask for informed consent for further referrals

If necessary, during the follow up stage you may need to develop a safety plan.

(i) FOLLOW UP WITH YOUR CLIENT AND MONITOR PROGRESS

Throughout case management, caseworkers and their supervisors are responsible for follow up with their clients, and monitoring progress made toward the case action plan in partnerships with their client, the client's family/carer and other pertinent service providers. Caseworkers should follow up with their clients frequently according to the risk level of the case. Supervisors and caseworkers should agree on appropriate steps for following up and monitoring a case.

During these follow up sessions, caseworkers and clients can update each other on the implementation of their assigned actions in the action plan, such as feedback from a service provider, and discuss any challenges or difficulties.

During these visits, the caseworker can also collect information on changes or outcomes which have occurred since the initial risk assessment with the client and, if needed, adjust the case action plan in agreement with the client in response to these new developments:

- Meet with or contact the client as agreed
- Reassess the client's risk / safety
- Reassess the client's mental health and psychosocial wellbeing using the mental health and psychosocial assessment form to determine any changes. You can do this after a sudden event or on a regular basis, for example once a month.
- Should there be any significant changes observed you can talk to your supervisor and you can consider putting a safety plan in place or conducting a suicide assessment at any time through the case management process if agreed by the client.
- Review the action plan with the client each visit to update it, and make any revisions as needed
- Revise the case action plan with the client making sure to document outcomes of referrals, emerging risks and schedule a follow-up visit.
- Implement the revised case action plan, making sure to obtain informed consent for new referrals.

Remember: very often clients' situations change, new information emerges or the plans made prove not to be effective. Case management is typically not a linear process, so you need to be prepared to circle back to the assessment and planning phase and revise your action plan. This is a usual occurrence in case management.

Step 6: Case closure or transfer

WHEN & WHY

Case closure is undertaken when the action plan goals are achieved or when services are discontinued for other legitimate reasons (death, relocation, request of client, etc.). **Case closure** ensures the safe, responsible and appropriate termination of services for the client. This process should be done in consultation with the client.

Case transfer is undertaken only as a last resort in specific situations, usually due to greater technical proficiency or geographical proximity. **Case transfer** is to ensure the best possible service provision for the client, in all the circumstances. Documentation related to case transfer should explain the reason for the transfer, outline discussions with the client regarding the transfer, include proof of the client's consent for the transfer, and list the information provided to the new case management organisation as part of the transfer process.

DOCUMENTATION

1. Form 8 Case closure

KEY STEPS

1. Deciding when to close a case
2. How to document a closed case
3. Case transfer

The decision as to whether to cease involvement or end the case management relationship can be influenced by several factors. The case action planning done at the time of the initial risk assessment may have indicated that case management services were intended to assist with a specific set of issues/risks over a limited time. Even so, new issues may emerge that raise significant concerns or questions as to the appropriateness of concluding the case management relationship.

(i) DECIDING WHEN TO CLOSE A CASE

The caseworker should review the case and discuss closure with the supervisor and the client. The action plan has to be reviewed together with the client. The caseworker, in partnership with the client, can then identify any issues or matters of concern that may require ongoing support or assistance. **Always reassure the client that they can return if they have new issues or challenges as a case can be reopened.**

Reasons for case closure:

- When agreement is reached that goals set in the action plan have been met, there are no additional protection risks and that the client (as well as their family, if relevant) will not benefit from continued case management services, the relationship can be ended.
- If the client cannot be found for a minimum period of 60 days and cannot be contacted (despite repeated attempts), this case can be considered closed. All attempts to contact the client must be recorded in the client file. The case file can be reopened in the event that the client returns.
- The client wants to close the case for any reason; our goal is to respect their wishes.
- Where the client is deceased, the case will be closed, but support for the family must be considered. Where you are working alongside the government to provide services, you need to ensure that the incident of death is reported to the responsible government department.
- Where the client's primary needs cannot be met, and/or the client does not wish to receive direct support or be visited on a regular basis, the case should be closed.

Future planning approach: Where a client's support needs are long-term and complex, they and their family might seek the continuation of the case management relationship. This might involve you needing to plan for and anticipate changes for the client and/or their family, and agree to renew contact at those times. Future planning recognizes that some people will require recurrent case management support until they find a durable solution. When it is agreed that no current case management involvement is needed, it may be agreed with the client that contact can be resumed at a future time, for instance in preparation for a future significant change or transition.

(ii) HOW TO DOCUMENT A CLOSED CASE

The caseworker should complete the case closure form and review the case with their supervisor to obtain approval. Review all the forms in the client's file and ensure the case file is complete. **Ensure that the client's file is appropriately archived according to your organisation's policies.**

Closed case files should be stored in a secure and private place for a specific period of time according to your organisation's data protection protocol or national legislation.

(iii) CASE TRANSFER

Case transfer should be avoided unless it is absolutely necessary, such as when **the client leaves the area or country, when the organisation leaves as part of an exit strategy, and for reasons of technical quality**. In the latter case, there must be a good indication that the client will receive better services than they are already receiving, otherwise case conferences or joint support can be an option. Good coordination between case management streams from the beginning can avoid unnecessary transfers between CP, SGBV and other case management technical teams.

Case transfer requires that full responsibility for coordination of the case plan, follow up and monitoring of the client to be handed over to another organisation or department. You will need to put in place a hand-over plan with the receiving organisation and this must be communicated with the client, and family/carer (where relevant). It is best practice for the known caseworker to accompany and introduce the client to the new caseworker who will assume responsibility for the case.

In situations where whole caseloads are transferred to another organisation or government department, all case files must be reviewed to confirm it is safe to transfer, and the consent of clients has been given to share information.[108]

Chapter 4: Key tools & resources

Preparation & interviewing tips:

- Communication Tips for Persons with Disabilities (Pages 52-59)
- Tips to Plan and Inclusive Meeting (page 65)
- Washington Questions Training Resources

Case Management Forms

- Form 0: Prioritisation Reference Tool
- Form 1: Introduction & Intake Form
- Form 2A: Informed Consent Form
- Form 2B: Easy Read Consent Form
- Form 3: Interpreter Non-Disclosure Agreement
- Form 4: Protection Risk Assessment
- Form 5: Case Action Plan
- Form 6: Safety Planning Form
- Form 7: Referral Form
- Form 8: Case Closure Form

[108] Child Protection Case Management Guidelines, p. 68

CHAPTER 5: YOUR SUPERVISION PRACTICES

Let's look at how to supervise and support your staff!

In this chapter, we will look at:

1. Supervision & coaching
2. Staff and self-care

Training Modules:

- **Module 13: Supervision & coaching**
- **Module 14: Self-care**

5.A Supervision & coaching[109]

FIGURE 11: Your supervision process

Case management is complex and challenging work that requires the ongoing assessment and monitoring of skills and practices in a supportive manner. **All protection case management teams should have at least one case supervisor overseeing not more than between 5-6 caseworkers.** Supervisors are responsible for ensuring that the staff are trained and prepared for their case management role, for regularly monitoring caseworkers' and officers' practice and providing the support that they need to provide services in line with best-practice. Case supervisors should be available for consultation in emergency situations and should provide regular case supervision to caseworkers. The key to an impactful supervision practice is the relationship that is developed and nurtured through regular and structured sessions. Below are practices and forms to support the supervision of caseworkers.

[109] This entire section draws heavily from The Alliance for Child Protection in Humanitarian Action, Case Management Task Force, *Child Protection Case Management Supervision and Coaching Training Package*, 2018.

(i) FUNCTIONS OF SUPERVISION WITHIN CASE MANAGEMENT WORK

Three required functions of supervision within case management		
Functions	**Purpose**	**Includes**
Accountability and administrative	To ensure competent, accountable staff practices.	• Human resources. • Planning and assigning work. • Coordinating with other players. • Documentation and reporting. • Material and logistical support. • Reinforcing safety and ethical standards.
Educational and professional development	To ensure staff are continually updating their knowledge and skills and applying them to their daily work.	• Assess competencies. • Collaborate on personal learning plans. • Promote reflective practices. • Reinforce guiding principles. • Encourage self-awareness.
Supportive	Ensuring the emotional and psychological wellbeing of case management team.	• Creation of a safe space for reflection. • Promotion of self-care. • Having empathy and normalizing feelings. • Reinforcing realistic expectations and healthy boundaries. • Recognition and encouragement.

Supervision is a protective practice: The provision of consistent, quality, supportive supervision directly relates to positive outcomes for clients in the following ways:

- Clients should remain at the centre of the supervision process.
- Supervision protects clients and families from caseworkers who have inadequate experience, are careless, or who breach professional boundaries.
- Supervision protects caseworkers from making mistakes, burnout or over/under involving themselves, which may cause harm to clients.
- If processes are designed in such a way that staff are encouraged and supported to reflect on their practice, a culture of openness and transparency is more likely to be fostered, resulting in better outcomes for clients.

(ii) HOW TO EFFECTIVELY SUPERVISE AND COACH CASEWORKERS

Coaching is at the heart of supervision. It is an attitude that places the caseworker as the driver of their own development. The supervisor's role as coach is to use specific practices to help the caseworker recognize their strengths and challenges, and assist them to set – and realize – realistic goals towards achievement. Coaching also helps the caseworker to reflect upon his or her work and role.

Supervision needs to be:

- **Regular and consistent:** This means meeting once a week, but this can depend on your own established individual supervision cycles. It is important to meet at a set time so that the caseworker and supervisor can prepare for the session. Ad-hoc support may also be necessary and should be provided but **should not** take the place of a regular supervision meeting.

- **Collaborative:** Supervisors should encourage their case management staff to come to supervision meetings

with an agenda, identifying the cases they want to discuss, specific questions they have, and/or topical areas of technical support.
- Give the caseworker the space to talk first, before asking questions
- Facilitate an environment for discussion so that caseworkers can learn from one another
- Problem solve with the caseworkers - letting them lead the process - before providing solutions.

■ **An opportunity for learning and professional growth:** Supervisors should use the sessions to support caseworkers' learning and professional development.
- Give the caseworker the space to talk first, before asking questions
- Provide concrete feedback on what the caseworker did well
- Ask the caseworker to reflect on what they think could have been done differently or better and provide your feedback. Provide them with the opportunity to role-play their suggestions with you. You can also play the role of the caseworker to demonstrate how to do something accurately.

■ **Safe:** Supervisors should ensure that supervision meetings feel like a safe space for caseworkers - where they can make mistakes and not be judged, and where they can receive constructive feedback, not criticism.
- Be sure to emphasize to the caseworkers that it is important for them to show you what they did or said to the client NOT what they think they should have done. Explain that this is the best way for them to learn and for you to provide support.

(iii) TYPES OF MEETINGS: SETTING OF SUPERVISION: WHERE SUPERVISION SHOULD TAKE PLACE

Supervision Practice	**Individual supervision session:** Routine or regularly scheduled sessions between the caseworker and supervisor	**Group supervision session:** Routine or regularly scheduled group sessions between the supervisor and case management team
Capacity assessment	X	
Shadowing	X	
Observation	X	
Case file review	X	
Case discussion	X	X

INDIVIDUAL SUPERVISION

Individual supervision meetings with caseworkers are one of the best ways a supervisor can provide support to caseworkers and monitor the quality of their work. These meetings are regularly scheduled one-on-one sessions between the supervisor and caseworker that can address all three core functions of supervision.

Frequency/duration: Depending on the schedule of the case management team, individual supervision meetings can be held for an hour once a week or however frequently the case management team decides is possible and useful.

Guidance: Supervisors and caseworkers are both responsible for preparing ahead of the meeting, depending on the week's activities, and any other topics (as discussed in a previous meeting and/or as decided within a capacity building plan). These can include cases, questions from the caseworker and feedback or guidance from the supervisor. Supervisors should create an environment of openness where caseworkers are encouraged to reflect honestly.

- **Administrative:** The supervisor should discuss any administrative, human resources, or logistical challenges and update and review the total caseload.

- **Development:** The supervisor should review any skills, knowledge or learning that the caseworker or supervisor has identified as a priority. Supervisors should refer to the Capacity Building Assessment.

- **Supportive:** The supervisor should use this time to check how the caseworker is feeling in their practice and in managing their stress levels generally. The supervisor should explore and review self-care strategies or additional support if needed.

- **Feedback on supervision practices:** Supervisor can provide constructive and positive feedback based on whatever supervision practices have been completed that week (observation visit, case files reviewed, shadowing visit)

- **Case discussion:** The supervisor will review a case, generally a challenging one, with the caseworker as outlined in *Supervision Form 5-Case Discussion-Page 233.*

Supervision Record 1-Individual Session Meeting-Page 235

GROUP SUPERVISION

Group supervision meetings are regularly scheduled gatherings between the supervisor and the case management team that can address the functions of supervision (but should not be used as a replacement of individual supervision.) They are useful for promoting learning exchange between caseworkers and for providing technical support on any common challenges that the supervisor has identified across caseworkers.

Frequency/duration: Should be held once every 1 to 2 weeks at the same time for a minimum of 1 hour, depending on the context and needs. It is recommended that once a month the supervisor organize an extended meeting (for an additional hour, up to half of the day) to focus on skill development or staff care and well-being. Regardless of the frequency of meetings, they should be held consistently and according to a schedule (e.g. the first Tuesday of every month), so that caseworkers and supervisors know to set that time aside in their schedule.

Guidance: Case management supervisors are responsible for regularly scheduling and organizing case management meetings with their teams. Caseworkers are expected to undertake necessary preparation and participate fully in the meeting. The supervisor should facilitate collaborative discussions between team members and encourage caseworkers to offer suggestions and facilitate the discussion.

- **Case discussion:** The supervisor assigns a caseworker to discuss an interesting, or challenging case from which other staff can learn. Case presentations should follow the format outlined in the case discussion form (Supervision Form 5-Case Discussion-Page 233).

- **Topical sessions:** The supervisor should either choose the topic in advance (based on the technical support s/he identifies to be a priority) or ask the caseworkers to identify topics for which technical support is desired.

- **Teach back:** The supervisor can identify a caseworker with a particular strength or who has been successful with a new strategy to lead the group session and "teach" their colleagues. If this strategy is used, it is important that the case management supervisor reviews with the caseworker their plan for the group session.

- **Guest speaker:** The case management supervisor may invite technical experts to share information on a specific protection issue or a skill to be developed within the team. Supervisors can also request a presentation to be made by a representative from a community service (legal, police, medical, registration, etc.).

Supervision Record 2-Group Session Meeting-Page 238

Supervisors and caseworkers are both responsible for preparing ahead of individual and group supervision sessions. Preparation will depend on the content of the session.

Supervisor role	Caseworker role
Prepares for supervision sessions in advance, including anticipating issues, creating an agenda, etc.	Comes prepared and actively participates in the supervision sessions to support reflective learning.
Develops a safe space for the caseworker(s) to speak about their work in their own way.	Identifies practice issues which they need help in, and what supervision practice is useful to them.
Gives useful, insightful feedback and supports the caseworker(s) to explore and clarify their thinking.	Is open to feedback and seeks clarification if needed. Proactively engages to seek solutions.
Shares information, knowledge and skills appropriately.	Develops a level of trust in supervision to share their work issues.
Challenges practices considered to be unethical or risky, as well as personal and professional blind spots.	Uses supervision to identify learning and development needs.
Manages the time and structure of individual sessions and case management meetings.	Uses individual sessions and case management meetings to review and reflect on current workload.
Reviews and updates capacity building plan(s) during individual sessions and, when appropriate, during case management meetings.	Identifies what supervision practice is useful to them/their colleagues.
Ensures everyone is given space to participate in case management meetings.	Respects and supports the other caseworkers; respects confidentiality.

(iv) SUMMARY OF SUPERVISION FORMS/PRACTICES

CASEWORKER CAPACITY ASSESSMENT FORM

A capacity assessment is a supervision practice used to examine a newly recruited caseworker's attitudes, knowledge and skills. It outlines areas where further development and support may be needed to perform effectively in the role. These are minimum competency standards for all caseworkers providing case management services. It is important that caseworkers do not feel that they are being evaluated or that they will be punished if they do not demonstrate accurate knowledge and skills. Instead, we want them to understand that the questions and the role-plays included in the skills part of the assessment form are to support the caseworker's skills development.

Frequency/duration: Should be conducted immediately after the caseworker is recruited and then reassessed at 3-6-month intervals, depending on organizational capacity, staff ratios and needs.

Guidance: How to use this form: This form is used on recruiting a new caseworker but should continue to be used at regular intervals with caseworkers. A supervisor can use this form in the initial individual supervision sessions with a caseworker to understand their strengths and areas for development. Ideally, this should be administered prior to staff working directly with clients at risk. The outcome of the assessment should inform the capacity building and development actions that a supervisor provides in individual and group supervision sessions.

Supervision Form 1-Caseworker Capacity Assessment-Page 210

SHADOWING FORM

This is a useful and effective practice to show new or inexperienced caseworkers how to engage with clients by modelling best practice. During a shadowing visit, the caseworker attends an experienced caseworker's or supervisor's meeting with their client and acts as a neutral observer in order to learn and develop. Unlike the other forms, the shadowing form is meant to be used by the caseworker to note and reflect on the interactions between the senior caseworker/supervisor and the client. Reflections and discussions of shadowing sessions should occur in individual supervision sessions.

Frequency/duration: It is suggested that 5-10 shadowing visits occur during a caseworker's first month of employment. Before shadowing visits occur, a caseworker must have successfully completed protection case management training.

Guidance: How to use the form: This form can be used for the shadowing of sessions at all stages of the case management process. Whilst particularly useful for new caseworkers, it can be a useful practice for all caseworkers of any experience level. It is suggested that the supervisor determine which cases should be observed according to the caseworker's capacity building plan, but always considering the confidentiality and safety of the client as a priority. Supervisors should consider the client's current vulnerability, safety and wellbeing according to the "do no harm" principle. It is essential that informed consent is sought from the client prior to the meeting and that the clients are told the purpose of the visit. Only one caseworker should be invited to shadow a session in order not to overwhelm the client.

Supervision Form 3-Shadowing-Page 227

OBSERVATION FORM

This is a supervision practice used to assess a caseworker's application of case management competencies during a face-to-face interaction with a client. During the observation, a caseworker conducts a meeting with the client as though the supervisor is not present. The supervisor is a neutral observer during this contact, unless it is essential to intervene due to a case management principle being significantly violated (i.e. there is a risk of causing harm) or if the caseworker explicitly asks for support or feedback. The goal of the exercise is for a supervisor to observe client/caseworker interactions to support the caseworker's development in applying case management and best practices.

Frequency/duration: It is suggested that observations occur more regularly (i.e. once every two weeks) with new caseworkers as they are building their skills, but should continue less frequently with more experienced caseworkers (i.e. once every two months).

Guidance: How to use this form: This form can be used to observe all stages of the case management process. It is suggested that the caseworker and supervisor determine together which cases should be observed according to the client's vulnerability, safety and well-being. It is important that caseworkers or officers do not feel that they are being evaluated or that they will be punished if they do not demonstrate accurate knowledge and skills. Instead, we want them to understand that the questions and role-plays included in the form are to support the caseworker's skill development.

Observation can only happen with the consent of the client beforehand, explaining that this is done to support the caseworker to learn and that all information disclosed will remain confidential.

Supervision Form 2-Observation-Page 225

CASE MANAGEMENT FILE CHECKLIST

Supervisors should also review case files on a regular basis, focusing on active cases to make sure that: a) forms are being used and filled out appropriately; and b) to monitor the services that are being provided (as documented in the case file). It is also an opportunity for a supervisor to identify areas of development and support that might be beneficial for the caseworker.

Frequency/duration: A supervisor should review 3-5 files for each caseworker on a monthly basis.

Guidance: How to use this form: This form can be used for the review of case files at all stages of the case management process. It is suggested that the supervisor selects some cases (can be open or closed) randomly for review. The supervisor should review the cases independently and then provide feedback to a caseworker in an individual supervision session and follow up on the progress. This form is part of regular coaching. Supervisors can also use this form to independently review multiple files in a short period of time. If there are trends within the case files regarding common record keeping mistakes or misunderstandings, these can be addressed during group supervision sessions as observed trends.

Shadowing can only happen with the consent of the client prior to the session, explaining that this is done to support the caseworker's learning and that all information disclosed will remain confidential.

Supervision Form 4-Case File Check List-Page 230

CASE DISCUSSION FORM

A case discussion is a supervision practice to support a caseworker process and analyse a case, explore potential options and determine ways forward. Case discussions can be used as a learning opportunity to reflect on how guiding principles were applied and how difficult situations were managed through a collaborative dialogue.

Frequency/duration: Cases should be reviewed frequently, based on the needs of a caseworker(s) and in accordance with organisation standards.

Guidance: How to use the form: Case discussions can take place in an individual supervision session or group supervision session. At the start, the caseworker presents the background, concerns and current status of the case. Following the presentation, a discussion is opened that includes questions, brainstorming options, and agreeing upon next steps. In order to maintain confidentiality, the discussion should occur in a private space without using identifying information and according to the 'need to know' principle. No details related to the case should be discussed externally.

Supervision Form 5-Case Discussion-Page 233

Supervisors are responsible for putting in place a supervision plan for each caseworker based on their capacity assessment and their changing needs. This can include each tool with the frequency and date they will be used.

5.B Staff care

Protection case management can be challenging, especially to the psychological health of caseworkers and other staff working or volunteering. Organizations have a legal and moral obligation to protect and enhance the wellbeing of their staff. They have the responsibility to take reasonable steps to mitigate foreseeable risks to their physical and psychological health and safety. Therefore, when implementing protection case management services, it is essential that staff care is integrated into supervision practices.

This is critical because caseworkers and other frontline staff are often exposed to stories, information, or images about conflict, suffering, loss, abuse, violence, and torture on a frequent basis. They are often from the same communities as their clients, which may be conflict and crisis-affected. Therefore, they are at increased risk of vicarious trauma because they may be personally impacted (loss of property, loss of loved ones), may know people who have suffered, and face personal risk themselves.

Supervisors must ensure that adequate time and resources are given to support caseworkers to prioritise their self-care. This can be in the form of peer support groups, away days or internally directed psychosocial resources, such as self-care resources and support mechanisms.

Resources for protection case management staff on self-care should be included within supervision and should be an integral part of the supervision process. Self-care can be defined as any activity that an individual deliberately takes to care for their own mental, emotional, and physical health. Self-care encompasses a wide variety of approaches, but usually all focusing on restoring a sense of balance in one's life.

Chapter 5: Key tools & resources

Supervision Forms

- Form 1 Caseworker Capacity Assessment
- Form 2 Observation
- Form 3 Shadowing
- Form 4 Case File Checklist
- Form 5 Case Discussion
- Record 1 Individual Session Meeting
- Record 2 Group Session Meeting

Self-Care Resources

- Staff Wellbeing and Mental Health (UNHCR)
- Online Course: Wellness and Resilience for Frontline Workers and Managers (Humanitarian Leadership Academy)
- Managing stress in humanitarian workers - Guidelines for Good Practice [EN/AR] (Antares Foundation)
- Self-Care Manual for Humanitarian Aid and Development Workers (Plan International)
- Self-Care Manual for Front-line Workers (NMHP, ABAAD)

CHAPTER 6: MONITORING, EVALUATION AND LEARNING

Always make sure to provide clients with an opportunity for feedback and learn from it!

In this chapter we will look at:

1. Your MEAL practices

Training Modules:

- **Module 11. Your MEAL practices**

6.A: Your MEAL Practices

Monitoring, evaluation and learning (MEAL) is necessary to assess whether your protection case management services are achieving the quality and outcomes you intended. Through a variety of information collected through MEAL activities, you can learn about the quality of your services and their impact, and take necessary steps to improve them.[110]

Information collected through your MEAL activities is only useful if you make sure it is analysed, reviewed/ discussed and that it leads to actions. One approach is to produce a monthly MEAL product to capture non-identifying trends gathered through the various channels you have for complaint and feedback (client feedback surveys, call centres, complaint boxes, community meetings, client outcome surveys, protection mainstreaming surveys etc) and discuss the results of these findings with your team.

To support collective learning, programme adaption and best practice do not shy away from sharing or discussion negative feedback. This should be viewed as an opportunity for learning and correction. Make sure that where possible you share your results with your team, your organisation and coordination forums.

(i) SUMMARY OF MONITORING, EVALUATION & LEARNING FORMS/PRACTICES

CLIENT FEEDBACK SURVEY

The final step in case management is to evaluate the service provided from the perspective of the client. Service evaluation is done through direct client feedback. Client feedback surveys provide an opportunity for clients to give feedback on the services they received and key information to help caseworkers, supervisors and your programme to identify gaps, challenges, and areas for improvement. Information collected by the client through the feedback survey always remain anonymous, and must be voluntary.

Frequency: This survey is provided to the client after case closure or also after 3-4 sessions. At the case closure meeting, the caseworker should ask for verbal informed consent from the client if they are willing to complete an evaluation form in the future. Caseworkers mark the response on their case closure form.

[110] IASC MHPSS Reference Group, *A Common Monitoring and Evaluation Framework for MHPSS programmes in emergency settings*, 2017, 7

Guidance: How to use the form.

- A different caseworker, supervisor, monitoring and evaluation staff or other relevant staff member should be the one who gives the survey to the client and collects it from them at the end.

- Always make sure to capture your client's age, gender and disability status through disaggregated data. Use the Washington Group Questions – Short Set, which has been integrated into your client feedback survey to capture disability disaggregated data.

- Always address barriers that may prevent the client from providing their feedback in a confidential and anonymous way. For literate clients, this can be done on their own using a paper form or an electronic form (on a handheld device) in which the client does not have to provide their name, just the name of the caseworker with whom they worked. For other clients, you may need to read the form to them, use an 'easy to read' form, or where appropriate ask a family member/caregiver to support them to provide feedback. (See Chapter 4, Step 1 for guidance on addressing barriers to participation)

- Explain to the client that no information about their actual situation will be requested, but their feedback on the quality of services is valued and that the purpose of the feedback is to help you and your organization to improve your services.

- Explain that this survey is voluntary and all the information they share will remain anonymous and confidential and will not impact the services they currently receive or may need in the future.

Meal Form 1-Client Feedback Survey-Page 240

PROTECTION CASE MANAGEMENT INDICATORS

The following list consists of a catalogue of suggested custom indicators that can be used to monitor the outputs of your protection case management services. The list is indicative and indicators can be adapted to the context of your intervention. It is always advised that you work with a MEAL specialist when developing and putting a methodology in place for using your indicators.

It is advised that you develop a client outcome survey to measure the impact of protection case management services on your clients. From this, you can develop outcome/impact indicators.

Meal Form 2-Protection Case Management Indicators-Page 246

PROTECTION MAINSTREAMING

You can refer to the MEAL tools in the Global Protection Custer Protection Mainstreaming Tool Kit to ensure that you are monitoring, evaluating and learning from your client's perspectives and experiences when accessing your case management services in terms of their safety, dignity, access and participation. You can also use these tools to monitor and evaluate the impact that protection mainstreaming has had on your service delivery. In particular, it is suggested that you choose approximately 2-3 protection mainstreaming indicators to include in your monitoring process to monitor the quality of your services.

Chapter 6: Key tools & resources

MEAL forms

- Form 1: Client Feedback Survey
- Form 2: Protection Case Management Indicators

MEAL resources:

- Protection Mainstreaming Tool Kit (GPC)
- IASC Common MEAL Framework for MHPSS in Emergency Settings (IASC) this document is currently under review and will be updated with selected qualitative and quantitative tools for means of verification.
- Toolkit for Monitoring & Evaluating GBV in Humanitarian and Development Settings (USAID)
- Sphere Handbook (Sphere)

FORMS & ANNEXES

ANNEXES

CASE MANAGEMENT FORMS

SUPERVISION FORMS

MEAL FORMS

ANNEX 1

KEY QUESTIONS FOR PROTECTION ANALYSIS

Purpose of the form: You can use these questions to guide conversations with your team to unpack your findings as part of your protection analysis exercise. These questions can help you to organize and analyse your findings.[1]

Environmental Risk-Factor Analysis [Threat + Barriers]

1. What are the threats?

a. Type/manifestation: threats are external to the person; it is the potential for physical or psychological harm caused by a perpetrator. It represents the source of the risk/cause of the risk.

2. What are the barriers?

b. Type/manifestation: barriers are external to the person; it is the potential for discrimination or deprivation; this represents the source of the risk. Barriers can be social and attitudinal, physical, informational and communicational and institutional

3. What are the main characteristics of the threat/barrier?

a. Frequency/prevalence

b. Geographic area

c. Is it a formal or informal practice (harmful cultural tradition, poor urban design)? How do communities see these practices? What happens if we remove this risk factor? Will other risk factors appear?

d. What is the community's perception of the risk factor?

4. What are the main sources of the threat/barrier? What are their main characteristics (i.e. structure, behaviour? approachability)

a. Do they come from an individual player or group player

b. Is the source approachable?

c. Does the threat come from within the community, displaced population, host communities, or from the outside?

d. What is the relationship between the source and the affected individual/population?

e. What is the structure of the source and where does its decision-making power lie?

f. Where relevant, is the chain of command of the source ambiguous or clear/loose or tight?

g. What are the incentives for action/inaction by the source? The reasons for this? Why does it act or not act

h. Is the actor a duty-bearer?

i. Are we (INGOs/LNGOs/UN/) a threat? Do we exacerbate the threat? Practices of staff? Compliance with internal policies/procedures, or readiness to comply?

[1] For more information, see Inter-Actions Cheat Sheet on Results Based Protection: https://protection.interaction.org/results-based-protection-cheat-sheet-key-terms-concepts/

5. What are the main factors driving the behaviour of duty bearers and perpetrators?
   a. Reasons for mistreating the individual/population: economic, political, legal, social
   b. Formal and informal policies and practices, or absence thereof
   c. Relevance of governing norms—social, religious, legal (domestic, international)
   d. Attitudes, ideas and beliefs driving behaviour
   e. Power dynamics. Who has power? What gives them power? Wat is the relationship between the actor responsible for threats and the affected or targeted individual/population?

6. What is their (duty bearers and/or perpetrators) will and capacity to comply with IHL, HRL, Refugee Law and other protective norms?

7. What are the possible incentives for changing their policy, practices, attitudes and beliefs?

8. What is the severity and the likelihood this will occur?

9. What are the disincentives for complying with the norms/making the desired behaviour change?

Age, gender, diversity factor analysis. Depending on the context, these factors can increase the likelihood of a rights violation.

1. What are the individual characteristic/circumstances that contribute to the risk of a person experiencing the violation?
   a. Location
      i. Look at security categories: low-intensity vs frontline
      ii. Constant movement/changes
   b. Time (month/day, year, hour, season)
   c. Activity
   d. Access to resources
   e. Education, knowledge
   f. Gender
   g. Age
   h. Disability
   i. Social, religious, economic, political group or identity
   j. Access to and availability of services
   k. Lack of documentation, nationality
   l. Ethnicity, culture, traditions, land
   m. Trauma
   n. History of abuse

2. Has the risk factor changed over time? What has prompted this change?

3. Are there particular characteristics/circumstances an individual may experience at the same time which intersect and, due to their environment, often exacerbate the how discrimination and power are experienced? (i.e. being female and from a marginalised group)

4. What are the impacts/consequences of these risk factors be in relation to the threat/barrier if not countered by protective factors?

a. Life-threatening
b. Permanent injury or disability
c. Non-life-threatening injury
d. Loss of property/assets/livelihood
e. Loss of access to life-sustaining resources
f. Loss of access to essential services
g. Loss of ability to sustain life and health
h. Marginalization/exclusion
i. Separation from family
j. Recruitment into armed forces
k. Detention

Protective Factors Analysis (capacity, coping mechanism, motivation)

1. What resources, capacity, and strengths exist to cope with and/or mitigate the risk of and/or violation itself?

2. What resources, capacity, and strengths exist to cope with and/or overcome the consequences of the violation?

a. At individual and household levels? Family and community levels? Structural and Institutional levels?
b. Physical, psychosocial, moral dimensions
c. Human, economic, social, religious, legal, material, moral, etc.
d. Internal and external to the affected individual, including traditional or social norms
e. Accessibility of these resources, capacity and strength for the affected individual

3. Has the capacity to cope changed, grown, diminished over time?

4. What protective mechanisms exist within the community/family/individual which can be reinforced/supported?

5. What synergy exists within communities and families to provide protection?

6. Identify the duty-bearers, key stakeholders, civil society organisations, INGOs who are responding and how they are linked to current community-based initiatives/protective measures.

7. What did the protective environment look like prior to the crisis/emergency? (Health services, mental health and psychosocial support (MHPSS) services, child and family welfare, legal/judicial system, workforce, etc.) What is functioning? What referral pathways exist?

8. At each level (individual, family, community, structural, institutional, national), what are the relevant points of influence and leverage? Where are the linkages within the protective system (environment) where a change in one factor can influence a positive change in another?

9. What commitments exist within civil society organisations, actors, INGOs?

10. Why and how are individuals motivated?

11. Do we understand the interconnectedness of the system, the resources, capacities, strengths, to identify entry points and integration points for services to support the resilience?

12. Where are the opportunities that can be tapped into? (Partnerships, entry points)

a. Individuals
b. Civil society
c. Existing or non-existing services
d. Community-based protection mechanisms

13. How can we support coping strategies, existing skills, and community/individual strengths?

ANNEX 2

PROTECTION CASE MANAGEMENT RISK MATRIX (PROJECT AND PROTECTION MAINSTREAMING)

Purpose of the form: This form is designed to guide you in considering the risks and mitigation measures associated with protection case management services in your context. This risk matrix encompasses identified risks related to your ability to operate, as well as risks related to protection mainstreaming and providing quality services for your clients. This can help you to avoid situations of unintended harm and uphold the protection of your clients and the communities you work in.

When and how: This form needs to be adapted based on your context-analysis through your do-no-harm assessment and your protection analysis. You should develop this with the involvement of local staff. This should be reviewed and updated at regular intervals (every 6 months), but also in response to contextual changes.

High	Significant impact; safety, quality and work plan success not achievable or unlikely	Very high probability of occurrence
Medium	Some measurable impact on safety, quality, work plan or success	Likely to occur
Low	Minimal impact on safety, quality, work plan or success	Some probability of occurrence

#	Risk	Impact	Likelihood	Mitigation strategy	Y/N
Conflict-sensitivity through the Do-No-Harm Assessment - Risk related to increasing harm as a result of case management services which are not context-appropriate					
1	Humanitarian principles (neutrality, independence, impartiality, humanity) are compromised.			Train staff on humanitarian principles. Ensure humanitarian principles guide decision-making and establish clear red lines. If available, engage with humanitarian access teams to explain your services, and how to effectively communicate about them.	
2	Tensions between community members/communities are aggravated due to perceived lack of impartial prioritisation criteria for case management.			Develop clear and transparent messaging which explains who your services seek to support. Develop effective outreach, which reaches all age, gender, disability and diversity groups in various formats. Work closely with access teams where needed to explain your services to them. Develop conflict-sensitive indicators to include in your log frame to measure the impact of your services.	

3	Addressing harmful community practices (tradition or superstition driven) may lead to tension in the community and with community leaders			Discuss with the community their perception and experiences of these practices. Learn from them what the drivers are for these practices and how these could be mitigated/addressed in a context-appropriate manner while maintaining a focus on the negative consequences the practice has on affected individuals. Avoid supporting these practices through your case management services.	
Internal Capacity Assessment - Risks related to the ability to effectively resource your case management services					
1	Lack of financial resources to design suitable modes of service or to provide direct services, such as protection cash.			Identify ways of working and a scale for your programme (i.e. how many cases you can support and in which areas) that would still allow for a quality service, while identifying strategies for expansion in the event of increased financial capacity. Develop an exit plan that would provide continuity for priority cases in the event of a reduction in grants. Build the capacity of the community to take part in service delivery – both as a way of expanding resources and to develop an exit strategy.	
2	Lack of previous organizational experience in addressing a particular violation, lack of technical capacity and knowledge within the organization.			Develop an internal SWOT analysis (strengths, weaknesses, opportunities and threats) to determine where your capacities are best suited and only deliver services accordingly.	
3	Case management activities could be interrupted because of short-term grants.			Only establish case management activities where you have grants for a period of 6 months or, ideally, a year or longer, otherwise explore alternative complementary activities to address the risk. From the beginning, ensure that you have an exit plan in case of unexpected circumstances that may require you to case transfer.	

Internal Capacity Assessment - Risks related to the safety and security of your staff and clients.					
1	Staff are put at risk by authorities due to provision of services for minority/at risk/discriminated and excluded populations			Engage with partner organizations that have existing networks and coping capacities for working with vulnerable groups. Ensure strong data protection protocols. Coordinate and liaise with security and humanitarian access teams	
2	Geographical access is limited if clients are to be reached safely			Consult with people to understand how to provide support to them safely; this might be remotely or meeting in another location.	
3	Unstable security environment			Ensure staff are involved in discussions to develop security and safety measures in your organization. Some examples might be: caseworkers do not go on home visits alone, establish check in policies, all staff to have work phones and phone credit. Develop evacuation plans as part of your data protection protocol for the protection of client data in emergency situations.	
4	Community acceptance is low due to the provision of services for people at risk of harmful community practices, or due to the normalization of risks, or due to the criminalization of some practices (i.e. LGBTQIA)			Cultural sensitivity and awareness of any existing tensions should be emphasized in caseworker training as it contributes to acceptance within communities and the overall safety and neutrality of the staff and agency. Case management providers should consult with these communities to ensure provision of services in a safe way.	
5	Staff are put at risk by authorities due to provision of assistance for minority, excluded or at-risk populations.			Engage with partner organizations that have existing networks and coping capacities to work with vulnerable groups. Strong data protection protocols. Coordinate and liaise with security and humanitarian access teams.	

Protection Mainstreaming Risk Mitigation: Addressing risks identified to **meaningful access without discrimination, safety, dignity and avoid causing harm, accountability, participation and empowerment** for your clients					
1	Clients are put at risk due to breaches in confidentiality if information is seized or stolen as a result of the incorrect collection, storage and sharing of client information. This might put the client and household at risk of harm.			Strong data-protection and information-sharing policies are in place. These include plans for how to handle data in case of evacuation, including moving or destroying the most sensitive documents. Caseworkers are trained on data-protection policies and on confidentiality. Data-collection tools and systems are password protected; identifying bio data is stored separately from protection risks. Case workers meet clients in locations that are confidential.	
2	Caseworkers are unable to have sustained, confidential and safe contact with clients due to the presence of authorities. In these instances, it is likely to be harmful to provide services.			Consider the provision of complementary alternative services, such as group sessions, rather than case management.	
3	Clients are put at risk due to an authority's intervention in requesting client data and lists.			Develop a clear information-sharing protocol prior to establishing case management services and negotiate with authorities, in close coordination with security or humanitarian access teams	
4	Clients are disappointed with services due to raised expectations about the type of support case workers can provide and due to limited external referral options available.			Ensure case worker explains clearly what case management is during initial intake.	
5	Lack of specialized services to meet the needs of clients.			Regularly update service mapping. Advocate to relevant sector/cluster based on gaps in service provision.	
6	Lack of complementary services to prevent risk factors in the community which cause clients harm. This can undermine the effectiveness of your services.			Examine whether there are external/internal community-based interventions to reduce this risk in your area. Advocate with coordination mechanisms and donors to establish complementary services.	

7	Caseworkers are not sufficiently supported and trained to support higher-risk clients.		High-risk protocols are established. Caseworkers are properly trained on high-risk protocols and how to support clients. Supervision systems are in place with a safe supervisor to caseworker ratio. If caseworkers cannot be properly trained, reconsider the provision of case management for all and/or certain high-risk groups.	
8	It may be difficult to identify solutions that are seen as acceptable to the family or community due to culturally harmful practices or beliefs.		Caseworkers should seek to address the underlying causes of social conditions. This may also require you to address these issues through other complementary preventative services, such as community awareness or advocacy.	
9	Lack of translation services for minority language speakers and or persons with disability creates barriers to accessing protection case management.		When required, hire interpreters to support with translation. Identifying professional sign language interpreters at local and national level can be done by consulting professional networks and organizations of persons with disabilities. Ensure interpreter non-disclosure agreements are in place.	
10	Fluidity of population movement reduces consistent access to clients.		Caseworkers are trained and supported to adapt to situations where people are on the move. This may be through providing information on services, on conditions for onward movements, and adapted safety planning.	
11	Security situation worsens and reduces access to clients.		Organization to establish clear safety protocols to protect client data and to provide continuity of care, where possible, to clients.	
12	Caseworkers might not have sufficient links to target populations (such as LGBTQIA+) and are unable to gain trust and access clients.		Link with partner organizations that are led by members of the groups.	
13	Persons with disabilities and older persons are not able to submit complaints or feedback independently or confidentially.		Complaint and feedback channels are designed in collaboration with all age, gender, disability and diversity communities to ensure that channels are designed based on preference and they are inclusive.	
14	Harmful community practices or historical patterns of exclusion and marginalization are unintentionally supported through working with the community.		Examine and support local practices and resources only if they fit with international standards of human rights.	

15	Clients with impairments and reliant on caregivers are not placed at the centre of the case management process and/or there is over-involvement of the caregiver.		Caseworkers are trained on a client-cantered approach. Where trusted persons are present in case management meetings with the client, ensure that this has been consented to by the client. Caseworkers ensure that decisions are not made on behalf of the client by the caregiver.	
16	Centres and physical spaces for meeting clients are not accessible for persons with disability or older persons.		Access should be assessed by the community by asking them and checking what transport options are available. Accessibility audits of all physical facilities to which caseworkers refer clients and where they meet clients should be made and included in-service mappings as relevant. Reasonable accommodations will need to be made to support access. Case management spaces, such as community centres or health facilities, should be designed to be universal from the start.	

ANNEX 3

KEY QUESTIONS FOR PRIORITIZATION

Purpose of the form: This form provides some guiding questions to support your prioritisation process for case management. In particular, it tries to support your discussions with relevant stakeholders about **which rights violations in your context you are in a position to address through protection case management services**. This takes into consideration what other services are being provided in your context, where you can contribute and complement most effectively, where you are best able to deliver services to an adequate quality of care, the safety and security of your clients and staff, and where you will have maximum impact.

You will need to draw on the information you gathered to inform your understanding of the context (Chapter 2) in order to respond to these questions. Questions related to internal organisation considerations are best asked to senior technical or management staff in your organisation.

For each violation, you can ask some key questions to help you to assess whether you are best placed to address it through protection case management:

SEVERITY AND IMPACT

■ Is this violation common in your context? (more common than others)

■ How grave is the impact of this violation on people? (What would be the impact/consequence of these risk factors if they were not countered by a case management response to enhance protective factors)
- Life-threatening
- Permanent injury or disability
- Non-life-threatening injury
- Loss of property/assets/livelihood
- Loss of access to life-sustaining resources
- Loss of access to essential services
- Loss of ability to sustain life and health
- Marginalization/exclusion
- Separation from family
- Recruitment into armed forces

RELEVANCE TO CASE MANAGEMENT

■ Can the key risk factors leading to this type of violation be adequately addressed through a sustained case management approach? Consider what the risk factors are for the specific violation, how they would require reduction/protective factors to be enhanced and whether case management would be an appropriate response to address risk for the individual.

■ Are there resources, capacities and strengths that we could build on to mitigate the risk or overcome the possible effects of this violation to achieve more sustainable and meaningful outcome?

ENGAGEMENT WITH KEY STAKEHOLDERS/COORDINATION

- Are there existing systems in place to address this violation that should be strengthened through partnership, or are there other players in the response already addressing this violation or are more specialized to address it?

- Is this type of violation prioritized as part of the overall humanitarian response plan/protection strategy in country? Or as a part of your organisation's strategy?

- Are specific services required internally/externally to effectively respond to this violation type? (i.e. health services for survivors of torture).

INTERNAL ORGANIZATION CONSIDERATIONS

- Does your organization have previous experience of or is mandated to address this violation?

- Does your organization have the technical capacity and resources to provide quality care while addressing this violation?

- Are you able to address this violation without creating additional threats and risks to staff and clients?

- Does your organization have the human and financial resources to reduce risk of this violation – in terms of the geographical reach and mode of service required (home-based/mobile/centre-based) and the grant length (i.e. case management is not advised unless grants are for longer than 6 months to 1 year)?

- Where there are few external services available, does you organization have the required internal capacities to provide direct services (mental health and psychosocial support, protection cash, etc.)?

- Do case management staff currently have positive attitudes toward certain group(s) that could be affected by this violation to avoid situations of re-traumatization?

- Do your case management staff have positive attitudes to working with all individuals in a way that is client-centred and avoids re-traumatisation?

- Does your organization have the resources to address potential physical and/or communication barriers that the individual may face (e.g. accessible facilities, financial resources for transportation or interpretation)?

ANNEX 4

SERVICE MAPPING: SERVICE INFORMATION COLLECTION FORM[1]

Purpose of the form: The service mapping information form aims to capture useful information about the organizations and services available in this area [location]. You should complete this form separately for each type of service provided by the service provider. Where possible, for ease of compilation, you should complete this form online. When meeting with a service provider, you can explain:

'We would like to collect details about your services to help caseworkers to facilitate safe, accurate and timely referrals for their clients, and importantly to inform them about what they can expect when accessing your services and how to access your services.'

Internal Capacity Assessment - Risks related to the safety and security of your staff and clients.	
WHO: Name of service provider	
WHO: Type of service provider	
WHAT: Sector of operation	☐ Health ☐ Education ☐ Livelihoods (early recovery) ☐ Food security and basic assistance ☐ Water, sanitation and hygiene (WASH) ☐ Shelter ☐ Camp coordination management ☐ Sexual and gender-based violence ☐ Child protection ☐ Protection ☐ Social stability/governance ☐ Other. Please specify
***WHAT: Type of service** *Develop service types for each sector of service that are standardised so that you can select them.*	
WHAT: Description of service *Provide more information about the service, including the modality of service provision, any exceptions, cash amounts, safe and private space for one-on-one counselling, etc.*	

[1] This form has been adapted from the Service Mapping New Service Information Form in the Signpost Launch Toolkit and the Inter-Sector Service Mapping in Lebanon.

WHAT: Service accessibility *Have you conducted a Safety or Accessibility Audit on your services?*	☐ Yes ☐ No *Please specify. (Explain whether one can be conducted)*
WHAT: Service accessibility *Can all persons reach, enter, circulate and use the location?*	**Acessibilty** ☐ The entrance to this location has a ramp ☐ This location has an elevator ☐ This location has female staff ☐ This location has separate accessible ☐ bathrooms for men and women ☐ All services listed are free of charge ☐ The following services charge a fee: **Languages** Please list all languages for which interpretation is consistently available at your premises: ☐ Can you arrange for an interpreter if required? *Please specify which for languages this can be done (If not mentioned, ask about sign language):*
WHAT: Service accessibility *If not already done so, can we conduct a Safety & Accessibility Assessment? (See Safety & Accessibility Form)* *If one has already been done, ask for the types of barriers identified (i.e. entrances with stairs, no ramp, services located on first floor with no elevator) to be noted down.*	Yes No *Please specify. (Explain whether one can be conducted)*
WHAT: Opening hours & appointments *If particular services, activities, or specialists are available at times different from your general visiting hours, please specify this.*	**Opening days/hours:** ☐ Monday: ☐ Tuesday: ☐ Wednesday: ☐ Thursday: ☐ Friday: ☐ Saturday: ☐ Sunday:

	☐ This service is available 24/7 ☐ This service is closed on public holidays ☐ Calling hours (if different from visiting hours): ☐ Visiting hours vary per service (please indicate the hours) **Is an appointment required?** ☐ Yes ☐ No ☐ Yes, but only for certain services. (Please share this information) **How should an appointment be made?** ☐ Come in person. (Please specify the times): ☐ Call. (Please specify the times): ☐ E-mail: ☐ Other (phone, WhatsApp, Viber, Facebook, etc.): **Do you have a hotline in place?** Yes No
WHEN: Activity end date *Please insert the end date for your intervention*	
Referral accepted *Specify whether this service accepts referrals for assistance*	☐ Yes ☐ No
WHERE: Location where your services are provided *If your service is a hotline or you do not wish to disclose the exact location, please fill out only the city/region you cover. Your service will not appear on an actual map, only on a list. If you have a list of locations in your area, you can input this as a drop-down list if it is an electronic form.*	**District/region:** **City:** **Street:** **Floor:** Name of building /which doorbell to ring/landmarks to help identify location/address: Additional information not mentioned:

For WHOM: Eligibility *Do nationality, age, gender, legal criteria apply for access*	☐ Yes ☐ No *Add any specific eligibility requirements for this intervention:*
Referral protocols: *Add additional information required to access the service, for example, specific requirements. Example: an ID document, birth certificate.*	
CONTACT: Primary focal point	Name: E-mail: Telephone:
CONTACT: Secondary focal point	Name: E-mail: Telephone:
Complaint & feedback: *Please specify your complaint and feedback channel for service users to contact you, submit comments, file complaints linked to your service provision.*	**Focal point for accountability, protection from sexual, exploitation and abuse (PSEA), community engagement.** Name: E-mail: Telephone: **Available channels to provide feedback:** Telephone: WhatsApp: E-mail: Website: Facebook: Instagram: Other: Channels which include feedback for sensitive protection incidents/PSEA: Geographical coverage: Expected timeframe for response to feedback received:

	Expected channel for response to users who have raised complaints/feedback (e.g. by e-mail):
Service mapping contact: *Two focal points who we can contact in order to regularly update the service entry.*	**Name of focal point A:** E-mail: Telephone: **Name of focal point B:** E-mail: Telephone:

List of potential 'TYPES OF SERVICE' for each operational sector. Note that MHPSS services are coordinated in and across sectors of intervention.

Health

Primary Health Care

•Vaccination

•Medication for acute and chronic disease

•Communicable diseases care

•Sexual and reproductive healthcare, including pregnancy care and family planning

•Malnutrition screening and referral or management

•Clinical management of mental disorders by non-specialized healthcare providers

•Dental care

•Basic laboratory and radiology tests

•Health promotion

•Medical consultations

•Medication for acute diseases

•Non-communicable diseases care

Secondary Health Care

•Orthopaedic

•Neurology and neurosurgery

•Cardiology

•Urology

•Ear nose and throat (ENT)

•Pulmonary

•Gastroenterology

•Vascular

•Obstetrics and gynaecology

•Neonatology
•Paediatrics
•Oncology
•Nephrology and dialysis
•Endocrinology
•Ophthalmology
•Blood disorders
•Cleft lip palate
•Radiological tests (X-ray, CT, MRI)
•Tuberculosis (TB)
•Malnutrition
•HIV prevention & response
•Endoscopy
•Psychiatry
•Surgery and rehabilitation
•Clinical management of rape (CMR) (only to be referred by case management case workers)
•Legal documentation of cases of torture
•Physiotherapy
•Provision of assistive devices

Mental health and psychosocial support (MHPSS) services
•Psychiatric and psychological consultations, including diagnosis and treatment
•Pharmacological management and other specialist clinical management
•Inpatient mental health care
•Laboratory tests
•Individual and group psychotherapy
•Interventions for alcohol/substance use
•Psycho-education/awareness raising
•Information dissemination to the community at large
•Psychosocial support for staff/volunteers

Shelter/camp coordination and management
•Weatherproofing shelter kits
•Distribution of tents
•Cash for rent
•Rehabilitation of unoccupied shelters, occupied shelters, collective shelters
•Fire prevention
•Site improvements

Water, sanitation and hygiene

•Rehabilitation of latrines and construction of latrines

•Rehabilitation of WASH facilities

•Hygiene promotion sessions

•Distribution of hygiene kits

•Water-quality testing

•Distribution of water tanks

•Distribution of drainage kits

•Distribution of garbage bins

•De-sludging services

•Water trucking

•Construction of grey-water systems

•Construction of septic tanks

•Construction of water reservoirs

•Construction of water network

Social stability/governance

•Support for municipal capacity & services

•Establish & support community dialogue mechanisms

Protection

•Legal aid (mediation, legal counselling/legal case management, civil status documentation services)

•Family tracing & reunification

•Advocacy for humanitarian border admission

•UNHCR reception centre services

•Protection case management

•Mental health and psychosocial support services

•Psychoeducation/awareness raising

•Individual and group psychotherapy

•Basic counselling for individuals, groups/families

•Information dissemination to the community at large

•Psychosocial support for staff/volunteers

•Linking vulnerable individuals to general humanitarian resources

•Specialized servicers - rehabilitation for persons with disability and older persons

•Protection cash

•Protection monitoring

•Housing, law and property

•Support for detainees

•Mine risk awareness

SGBV

•Case management - Survivors of gender-based violence

•Psychoeducation/awareness raising

•Individual and group psychotherapy, psychological debriefing, and mental health and psychosocial support services

•Supporting community-initiated social supports

•Strengthening community and parenting/family support

•Psychosocial support for staff/volunteers

•Capacity-building activities (including training and coaching)

•Community outreach & awareness activities

•Women and girls safe spaces

Child protection

•Case management

•Recreational activities

•Individual and group mental health and psychosocial support services

•Psycho-education/awareness raising

•Supporting community-initiated social supports

•Basic counselling for individuals, groups/families

•Strengthening community and parenting/family support

•Psychosocial support for staff/volunteers

•Focused psychosocial support

•Alternative care solutions

•Parenting support

Livelihoods

•Vocational training

•Agriculture support

•Provision of in-kind agricultural inputs

•In-home income generating activities

•On the job training

•Business grants

•Cooperatives support

•Village savings and loans (VSLs)

•Cash-for-work

•Life skills

Education

•Basic literacy and numeracy programme

•Non-Formal early childhood education

•Formal education

•Social emotional learning (SEL) activities

•Psychosocial support in education

•Psycho-education/awareness raising

•Retention support (school-based or community based)

Food security and basic needs assistance

•Multi-purpose cash

•Winter cash

•Fuel vouchers

•Non-food-item distribution

•Food assistance for assets

•Food assistance for training

•In-kind food assistance (food parcels, hot meals)

•Food vouchers/e-cards

•Cash for food

ANNEX 5

SERVICE MAPPING: PHYSICAL SPACE ACCESSIBILITY AUDIT

Purpose of the form: This form can be used to assess accessibility – how someone can reach, circulate, enter and use a space to receive services. This audit provides useful information for caseworkers to be able to share information with their clients about the accessibility of referral services, and provides a list of recommendations for reasonable accommodation which case workers may need to make to support their clients' access.[1]

Why is this form important?
Persons with disabilities, and others such as older persons, persons with injuries, pregnant women, new parents, adolescent girls, LGBTQIA+ and young children, may face additional barriers when accessing and using services. Caseworkers who refer clients to services must be aware of the accessibility of those service beforehand and put in place support where required.

What to look at when using this form?
We need to look at the environmental (physical, information and communication) barriers: physical obstacles and informational and communication obstacles that people face, including persons with disabilities or other individuals, when trying to reach, enter, circulate and use facilities to which they are referred.

The service mapping should include information on barriers related to the services mentioned and provide the support options available that caseworkers can draw on to support clients' access. To do this, we need to identify barriers to services through direct observation of the facility. By assessing and supporting clients' access a specific service, we can ensure our services are client-centred and uphold our clients' participation and safety.

How to use the form to assess physical accessibility

- Select two focal points - ideally staff who do not work in the facility to ensure objectivity - to use this form to assess the accessibility of the facility. It is good practice, where possible, to involve persons with disabilities, older persons or organisations of persons with disabilities or older persons associations to carry out/be involved in the survey.
    1. Another good practice and option which can be used is to establish a small group/committee, which is formed by clients with disabilities themselves, to provide regular feedback on their own access issues. Usually this is done through a "Disability walk-through", where clients with different types of disabilities visit the structure and explain how they usually engage with services, including call-in modalities, filling forms, using facilities, etc.

- Focal points should have received training on protection principles and inclusion, and have been trained on how to administer the form prior to use.

- To complete the form, focal points will have to walk through the physical space or centre. Each staff member should complete the form independently and then cross-check it with a colleague at the end. A discussion should take place where they come to different conclusions.

- Based on the audit findings, compile a list of the key barriers to access and key recommendations to enable access to the facility. This may be in the form of what reasonable accommodation may be required for clients to access the facility. Make sure to share these with the focal point who will update the service-mapping template. This information will accompany the information collected in the 'Annex 4 Service Mapping: Service Information Collection Form'.

- If this facility is an internal organization facility, send the recommendations to your manager.

[1] This form has been adapted from the International Rescue Committee Gender-Based Violence and Child Protection Services inclusivity Assessment Tool. Where possible, you should try to assess the attitudes of staff providing services within the facilities. This may be more difficult for external services, but you will be able to do this for your own internal agency services through an attitude assessment for staff. You can also ask persons with disability and older persons directly for their perceptions of the safety and accessibility of services. These three tools together will provide a comprehensive inclusive assessment.

Preliminary information	
Completed by: *Insert the focal points who will complete the audit*	**Name of focal point A:** E-mail: Telephone: **Name of focal point B:** E-mail: Telephone:
Location: *Insert the location you are auditing.*	Internal External **Please specify for both:**
Date of audit:	
Summary of key findings (barriers & enablers)	
Key barriers *What key barriers are preventing access for people? Are these barriers related to physical, attitudinal or information and communication issues?*	**Attitudinal:** **Physical:** **Information and communication:**
Key enablers *What key adaptions are required to support the accessibility of the facility for everyone? What reasonable accommodations can caseworkers make to support access by their clients?*	

Physical barriers *Please check yes or no for each box. If the question is not relevant, check N/A and provide a brief explanation*			
REACH - Reaching services, including accessing information, transport to/from *Ask what information is available in different formats and how everyone, including people with disabilities, can reach the service*	**Y**	**N**	**N/A**
REACH - Information Are outreach or awareness activities conducted in the community regarding the services available?			

	Y	N	N/A
IF YES: please describe the channels you use: *(Circle all that apply)* a. Community meetings b. Local radio c. Billboards d. Leaflet and brochures e. Text messaging f. E-mail g. Through staff member h. Through community volunteers i. Through local leaders j. Other (please specify)			
Is specific outreach done for people who are caregivers, illiterate, older persons and people with disabilities regarding the available services?			
IF YES: Does the outreach involve alternative communication channels, such as sign language translation, availability of documents in Braille or easy-to-read formats?			
Do you have a hotline?			
Does the hotline offer options for alternative forms of communication?			
REACH – Physical access Is transport available to assist someone to reach the service?			
IF YES: please circle the type of transport : *(Circle all that apply)* a. Public transport b. Walking accompaniment c. Personal vehicle d. Hired car, i.e. taxi e. Other (please specify)			
Do persons with disabilities find this transport accessible?			
Is the facility clearly signposted? E.g. The building has a clear sign. The entrance is easy to identify.			
REACH – Safety Are there any potential threats along the road for someone travelling to this facility? I.e. checkpoints at key towns/villages, poorly surfaced road, etc. If yes, what? (Please specify)			

ENTRY, CIRCULATION, AND USE OF THE SPACE- Actual building structure and internal facilities *Can all persons, including persons with disability, easily enter the space, use and circulate within the space, including the bathrooms?*			
ENTER – Physical access considerations related to the entrance Please verify the following, mark yes or no for each item: a. Gate is easy to open once entrance is permitted b. Gate is secure or guarded c. Door is easy to enter (no less than 800mm in width, without lip or stair) d. Stairs are clear of material and safe to use (e.g. non-slippery surfaces, presence of handrails) e. Step edges are highlighted f. Stairs are slip resistant g. A ramp is available, safe and easy to use independently (e.g. non-slippery surfaces, presence of handrails, not too steep) h. Entrance door handles are mounted 800-900mm above the floor i. Door handles are easy to use (not round) j. Ramp is at least 1000mm in width (1800 mm is ideal) k. Entrance is free of obstructions l. Entrance is well-lit m. Main entrance is clearly sign-posted n. Are staff available to assist those who may require support? (Blind, children, older persons) o. Other/comments *(Are there any other hazards not mentioned or further details of any aspects listed as No? —Please specify)*	**Y**	**N**	**N/A**
ENTRY - Safety Are there any safety concerns within the facility? E.g. leaking water, slippery floor, exposed wires, stair-only access, etc. If yes, please specify the safety and accessibility concerns present and any recommendations?			
CIRCULATION & USE – Safety and dignity Are separate male and female bathrooms available in the facility?			
USE – Dignity Are the bathrooms clean? If no, what adjustments are required to ensure cleanliness? *(Please specify)*			
For the bathrooms, are there adequate supplies? E.g. waste bins, soap, etc. If no, what supplies are needed? *(Please specify)*			

CIRCULATION and USE – Accessibility Are separate male and female bathrooms accessible at the facility for persons with a disability? If no, what adjustments are required to ensure accessibility? *(Circle those that apply)* a. They are clearly sign-posted (includes pictures and not just words) b. There are no exposed wires c. Toilets are available on the same floor as where the services are provided, with no steps for access d. The doors to access toilets and cabins are wide enough to allow wheelchair access e. Water points and soap dispensers are accessible f. Toilet paper/hose pipe is accessible from toilet g. There are handle bars present close to the toilet and on the back of the door *Please specify additional features required:*	**Y**	**N**	**N/A**
Are all areas of the facility accessible for all persons, including persons with disability, to move around from one room to another and across different floors? *(Circle those that apply)* a. They are clearly sign-posted (includes pictures and not just words)? b. There are no exposed wires c. There is sufficient and safe space in which to wait in the reception area d. The temperature is adequate (not too cold, not too hot) e. Water points are accessible f. Lights are functional g. Wheelchair users can access all parts of the building, including washing facilities h. Interior doors are wide enough for wheelchair users i. Door handles are mounted 800-900mm above the floor j. Door handles are easy to use (not round) k. Materials such as posters, leaflets, etc., in the facility are available in a variety of formats (Braille, pictorial, easy-to-read) l. There is a calm space for clients who may need it m. There is a child-friendly/play area for children, accessible and with toys for different ages and development skills *Please specify additional features, if required:* **Is there a protocol/service agreement in place for cases where interpretation is required to support communication? (i.e. minority languages, sign language, etc.)**			

COMPLAINTS & FEEDBACK *Can all persons, including persons with a disability, submit a complaint or provide feedback independently in a way that preserves their anonymity and privacy?*			
Are the various channels for service users to submit a complaint or to provide feedback clearly marked in the facility? **IF YES:** Please specify. *(Consider whether different formats are being used)*	**Y**	**N**	**N/A**
Are these complaint and feedback channels easily accessible for persons with a disability to use independently? *(Circle those that apply)* a. They are mounted 800-900mm above the floor (complaint box, phone) b. Positioned in rooms that are wheelchair accessible c. Clearly sign-posted in a variety of formats (Braille, pictorial, easy-to-read) d. Posters in the facility are in a variety of formats (Braille, pectoral, easy-to-read) e. They are positioned in a place that is private and preserves confidentiality *Please specify additional obstacles, if present:*			

ANNEX 6

MINIMUM STANDARDS FOR DATA PROTECTION[1]

Part A: Data Protection Checklist
Part B: Staff Data Protection Agreement
Part C: Data Protection Protocol

Part A: Data Protection Checklist
You can use this checklist to assess whether you have the minimum standards in place for collecting, storing or sharing your client's data. If, after going through this checklist, you determine that you do not meet these standards, you should contact your technical advisor or head of unit for support.

Data Protection Measures	Y/N
Are records/files stored in a safe location? • Is access limited to authorized staff? • Are files with client information stored in lockable file cabinets or on computers in rooms that are locked when unoccupied? • Are electronic devices with client 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?	
Is there a Staff Data Protection Agreement in place? • Is it signed by staff interacting with information and stored in HR files?	
Have staff been trained on confidentiality, data protection protocols and the process for seeking informed consent? • Is consent for information sharing documented?	
Are staff informed about and comfortable with discussing applicable and functioning local mandatory reporting mechanisms? • Do staff know the applicable and functioning mandatory reporting requirements and how they are applied in the programme (the process and outcomes)? • Have the risks to clients mandatory reporting been discussed in the programme?	
Is there a protocol for safe destruction of paper forms (shredding, burning and wetting)? • 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 an imminent security threat?	

[1] This form is adapted from the GBV IMS Data Protection Protocols Guidance.
*Information refers to any data, records, case files or other files with information, whether identifiable or not.

Are electronic case management systems protected? • Do electronic case management systems have mandatory user log-in or other graduated access (depending on the role)?	**Y/N**
Do you routinely back-up data? • How often? Is it backed up to a safe location?	
Are clients informed of their rights in terms of data collection, storage and sharing? • The right to request that their story, or any part of their 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 they need 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 of a different gender or organization be assigned to their case. • The right to refuse referrals, without affecting our willingness to continue working with them. • The right to access their personal information at any time.	
Are you aware of the applicable data protection laws in the country of operation? • What are they? Has this been discussed in the programme?	

Part B: Staff Data Protection Agreement

Data protection and data security is the responsibility of every staff member who works with clients or has access to client information. Staff should be clear about why they are collecting data and should not collect or share any personal information other than in accordance with agency data-protection standards.

Protection data is particularly sensitive. It should only be collected, stored, or shared with the individual's explicit, written consent, adhering to the principles of 'need to know,' and in accordance with the protocols developed in country.

By my signature below, I affirm that I have been advised of, understand, and agree to the following terms and conditions of my access to information: (Please initial each point and sign below)

- I understand that my access to data, information, and records containing information about clients is limited to my need for that information in the performance of my job duties.
- I will not disclose information about clients without their appropriate and informed consent. I understand and agree that my obligation to avoid such disclosure will continue even after I leave my employment.
- I will be careful to protect Information against accidental or unauthorized access, disclosures, or destruction.
- I agree to follow the guidelines in my agency data protection protocol
- I will not access the protection information management database(s) or other client files or records when I am at home or in a public, non-private setting.
- I will not share any client data with anyone outside my agency and not without the express written permission of the client and following the proper protocols at my office. Inter-agency data sharing must go through/be approved by a central focal point, for example, the head of unit.
- I know that clients have a right to access their personal information. I will therefore be accurate and non-judgmental in what I write about clients and other agencies.
- I will keep all paper files containing personal information locked in a secure location (lockable filing cabinet, safe) as per the office protocol.
- I will not share my log-in information or passwords for the database.
- I will update my password regularly, as per the office protocol

Staff signature:

Date:

*Information refers to any data, records, case files or other files with information, whether identifiable or not.

Part C: Data Protection Protocol

This protocol is designed to support you in assessing your existing data security and to develop a customized data protection protocol. This is designed to be an active document that complements your other Data Protection Protocols/Policies.

GENERAL DATA PROTECTION
All staff involved in protection case management should be trained and aware of the data protection protocols, the security implications of sensitive data and have a strong understanding of the importance of confidentiality.
An obligation to adhere to data protection policy should be written into staff contracts.
All clients and caseworkers will be allocated a code based on an agreed standard coding format. The code should use letters or numbers from their last name or other details, such as areas of origin, but should guarantee anonymity. The code should be used to refer to the case, either verbally, on paper or electronically, in place of any identifiable information, such as a name or date of birth. All files should be stored according to the allocated code. Only the person who assigns the code should know the identity.
Access to information on clients should be limited only to those who need to know it and to whomever the clients have agreed can know it through giving their informed consent to storage of their data. Staff should understand that clients might ask for particular information not to be shared with certain people, and that this must be recorded and respected. The consent form should be signed, where possible, and kept in a locked filing cabinet.
Information must not be passed to a third party without the informed consent of clients and/or their caregivers and then only in accordance with the data sharing protocols. Only agreed mandatory fields may be shared and with supervisors only, or when cases require referral and consent has been given.
Store the consent form and the identification and registration form in a folder separate from the rest of the client's case file.
Clients have the right to access and review information about them at any time. Provisions should be in place to allow for this.
All staff working with client data should sign the data protection agreement as part of their hiring process.
It is important that managers ensure that data protection protocols are followed and updated regularly (i.e. when contextual changes occur).
PAPER FILE SECURITY
Where possible, try to be paper-free to avoid information being printed. Only print when necessary. Where information is printed, you should apply a code and track printed material in a spreadsheet so you are aware of and accountable for it. You should destroy all printed material if it is no longer needed.

*Information refers to any data, records, case files or other files with information, whether identifiable or not.

Paper documentation for each case must be stored in its own individual file, clearly labelled with the case number. Names of clients must NOT appear on the outside of paper files.
Paper files must be kept in a locked cabinet/drawer, accessible only to the competent individuals specified by the managers. No one else should be given independent access to paper files without permission and there should be limited access to keys.
For protection case management, identification and registration forms and consent forms must be stored separately from the casefile.
Rooms containing paper and electronic information must be locked securely when the staff leave the room. All staff must be aware of the importance of being vigilant as to who enters the room where they work and for what purpose.
ELECTRONIC DATA SECURITY
Establish protocols for all staff to access data with password-protected electronic devices and for limiting access to computers. Establish a series of strong case-sensitive and special character-included passwords, with a different one for each level.
All applicable staff must be aware that information should be transferred using encrypted and password-protected files, whether this is by Internet or using USB/memory sticks.
At least two backups must exist – one stored in the location in which the database is held and backed up each week when data is entered, and the second sent for secure storage in a designated off-site location (for example: the database copy sent to the head of unit or the information management officer once a month). Staff responsible for the data at the second site must follow the same data protection protocols. The reason for having an off-site back-up is so that the main database can be restored in case of technical problems, or be destroyed in an emergency evacuation without this meaning the loss of all electronic data. Typically, the on-site back up is an external hard drive which is kept locked in a filing cabinet, and the off-site back up is done by e-mailing the database to the designated receiver (most likely the Head of the Programme) as an encrypted, password-protected file.
All computers must have antivirus protection installed and active.
Ensure all computers have the latest software updates and security patches. You should also confirm that Windows Updates are correctly configured so that updates are downloaded automatically, and then periodically check for errors or failed updates.
If tablets are used in your setting, ensure that all devices are encrypted from the lock screen, a app lock is set up, and a device manager is enable in case the device is lost or stolen to enable features for locating it or erasing data.

*Information refers to any data, records, case files or other files with information, whether identifiable or not.

EMERGENCY EVACUATION/RELOCATION[2]

In the event of an evacuation/relocation, management must ensure that the computer(s) where the database is setup, its back up systems and paper files are moved to a safe location. When moving database assets and paper files is not possible, management should ensure that the assets are destroyed and papers burnt. Information saved in back-up systems will then become the only source of information on clients. It should be noted that, in some circumstances, it may not be necessary to destroy files and therefore is more important to ensure they are properly secured and protected during the period of evacuation/relocation.

A clear evacuation/relocation plan should be developed that outlines a 'scheme of delegation' dictating who has responsibility for making decisions on removing or destroying data (for both paper and electronic data) for each site. This plan should be incorporated into the standard evacuation/relocation plan for the whole agency by security managers/senior staff.

All staff should know their individual responsibilities as detailed in the evacuation/relocation plan and be aware of the sensitive nature of data being collected. Briefing on the evacuation plan should be part of the standard induction checklist for relevant staff.

Evacuation/relocation drills should be carried out to ensure that each individual knows their responsibilities and is able to act quickly in an emergency evacuation/relocation. In the event of a deteriorating security situation, evacuation/relocation plans should be reviewed—and if necessary, re-evaluated—by senior management and security personnel.

[2] Adapted from the data protection protocols for child protection case management developed by the child protection working group in Turkey.
*Information refers to any data, records, case files or other files with information, whether identifiable or not.

ANNEX 7

CASE MANAGEMENT STAFF ROLES AND RESPONSIBILITIES

Purpose of the form: Purpose of the form: A non-exhaustive list of examples demonstrating the key roles and responsibilities of protection case management staff to support programmes in developing job descriptions/terms of reference.

Role	Caseworker	Protection Case Management Officer (Supervisor)	Capacity Building Officer	Information Management Officer	Volunteer
Major Responsibilities					
Responsibility	• Identify and receive referrals of persons at heightened risk. • Conduct household visits and centre-based interviews to assess the needs of individuals and families. • Provide information to individuals and families about their rights and entitlements, including what services are available. • Work with identified individuals and families to develop and implement an action plan in accordance with their needs, capacities and goals. • Assess risk and support clients in understanding risks relevant to their situation.	• Ensure case management interventions adhere to international best-practice standards and guiding principles. • Oversee the development, maintenance and rollout of case management processes (service mapping, protocols, referral pathways, SOPs, etc.) where necessary. • Provide support to case workers in handling complex cases and, depending on the complexity of the case, seek guidance from the specialist. • Coach, train, supervise and mentor direct-report staff.	• Develop a case-management quality strengthening action plan and schedule based on identified need and gaps. • Conduct training sessions supporting capacity building plans. • lead the organization, development and facilitation of training, technical support provision, and regular coaching sessions.	• Support the development and implementation of regular monitoring and evaluation activities for case management activities. • Ensures quality information management, including case management databases.	• Provide information to community members about how to access protection case management services and refer cases to caseworkers. • Liaise with community leaders and members to introduce programme activities and encourage community involvement in programme implementation and activities. • Facilitate client's access to services through the dissemination of up to-date information about existing local services that are available within their communities.

Data and Reporting	• Ensure complete and updated documentation related to each individual case. • Manage, file and store data, ensuring the confidentiality of the information collected • Prepare and submit weekly and monthly work plans. • Support the implementation of monitoring and evaluation tools and report on problems in the implementation of the programme.	• Ensure that the case management teams maintain complete, accurate, and confidential-case files. • Compile and produce weekly and monthly protection case management reports. • Support the implementation of monitoring and evaluation tools.	• In coordination with the supervisor, analyse data collected through the supervision tools. • Input into donor reporting on activities, indicators and achievements, particularly around case-management staff-capacity development.	• Responsible for identification and execution of strategies to improve data-collection methodology. • Identify any new or potential risks to clients and staff due to data collection. • Conduct data-quality checks and regular data cleaning. • Manage the development of protection case management databases. • Analyse qualitative data collected from site visits, focus group discussions, key information visits and other qualitative methods; identify relevant trends and patterns.	
Coordination	• Contribute to the maintenance of an up-to-date service mapping of the service providers. • Receive cases referred from other agencies. • Advocate on behalf of clients to access services and support clients to effectively represent their views, needs and capacities in all meetings affecting them.	• Work with service providers to implement standard operating procedures and monitor adherence to referral pathway. • Participate in local working groups.	• Participate in local/ national working groups.	• Support timely information sharing regarding challenges and needs at the field level.	

Qualifications					
Work Experience	• At least two years of experience in counselling or humanitarian assistance. Experience working within the relevant context preferred.	• Proven practical experience of providing direct case management. • Demonstrated understanding of case-management processes, protocols, service provision and referral systems. • Previous experience in managing a team.	• At least three to five years' experience providing technical coaching and mentorship for case management or PSS programs. • Practical experience providing direct case management.	• At least two years of experience working with data analysis. • Experience producing quantitative analysis and reports. • Full professional competency in Microsoft Office Suite, especially Word, Excel, Outlook, and PowerPoint.	
Demonstrated Skills and Competencies	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients at all times. • Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility • Ability to works effectively with people from all backgrounds, and develop strategies to address barriers faced by individuals most at risk of discrimination.	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients at all times. • Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility. • Ability to work effectively with people from all backgrounds, develop strategies to address barriers faced by individuals most at risk, and identify and address discriminatory biases in supervised staff.	• Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility.	• Strong analytical and reporting skills, with attention to detail. • Excellent organizational and time-management skills. • Good interpersonal skills and ability to work as part of a team.	• Well respected by the community. • Committed, motivated and willing to learn. • Good communication skills, including an ability to gain trust and build relationships with the community.

ANNEX 8

PROTECTION CASE MANAGEMENT MINIMUM STANDARD CHECKLIST[1]

Purpose of the form: You can use this form to assess whether your protection case-management services meet the minimum standards for a rights-based and client-centred approach to protection case management. For further information and guidance on each standard, you can refer to the relevant section in the protection case management guidance.

Find in Guidance	Meets Minimum Standards	Y/N	Notes for Recommended Action
Chapter 2	The Protection Case-Management approach is part of a defined strategy for response, which is adopted based on engagement with key stakeholders, a context-specific protection analysis, and an assessment of your agency's internal capacity to provide quality care.		
Chapter 2	Direct implementation for protection case management services is done only after assessing the possibilities of strengthening existing systems or of establishing local partnerships. A strategy for the withdrawal of your services is in place.		
Chapter(s) 2 / 3.A.	A context-specific protection analysis is used to inform the prioritization process for protection case management services.		
Chapter(s) 1.C / 3.D / 4. Step 1 / 6	Appropriate focused care is ensured by addressing barriers to full participation and access for all age, gender, disability and diversity groups at all stages of the programme cycle.		
Chapter 3.B	Established referral pathways exist for identification and referral supported through the protection sector, and case coordination with other case management streams is in place to define clear areas of responsibility.		
Chapter 3.G	Standard operating procedures (SOPs) for protection case management are developed in cooperation with the national protection cluster. SOPs are updated every 6-12 months.		

[1] This form has been adapted from the Case Management Quality Assessment Framework (QAF), which was developed under the Alliance for Child Protection in Humanitarian Action by the Global Case Management Task Force.

Chapter 1.C	Agency SOPs are in line with the guiding principles for protection case management, as outlined in these guidelines, and these guiding principles are monitored. Case management staff are trained and receive on-going supervision on these. The application of these principles is monitored through supervision and MEAL activities.		
Chapter 3. A.	Timeframes for different steps in the case management process are conducted according to the risk-level determination. Caseworkers are trained on determination of the risk level and this is reviewed throughout the process on an on-going basis. Implementation is monitored through on-going supervision.		
Chapter 3.D.	Complaints and feedback are actively sought from clients and families throughout the programme cycle. Channels for providing complaints and feedback, and to respond to it, are designed with the community to include all age, gender, disability and diversity groups.		
Chapter 3.C.	Case management forms are standardized to the extent possible. Caseworkers are trained on how to use them in a standardized way. For more on Information Management, please see the Annex 7, Data Protection Guidance.		
Training & On-going Capacity Building			
Chapter 3. E	There are job descriptions in place for all case management staff that outline clear roles and responsibilities, qualifications and competencies. Staff are recruited and trained accordingly.		
Chapter 3.E, 3.G.	Staff ratios are in place and respected. Caseworkers should not oversee more than 25 cases, and supervisors should not oversee more than 5-6 caseworkers.		
Chapter 3.E.	Case management staff receive orientation and training on Codes of Conduct, GBV and CP core concepts, guiding principles including informed consent and mandatory reporting requirements, data protection protocols, psychological first aid, case management, referral processes and other necessary topics in line with their job description.		

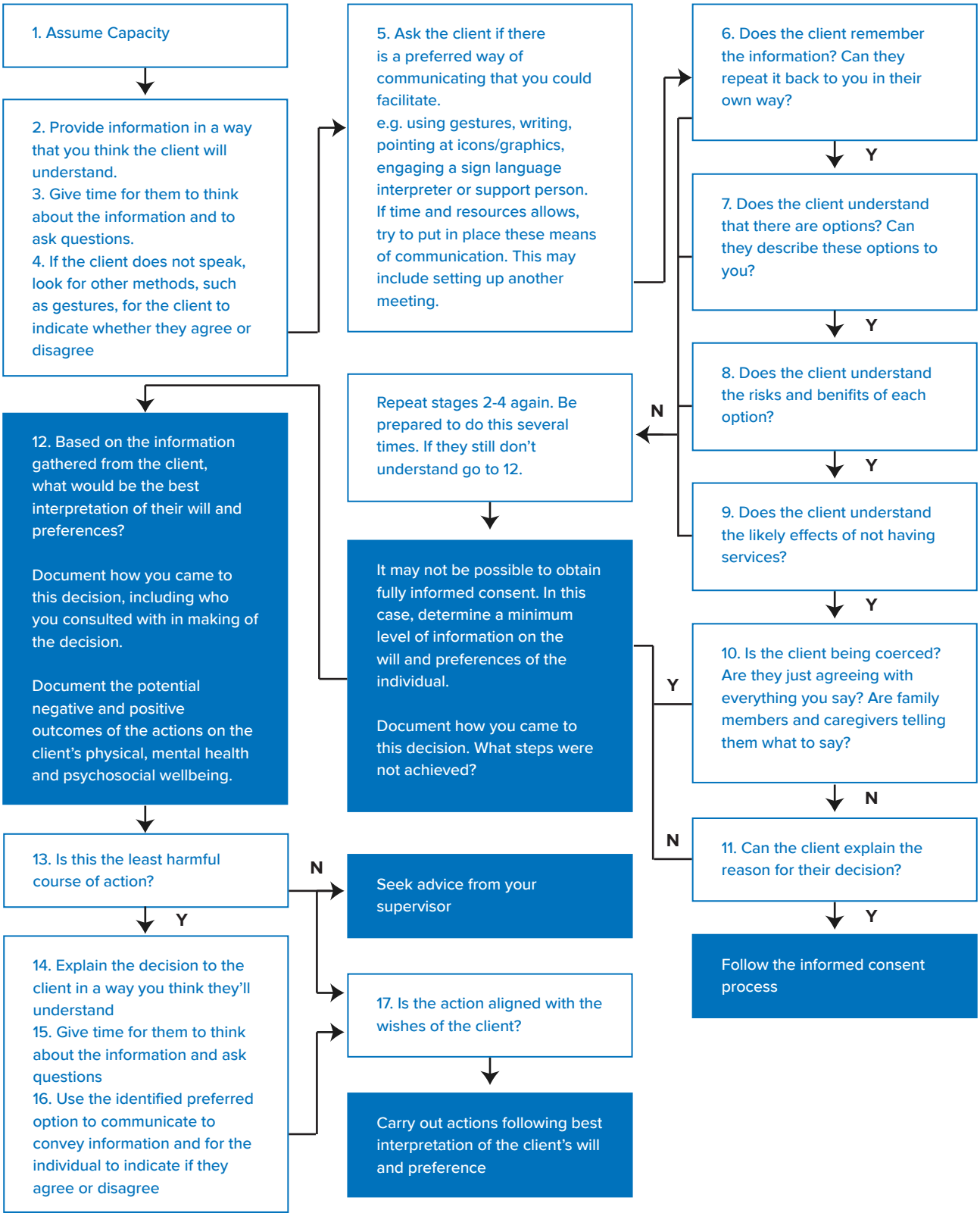
Case Management Process			
Identification & Registration/Protection Risk Assessment			
Chapter 3.A	Prioritization criteria for protection case management services are pro-actively communicated, clearly and transparently, to the community and other key stakeholders. Different formats are used to reach all age, gender, disability and diversity groups.		
Chapter 4,Step 1.	Caseworkers are trained to identify and immediately assess and address urgent threats to the life, safety and dignity of a client.		
Chapter 1B,4, Step 1.	Informed consent/assent to participate in the case management process, including documentation, storage and sharing of information, is sought prior to registration. All barriers to participation in this process are addressed through reasonable accommodations (communication, gender preference for case worker, physical space, etc.).		
Chapter 1.B, 4, Step 1.	All clients are assumed to be able to provide informed consent/assent. Where there are challenges, a three step- approach is followed in order to ensure that: a. Communication is adjusted, using a range of methods to convey information, in a way that the client can understand; b. Clients can choose any support persons they wish to include to support their understanding and communication in the decision-making process; c. Decisions made based on the vital or best interests of the client should only be used as a last resort.		
Chapter 4, Step 1 and 4. Step 2.	Caseworkers identify persons at heightened risk through an assessment of their risk and protective factors relating to specific rights violation(s). This requires a consistent approach, which owes the same duty of care to each client.		

Case Planning			
Chapter 4, Step 3.	Caseworkers support clients in developing goals and actions to reduce risks and enhance strengths identified in the risk assessment. All goals are specific, measurable, actionable, realistic and time-bound (SMART). Case plans are developed collaboratively and are signed by both the client and caseworker.		
Chapter 4, Step 3.	Case conferences are called for complexes cases requiring a multi-sectoral approach.		
Implementation of the case plan			
Chapter 5, Step 4.	Caseworkers connect clients to services through safe, accountable and timely referrals. Informed consent/assent is sought prior to each referral and the client is informed about the various options available to them, the service, its accessibility, any risks or benefits, their rights in relation to the referral, including the way their data will be protected, and the expected response time from the receiving agency. Accompaniment plans are put in place as required.		
Chapter 4, Step 3	Caseworkers assess client safety and security during every visit and, where necessary, support clients in identifying strategies to minimize the likelihood of harm. Safety plans developed should be customized to each client and build on coping strategies already being used by the client.		
Follow Up & Monitoring			
Chapter 4, Step 5.	Jointly, caseworkers and clients regularly review and record progress made toward the case plan. Caseworkers reassess the client's safety and mental health and psychosocial wellbeing, and changes that have occurred, and these are updated in the action plan in agreement with the client.		

Case Closure			
Chapter 5, step 6	Reasons for case closure are outlined in the SOPs and followed. Clients take an active part in decision-making around case closure. Caseworkers consult with their supervisors, who must sign, alongside the caseworker and client, the case closure form.		
Chapter 5, step 6	Clients with complex and long-term problems may require recurrent case management support. Clients should be assured that they can return to receive case management services if new concerns arise.		
Supervision			
Chapter 5	Caseworkers should take a capacity assessment (knowledge, skills, attitudes), to be used to develop a capacity building plan. Caseworkers are supported in addressing negative attitudes.		
Chapter 5	Supervisors conduct regular individual and group supervision sessions with their caseworkers. These are planned weekly or bi-weekly. Practical on-the-job observation and shadowing is done.		
Chapter 5	Case files should be checked, using a case file checklist, as a form of quality control and to support the caseworker.		
Follow Up & Monitoring Monitoring, Evaluation & Learning			
Chapter 6	Performance indicators have been adopted and disaggregated data is collected to feed into these indicators. These include protection mainstreaming process and impact indicators.		
Chapter 6	Non-sensitive and non-identifying aggregated data on trends from protection case management and complaint and feedback mechanisms are shared with the protection sector and the inter-agency in accordance with the data sharing protocols to inform learning, programming and advocacy.		
Chapter 6	During case closure, clients are asked whether they consent to taking part in a client feedback survey. This survey is conducted within 3 months of case closure to assess the quality of care received and make improvements.		

ANNEX 9

SUPPORTED CONSENT AND BEST INTERPRETATION OF WILL AND PREFERENCE FLOW CHART



CASE MANAGEMENT - FORM 0

PRIORITISATION REFERENCE

Form 0 Prioritisation Reference Form (Protection Incident List)	
When to use	To be completed after the context-specific protection analysis based on identified context-specific risk and protective factors for relevant violation types in your context. Caseworkers should be familiar with this form to support their determination of whether to open a case file during step 1 of identification and intake. This form should be linked to the **Step 1: Identification & Intake Form**. This form should be updated regularly to reflect changes in your context.
Who should use it	Caseworkers
Purpose of the form	This form captures the organisation's prioritisation criteria for protection case management. It can be used as a reference to support caseworkers in determining whether a person is at heightened risk of a rights violation and whether they can be supported by the organisation's case management services. The form should be completed with the risk and protective factors captured through the context-specific protection analysis. You can fill these factors in for each relevant violation type which your organisation plans to address. This will support case workers in; • Understanding what violations your case management services aim to address; • Observing correlated risk and protective factors which influence the likelihood of a person experiencing the violation in your context; • Supporting caseworkers with classifying and identifying specific risks correctly. This form can be adapted to be useful for operational field teams. Some useful inputs might be: • Highlighting the risk factors that are most severe or prevalent that lead to a specific rights violation; • Highlighting the protective factors that are the most important in managing the risks; • Identifying the potential consequences of being at risk of the violation type (i.e. the impact of this on the person; this may be health consequences, for example); • What actions might be relevant to reduce the risk of this specific violation? Drawing on your service mapping may be useful; • After case management coordination with other case management teams, inputting which cases require a referral to another case management team can be helpful for staff (i.e. SGBV, legal, CP or mental health).

What violations are relevant in your context:

The types of violations listed below are contrary to international human rights refugee and humanitarian law, and most can be applicable to a refugee and IDP context. This form can help case workers to understand what rights violations may or have occurred, who may be or is responsible for the occurrence, and who may be at heightened risk of experiencing or having experienced the violations in your context. You can complete this form in relation to the rights violations for which your organisation has decided to prioritise criteria for protection case management to support caseworkers.

- **Deprivation of the right to life:** killing/murder/manslaughter, summary extrajudicial execution;
- **Torture, inhumane, cruel and degrading treatment of punishment:** Torture, Inhumane, cruel and degrading treatment or punishment, physical and psychological violence;
- **Deprivation of the right to liberty and freedom of movement:** arbitrary arrest and/or detention, arbitrary restrictions on movement, forced return (IDP only), abduction or kidnapping, enforced disappearance, other;
- **Exploitation:** Extortion, trafficking in persons, forced recruitment, other;
- **Forced/denied access to territory & asylum:** Refoulement, rejection at border/frontier, denial of access to asylum procedure, other;
- **Denial of family life:** Denied a family or relationship, denied or unable to exercise family unity, family separation, other;
- **Access to justice:** Access to judiciary, legal counsel, representation, denied fair trial/effective remedy, other;
- **Denial of economic, social and cultural rights:** Deprived access to basic needs and services, denial of the right to work, forced eviction, destruction/loss of property, other;
- **Civil and political rights:** Denial of freedom of association, denial of freedom of expression, denial of freedom of religion, other;
- **Right to nationality, civil status registration and documentation:** Denial of birth registration and/or certificate, arbitrary deprivation of nationality, denial of travel documents, other;

Examples of: Risk level to determine the prioritisation of cases

These are examples of risk level but you will need to adapt these based on your context. Below each risk level are examples of what situations might constitute low, medium and high.

Low risk-level: The probability of a serious risk to individual safety is low; however, an intervention to respond to individual specific needs may be required to reduce vulnerability.	**Medium:** The probability of a serious risk to individual safety requiring intervention within a week. Bi-weekly follow-up required by phone and visit. The number of follow-ups will decrease in line with the clients' needs.	**High:** Serious and imminent risk to individual safety requiring immediate action within a maximum of 48 hours. Depending on situation, weekly follow-up is required by phone and visit. The number of follow-ups will decrease in line with the clients' needs.

Example: The individual has already been taken in charge by another organisation. No disclosure of support has been observed or requested. There is an existing solid community and/or family support network. No obvious use or risk of negative coping strategies. There may be an existing additional need for another type of support not directly related to the protection incident.	**Example:** The individual has already been identified by a partner and has received some form of support but this needs to be reinforced. There is fragile existing family and/or community support. There is risk of and/or use of negative coping strategies as a result of the protection incident and/or due to risk of the protection incident. There is no immediate threat to life.	**Example:** Threat to life is identified - suicidal behaviour, health consequences endangering the life of the individual and/or family member(s). There is a physical safety risk. There is absence or a very low level of family and/or community support. The person may live alone. There is a visible risk of resorting to and/or use of negative coping strategies. There are multiple protection risk(s) correlated thereto and/or as a consequence thereof.
DEPRIVATION OF THE RIGHT TO LIFE *The right to life is considered to be a fundamental right and therefore can never be unlawfully restricted. There are a number of accepted events in which the right to life is lawfully restricted (death penalty, certain killing seen as necessary measures of law enforcement, certain killing committed in armed conflict). Consequently, if an allegation is made of a violation of the right to life, it must be shown not only that the death occurred, but also that it was arbitrary or unlawful. There are 2 elements: (1) deprivation of life which is (2) unlawful.*		
Type of Violation *Killing, murder, manslaughter (Including attempts)*	**Definition** The killing of a human being by a sane person, with intent, malice aforethought (prior intention to kill the particular victim or anyone who gets in the way) and with no legal excuse or authority.[1]	**Examples** - Deliberate or indiscriminate killing of civilians during conflict - Killings by police - Denying access to life-saving resources (e.g. water source) - Denial of lifesaving medical care (for example high rates of unexplained deaths in prisons or IDP camps, etc.)
Type of Violation *Summary extrajudicial execution*	**Definition** The meaning of extra-judicial killing or extrajudicial execution is the killing of persons by authorities without sanction or any judicial proceedings or legal process.[2] This includes the summary and arbitrary execution of persons.	

[1] G Hill & K. Hill, The People's Law Dictionary.
[2] International Covenant on Civil and Political Rights and Universal Declaration of Human Rights

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Overstretched capacities of judicial bodies to effectively prosecute such cases - Power relations creating an environment of impunity for the commitment of these crimes - Discrimination and xenophobia tolerating violent actions against certain groups - A state practice of elimination and imposition of authority by terrorising individuals (applies to extra-judicial killing) - Increased gang, drug trafficking, organised crimes - Non-state actor funding methods (death squads, extortions, etc.) - Weak or unregulated weapon sale and ownership	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Belonging to particular race, colour, sex, language, religion, political group, nationality, status or social origin - Socio-economic status increasing risks of targeting by armed groups or gangs - Relationships between perpetrator-victim - Belonging to armed groups, police, or judicial bodies - Substance use - Political affiliation - Divorce and separation	*Example of Protective Factors* - Increased community engagement and relations - Effective judicial due process - Guidelines and manuals developed by the State preventing the excessive use of force by security agents - Community based protection
Outside the scope of protection case management requiring referral	**For SGBV CM services:** Refer all cases of 'honour killing' and/or any other acts of GBV that result in, or are likely to result in deprivation of life.	

TORTURE, INHUMANE, CRUEL AND DEGRADING TREATMENT OR PUNISHMENT (including physical and psychological violence)		
Type of Violation *Torture*	**Definition** "Torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him/her or a third person information or a confession, punishing him/her for an act he/she or a third person has committed or is suspected of having committed, or intimidating or coercing him/her or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions.[3] Elements to be present:[4] 1) Involvement of a public official; 2) Infliction of severe pain or suffering; 3) Intention of the perpetrator and a specific purpose; and, 4) Powerlessness of the victim (includes deprivation of liberty).	**Examples** - Torture by state or non-state armed players - Prolonged detention and apprehension - Excessive house searches - Absence of legal documentation and increased risks of arrests - Security incidents resulting in indiscriminate measures applied to minority groups
Type of Violation *Inhumane, cruel, degrading treatment or punishment*	**Definition** Treatment that humiliates or debases an individual, showing a lack of respect for, or diminishing, their human dignity, or when it arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance.[5]	**Examples** - Humiliation against particular groups - Corporal punishment and attack - Prevention of access to some forms of services - Evictions - Arbitrary employment termination - Constant raids - Inhuman shelters and living conditions - Mutilation - Medical or scientific experiments or any other medical procedure not indicated by the state of health of the person concerned and not consistent with generally accepted medical standards.

[3] Article 1, UN Convention against Torture and other Cruel, Inhuman and Degrading Treatment
[4] Manfred Nowak, "Torture and Enforced Disappearance", in Catarina Krause and Martin Scheinin (eds.), International Protection of Human Rights: A Textbook (Turku: Institute for Human Rights, Åbo Akademi University, forthcoming 2009).
[5] *European Commission, Migration and Home Affairs – Case law from the European Court of Human Rights. ECHR Svinarenko and Slyadnev v. Russia Applications nos. 32541/08 and 43441/08 & M.S.S. v. Belgium and Greece, Application no. 30696/09, § 220, ECHR 2011 & El-Masri v. the former Yugoslav Republic of Macedonia, Application No. 39630/09, § 202, ECHR 2012*

Type of Violation *Physical and psychological violence, including assault and abuse*	**Definition** "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a high likelihood of resulting in, injury, death, psychological harm, maldevelopment, or deprivation"[6]	**Examples** - Self-inflicted violence, such as suicide, self-inflicted injuries - Interpersonal violence, such as intimate/partner/family violence or community violence. - Collective violence
FOR ADAPTION: Examples of risk factors and protective factors in your context, based on your protection analysis		
Examples of environmental risk factors - Lack of political will to prohibit torture - A lack of openness of governance - A lack of respect for the rule of law - High levels of corruption - Culture of violence, or high levels of public support for "getting tough" on crime - Negative attitudes and beliefs with respect to a population group - Legal framework for the prohibition and criminalisation of torture - Few rules and regulations covering places of deprivation of liberty - Level of independence of the judiciary - The level of reliance on confessions in the criminal justice system - Institutional culture - The role and functioning of the police and recruitment and training processes for officers - level of accountability and transparency of the authorities - the existence of public policies on crime prevention - the effectiveness of complaints mechanisms	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Marginalized and disadvantaged groups within society – such as minority groups (racial, ethnic, religious or linguistic), women, minors, migrants, people with disabilities, homeless persons – commonly face a higher risk of torture and ill-treatment - In some contexts, misbeliefs and myths surrounding a population group can lead to targeted violence (e.g. accusations of witchcraft against older women; violence against persons with albinism) - Individuals crossing frontlines and borders - Relatives, and individuals affiliated with armed groups - Deserters	*Example of Protective Factors* - Visits of detention facilities - Public awareness campaigns - Rehabilitative models - Accountability processes - Access to remedies - Guarantees of non-disclosure - Procedural safeguards - Training of public officials

[6] World Health Organization (WHO), World Report on Violence and Health, pp 5, 2002, https://www.who.int/violenceprevention/approach/definition/en/

Outside the scope of protection case management requiring referral	Refer to **for SGBV CM services** for cases of: • **Gender-based violence.** This is a term that recognises that violence occurs within the context of women's and girl's subordinate status in society and serves to maintain this unequal balance of power. Violence against women is "any act of gender-based-violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life". **There are six GBV categories: Physical violence, psychological violence, denial of opportunities, forced marriage, rape, and sexual abuse.** • **Sexual violence** can occur at an interpersonal or collective level. Sexual violence incorporates non-consensual sexual contact and non-consensual non-contact acts of a sexual nature, such as voyeurism and sexual harassment. Acts qualify as sexual violence if they are committed against someone who is unable to consent or refuse, for example because of age, disability, misuse of authority, violence or threats of violence. **Rape** is defined as "physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using a penis, other body parts or an object. **Sexual coercion** is defined as "the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against his/her will. **GBV Case Management Services will lead on these cases.** • **For Children:** Refer to **Child Protection case management services** for cases where children require protection from violence, exploitation, abuse and neglect as per the definition of child protection in the UN Convention on the Rights of the child. **Child Protection services will lead on these cases**. Corporal punishment affecting children

EXPLOITATION		
Type of Violation *Human trafficking*	**Definition** "The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation should include, at a minimum, **the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.'**[7]	**Examples** - Forced labour or compulsory labour - SGBV - Intersecting protection risk(s): Close correlation with torture and other cruel, inhuman or degrading treatment or punishment, arrests and detention, deprivation of the right to life, risk of refoulement; depending on the type of forced labour, health consequences can be major physically and psychologically.

[7] UNODC

Type of Violation *Forced labour*	**Definition** "All work or service which is exacted from any person under the threat of a penalty and for which the person has not offered himself or herself voluntarily." Consists of three main elements: 1. Work or service refers to all types of work occurring in any activity, industry or sector including in the informal economy; 2. Menace of any penalty refers to a wide range of penalties used to compel someone to work; 3. Involuntariness: The term "offered voluntarily" refers to the free and informed consent of a worker to take a job and his or her freedom to leave at any time. This is not the case, for example, when an employer or recruiter makes false promises so that a worker takes a job he or she would not otherwise have accepted. **Article 2 describes five situations which constitute exceptions to forced labour: compulsory military service, normal civic obligations, prison labour, work in an emergency, minor communal services.**[8]	
FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Hospital/health system without medical ethics supervision (organ trafficking) - Absence of legal frameworks criminalising and prohibiting human trafficking - Widespread gangs and organised crime - Tolerance of labour exploitation - Debilitating socio-economic conditions - Lack of social protection: exclusion, stigma, absence of social ties - Lack of legal protection: lack of legal protection related to work or even legal existence - Lack of healthcare coverage resulting in out-of-pocket payments (often a driver for exploitation and organ trafficking)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Absence of livelihood opportunities - Exclusion from services - Increased debt and other imminent payments - Exclusion from social networks, such as a family or village - Single headed-household	*Example of Protective Factors* - Reliance on individuals with same experience - Family members (in case of organ trafficking) often provide additional support to the individual because of sacrifice for the others. - Seek harm reduction and friendly health services

[8] ILO Forced Labour Convention, 1930

Type of Violation *Extortion*	**Definition** The act of getting something, especially money, by force or threat[9]	**Examples** - Harassment of single female heads of household to take financial assistance away from them - Sharing false information on heads of family to force them to leave property - Utilising nepotism and relations with security agencies to put pressure on persons for them to hand over a portion of assistance
Examples of environmental risk factors - Anti-refugee sentiments - Nepotism and corrupt security agencies - Weak complaints and feedback mechanisms - Absence of legal protection - Inappropriate assistance modality - A state practice of elimination and imposition of authority by terrorising individuals (applies to extra-judicial killing) - Increased gang crime, drug trafficking, organised crimes - Non-state player funding methods (death squads, extortions, etc.) - Weak or unregulated weapon sales and ownership	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Widows, divorcees, single headed households - Members of the LGBTQ community - Former members of armed forces - Single young adults - Victims of sexual crimes	*Example of Protective Factors* - Reliance on community leadership to address incidents and prevent re-occurrence - Community based support - Avoidance of external interactions
Type of Violation *Forced recruitment (adult)*	**Definition** 'Recruitment, as distinct from enlistment, is the compulsory incorporation of individuals into an armed force or group'.[10]	**Examples** - Raids - Arbitrary arrest - Disappearances of family members - Isolation, being home-bound, lack of free movement - Threat to right to life

[9] Definition of extortion from the Cambridge Advanced Learner's Dictionary & Thesaurus
[10] ICRC, How does law protect in war? Online Casebook, available at: <https://casebook.icrc.org/glossary/armed-groups> [Online Casebook], Glossary, under 'recruitment', (emphasis added).

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Military developments - Lack of legal protection - Lack of military guidelines and regulations	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Young adults of fighting age - Deserters of hostile forces	*Example of Protective Factors* - Community leaders mediating protection - Negative coping mechanisms - Interconnectedness with extortion
Outside the scope of protection case management requiring referral	**For SGBV:** Refer to **SGBV case management services** for cases of early marriages, sex work, sexual exploitation, and/or any other acts of GBV that results in, or are likely to result in, exploitation. **For CP:** Refer to **CP case management services** for cases of child trafficking, and child labour	
FORCED OR DENIED ACCESS TO TERRITORY AND ASYLUM		
Type of Violation *Refoulement*	**Definition** Non-refoulement forms an essential protection under international human rights, refugee, humanitarian and customary law. It prohibits States from transferring or removing individuals from their jurisdiction or effective control when there are substantial grounds for believing that the person would be at risk of irreparable harm upon return, including persecution, torture, ill-treatment or other serious human-rights violations.[11]	**Examples** - Rejection at border/frontier/asylum-seeker is not granted entry to a state - Denial, by a state, of access to asylum procedures - The unlawful return of individuals, including asylum-seekers and refugees, in any manner whatsoever, to territories where they are at risk of persecution, torture, or other forms of irreparable harm.

[11] OHCHR, the Principle of non-refoulement under international human rights law

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Anti-refugee (and IDP) sentiment in hosting community - Securitisation of asylum policies - Absence of legal obligations or asylum policy - Mass influx that could overflow available system and impose revisions that could open the door to push factors - Assumed, or politically motivated, assumptions on conditions in a country/area of origin	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Lack of legal protection: Absence of representation - Intersecting protection risk(s): deprivation of the right to life, torture and other cruel, inhuman or degrading treatment or punishment, forced return - Lack of social protection: increasing economic vulnerability for family members - Women, children, older persons and persons with disability - Former detainees, persons with political and/or military profiles in opposition in the place of return	*Example of Protective Factors* - Qualification of status - Strategic litigation - Development of guidelines and manuals for public officials - Border monitoring - Intention assessments - Immediate referral to a legal case management team and/or a specialised service provider supporting detention issues to assess legal action and provide legal counselling. - Take actions in coordination with the legal team supporting the case to mitigate further risk to dependants or those impacted - Conduct advocacy with the relevant stakeholders - Use of psychological first-aid skills - Use of protection/emergency cash if it can be helpful to support personal safety or protection - Community and family support options with the client, to be explored and emphasized as appropriate
Outside the scope of protection case management requiring referral	**For SGBV:** Refer to **SGBV case management services** **For CP:** Refer to **CP case management services**	

DEPRIVATION OF LIBERTY		
Type of Violation *Arbitrary arrest and/or detention*	**Definition** Arbitrary detention is the violation of the right to liberty. It is defined as the arrest and deprivation of liberty of a person outside of the confines of nationally recognized laws or international standards. Arbitrary arrest and detention could be divided in 4 different categories:[12] 1. Either merely because persons have exercised one of their fundamental rights guaranteed under international treaties, such as their right to freedom of opinion and expression, their right to freedom of association, the right to leave and enter one's own country, as proclaimed in the Universal Declaration of Human Rights; 2. Or because, having been unable to benefit from the fundamental guarantees of the right to a fair trial, persons have been imprisoned without an arrest warrant and without being charged or tried by an independent judicial authority, or without access to a lawyer; detainees are sometimes held incommunicado for several months or years, or even indefinitely; 3. Or because persons remain in detention even though the measure or punishment which has been applied to them has been executed; 4. Or, finally, because of the growing and preoccupying practice of administrative detention, notably for those seeking asylum.	**Examples** - Prolonged detention without charge - Detention of innocent family members - Failure by authorities to issue ID or travel documents resulting in detention - Imprisonment of women for 'running away' from home (not a crime) - Detention for housing, land and property disputes - Intersecting protection risk(s): deportation, torture

[12] OHCHR, Fact Sheet 26, The Working Group on Arbitrary Detention, https://www.ohchr.org/Documents/Publications/FactSheet26en.pdf

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Lack of social protection - Lack of legal protection - Anti-refugee (and IDP) sentiment in the hosting community - Securitisation of asylum policies - Absence of legal obligations or asylum policy - Security events that could increase risks of raids and mass arrests - The role and functioning of the police and recruitment and training processes for officers - Level of accountability and transparency of the authorities, - The existence of public policies on crime prevention	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Lack of legal protection: absence of representation Intersecting protection risk(s): deprivation of the right to life, torture and other cruel, inhuman or degrading treatment or punishments, forced return - Lack of social protection: Increasing economic vulnerability for family members - Women, children, older persons and persons with disability - Former detainees, persons with political and/or military profiles in opposition in their place of return - Isolated individuals, social exclusion because of being a member of a specific group of the community - Use of negative coping strategies	*Example of Protective Factors*
Type of Violation *Enforced disappearance*	**Definition** The arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons or groups of persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law.[13] An enforced disappearance is defined by three cumulative elements: 1. Deprivation of liberty against the will of the person 2. Involvement of government officials, at least through acquiescence 3. Refusal to acknowledge the deprivation of liberty or concealment of the fate or whereabouts of the disappeared person	**Examples** - Intersecting protection risk(s): deprivation of life

[13] International Convention for the Protection of All People from Enforced Disappearance, Article 2.

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Authoritarian rule - Active power grabbing - Internal strife - Lack of the independence of the judiciary - Lack of legal protection - Lack of social protection	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Families of, and individuals, active political opponents - Men of military service age - Community mobilisers - Individuals of certain religious, ethnic or other minority groups - Youth groups crossing borders or frontlines - Witnesses of mass violations - Human rights defenders - Journalists - Lawyers - Use of negative coping strategies by family members	*Example of Protective Factors* - Explore community support to be put in place - Emphasize support to existing community/family support - Presence of victim led organisations in region
Type of Violation *Kidnapping*	**Definition** An act or instance or the crime of seizing, confining, deceiving, abducting, or carrying away a person by force or fraud, often with a demand for ransom or in furtherance of another crime.[14]	**Examples** - Self-restricted freedom of movement - Family members of the kidnapped: loss of livelihoods. Intersectionality with other violations, such as exploitation, GBV child labour and other

[14] "Kidnapping." Merriam-Webster.com Legal Dictionary, Merriam-Webster, https://www.merriam-webster.com/legal/kidnapping. Accessed 14 Aug. 2020

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Overstretched capacities of judicial bodies to effectively prosecute such cases - Power relations creating an environment of impunity for the commitment of these crimes - Discrimination and xenophobia tolerating violent actions against certain groups - A state practice of elimination and imposition of authority by terrorising individuals (applies to extra-judicial killing) - Increased gang, drug trafficking, organised crimes - Weak or unregulated weapon sale and ownership	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Insecure shelter - Failed/inconclusive smuggling - Ability to pay ransom	*Example of Protective Factors* - Safe and dignified shelter - Assistance to those most in need - Awareness - Community based protection and actions
Type of Violation *Forced return (IDP only)*	**Definition** Forcible return is the act of imposing on IDPs a requirement to return or settle in areas or any place where their life, safety, liberty and/or health would be at risk.[15]	**Examples** - Forced evictions - Interrupting assistance - Arbitrary arrest

[15] The following is a recommended incident typology for protection monitoring systems used by UNHCR (2015) and its partners for individual level protection monitoring which has been adapted by DRC for Protection Monitoring.

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Lack of social protection - Lack of legal protection - Anti-refugee (and IDP) sentiment in the hosting community - Securitisation of asylum policies - Absence of legal obligations or asylum policy - Security events that could increase risks of raids and mass arrests - A lack of respect for the rule of law - High levels of corruption - Rules and regulations covering places of deprivation of liberty - Level of independence of the judiciary, - The level of reliance on confessions in the criminal justice system - Institutional culture - The role and functioning of the police and recruitment and training processes for officers - Level of accountability and transparency of the authorities - The existence of public policies on crime prevention - The effectiveness of complaints mechanisms	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Widow, divorcees, single headed households - Members of the LGBTQ community - Former members of armed forces - Single young adults	*Example of Protective Factors* - Safe and dignified shelter - Assistance to those most in need - Awareness - Community based protection and actions
Type of Violation *Arbitrary restriction of movement*	**Definition** Permissible restrictions of movements must not nullify the principle of liberty of movement, and are governed by the requirement of necessity and prescribed by law. Such restrictions are only limited to: - protect national security, - public order (ordre public) - public health or morals - the rights and freedoms of others[16]	**Examples** - forced return or relocation - forced displacement - limits on moving in/out/within settlements and other areas (village, town, etc.) - limited access to essential resources (e.g. water) - failure by authorities to issue IDs or travel documents - closed borders - requirement for travel documents applied to certain tribes only

[16] ICCPR Article 12 and CCPR General Comment No. 27: Article 12 (Freedom of Movement)

<table>
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- Lack of legal protection
- Anti-refugee (and IDP) sentiment in the hosting community
- Securitisation of asylum policies
- Absence of legal obligations or asylum policy
- Security events that could increase risks of raids and mass arrests
- A lack of respect for the rule of law
- High levels of corruption
- Rules and regulations covering places of deprivation of liberty
- Level of independence of the judiciary
- The level of reliance on confessions in The criminal justice system
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- Safe and dignified shelter
- Assistance to those most in need
- Awareness
- Community based protection and actions</td></tr>
<tr><td>Outside the scope of protection case management requiring referral</td><td colspan="2">For SGBV cases: Refer for SGBV case management: some incidents could be related to arranged marriages, forced marriages and other forms of SGBV
For children: Refer to CP case management services</td></tr>
</table>

DENIAL OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS		
Type of Violation *Deprived access to basic needs and services*	**Definition** Every human being has the right to an adequate standard of living for him or herself and his or her family. At a minimum, persons affected by disasters and conflicts have a right to have access to or be provided with essential food and water, basic shelter and housing, appropriate clothing, adequate sanitation, healthy working and environmental conditions, health-related education and information[17]	**Examples** - authorities unwilling to provide for basic water, shelter, food, health needs - lack of access to basic needs due to poor assistance planning - unequal access to services for different age, gender, disability and diversity groups - denial of humanitarian access by state or non-state armed players - lack of emergency care if injured in conflict - insufficient clean drinking water or water for sanitation - unsafe access to water and sanitation facilities - attacks on water point, food convoys, livestock or crops - people lack essential food in emergency situations - IDPs denied equal access to adequate food - shelters built in unsafe locations - forced eviction - basic services and facilities unavailable - basic services are not accessible for certain groups - use of civilian homes by armed groups during conflict - attacks on civilian homes or other property (crops, wells etc.) - child labour used for shelter construction - inadequate standard of shelter (space, privacy, poor materials)

[17] International Standards on the Right to Food, OHCHR https://www.ohchr.org/EN/Issues/Food/Pages/Standards.aspx

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Lack of a fair, functional and effective judiciary Isolation or remoteness, including weaker infrastructure and poorer access to markets and services - Resource base, including land availability and quality - Weather (such as droughts) and environmental conditions (such as earthquakes) - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - All types of person at risk, including indirect victims(s), such as witness(es) - Members of the LGBTI community - Single parents/caregivers - Widows formerly married into opposition/radical groups - Person(s) with disability - Individuals with serious medical condition(s) - Older persons unable to care for self - Older persons with children - Single older persons	*Example of Protective Factors* - Explore community support to be put in place - Mental health and psychosocial support within group(s) (MHPSS) - Emphasize support to existing community/family support

Type of Violation	**Definition**	**Examples**
Denial of right to work	The right to work includes the right of everyone to the opportunity to gain his/her living by work which he/she freely chooses or accepts, and will take appropriate steps to safeguard this right. The steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include technical and vocational guidance and training programmes, policies and techniques to achieve steady economic, social and cultural development and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual.[18] Decent work conditions are part of the right to work. In the context of article 6, the obligation to ensure non-discrimination and equal protection of employment is included which requires: a) ensuring the right of access to employment, especially for disadvantaged and marginalized individuals and groups, permitting them to live a life of dignity; (b) avoiding any measure that results in discrimination and unequal treatment in the private and public sectors of disadvantaged and marginalized individuals and groups or in weakening mechanisms for the protection of such individuals and groups;[19]	- Forced labour or trafficking - Refusal of access to employment opportunities

[18] Adopted from ICESCR Article 6.
[19] Adopted from Economic and Social Council, General Comment 18, Core Obligations.

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Isolation or remoteness, including weaker infrastructure and poorer access to markets and services - Resource base, including land availability and quality - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - All types of person at risk, including indirect victims(s) such as witness(es) - Displacement status - Individuals without documentation/stateless - Members of the LGBTI community - Single females - Widows formerly married to ISIS members - Persons with disability - Single parents or caregivers - Individuals with serious medical conditions - Older persons unable to care for self - Older persons with children - Single older persons	*Example of Protective Factors* - Community support to be put in place
Type of Violation *Forced evictions*	**Definition** Forced or unlawful eviction is defined as the permanent or temporary removal against their will of individuals, families, and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection.[20]	**Examples** - Lack of shelter - Negative coping mechanisms - Interruption of access to services

[20] Forced Evictions, OHCHR, https://www.ohchr.org/EN/Issues/ForcedEvictions/Pages/Index.aspx

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Fair, functional and effective judiciary Isolation or remoteness, including weaker infrastructure and poorer access to markets and services - Resource base, including land availability and quality - Weather (such as droughts) and environmental conditions (such as earthquakes) - Inequality (such as gender, ethnic, and racial inequality) - Destruction of community and social support networks	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - All type of persons at risk including indirect victims(s) such as witness(es) - Opposing political affiliations - Socio-economic status - Individuals unemployed - Members of the LGBTI community - Members of a marginalised/stigmatised group - Divorcees/single women - Widows formerly married with opposition/radical group members - Single parents or caregivers - Settlements in proximity of security incidents	*Example of Protective Factors* - Existing community/family support
Type of Violation *Destruction/loss of Property*	**Definition** The wilful partial or total destruction of personal property for development or military purposes.[21] Destruction or loss of property encompasses intentional or non-intentional acts of vandalism which can occur by human or natural means. The person has lost her/his property and has no access to appropriate housing. Due to the destruction or loss of property, the person is at risk of physical or psychological harm.	**Examples** - Destruction of community and social support networks - Reduced access to shelter - Interruption of access to services in local community centres, - Interconnectivity with other violations - Theft or destruction of civilian property during armed conflict - Illegal occupation of land during displacement - Loss of documents proving land ownership - Right to recover property or to be compensated - Returnees/IDPs have no information on land/ property rights - Lack of enforcement of property laws - Discriminatory military compensation procedures

[21] Rule 50, Study on Customary IHL norms, ICRC, https://ihl-databases.icrc.org/customary-ihl/eng/docs/v1_rul_rule50

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - A lack of a fair, functional and effective judiciary - Isolation or remoteness, including weaker infrastructure and poorer access to markets and services - Resource base, including land availability and quality - Weather (such as droughts) and environmental conditions (such as earthquakes) - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - All types of person at risk, including indirect victims, such as witness(es) - Members of the LGBTI community - Single females - Widows formerly married with opposition/radical group members - Persons with a disability - Single parents or caregivers - Individuals with serious medical conditions - Older persons unable to care for self - Older persons with children - Single older persons - Settlements in proximity of security incidents	*Example of Protective Factors* - Existing community/family support
Outside the scope of protection case management requiring referral	**For SGBV:** Refer for SGBV Case management services **For CP:** Refer for CP case management services	

DENIAL OF FAMILY LIFE		
Type of Violation *Denial of family life*	**Definition** The necessary measures for the protection of one's family, especially with a view to ensuring that the unity of the family is maintained … [and for] the protection of minors, in particular unaccompanied children and girls, with particular reference to guardianship and adoption.[22]	**Examples** - Denial of family or relationship - Denial or inability to exercise family unity - Family separation

[22] UN Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, Final Act of the United Nations Conference of Plenipotentiaries on the Status of Refugees and Stateless Persons, 25 July 1951, A/CONF.2/108/Rev.1, available at: http://www.refworld.org/docid/40a8a7394.html.

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Members of the LGBTI community - Single females - Widows formerly married with opposition/radical group members - Single parents or caregivers - Older persons unable to care for self - Older persons with children - Single older persons - Settlements in proximity of security incidents	*Example of Protective Factors* - Individual relies on relatives and friends for short term hosting and support - Cash and financial support are often sustained through diaspora financial support (money transfer, hawala, etc.)
Outside the scope of protection case management requiring referral	Refer all above cases to SGBV or CP case management services	

ACCESS TO JUSTICE		
Type of Violation *Denial of access to justice*	**Definition** Denial of justice is traditionally defined as any gross miscarriage of justice by domestic courts resulting from the ill functioning of the State's judicial system.[23]	**Examples** - Formal justice system not able to resolve civil disputes over identity or property - Criminal perpetrators not punished - No compensation for unlawful property destruction during armed conflict - No access to legal aid or advice - Unfair criminal trials - IDP/returnees unable to claim for lost property - Armed groups impose death-sentences without fair trial

[23] Denial of Justice, Oxford Public International Law Dictionary, https://opil.ouplaw.com/view/10.1093/law:epil/9780199231690/law-9780199231690-e775#:~:text=Go%20to%20full%20text%20on%3A&text=1%20Denial%20of%20justice%20is,of%20the%20State's%20judicial%20system.

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- Securitisation of asylum policies
- Weak or absence of reliance on judicial systems
- Weak culture of rule of law
- Rampant corruption
- Lack of legal protection</td><td>Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual
- Individuals without legal status
- Stateless and undocumented individuals
- Displaced individuals
- Children
- Perceived affiliations to armed groups</td><td>Example of Protective Factors
- Reliance on informal justice mechanisms
- Reliance on community support</td></tr>
<tr><td>Type of Violation
Denial of fair trial/effective remedy</td><td>Definition[24]
All persons shall be equal before the courts and tribunals. Everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.
1. Everyone charged with a criminal offence shall have the right to be presumed innocent until proved guilty according to law.
2. In the determination of any criminal charge against him, everyone shall be entitled to the following minimum guarantees, in full equality:
(a) To be informed promptly and in detail in a language which he understands of the nature and cause of the charge against him;
(b) To have adequate time and facilities for the preparation of his defence and to communicate with counsel of his own choosing;
(c) To be tried without undue delay;
(d) To be tried in his presence, and to defend himself in person or through legal assistance of his own choosing; to be informed, if he does not have legal assistance, of this right; and to have legal assistance assigned to him, in any case where the interests of justice so require, and without payment by him in any such case if he does not have sufficient means to pay for it;
(e) To examine, or have examined, the witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;
(f) To have the free assistance of an interpreter if he cannot understand or speak the language used in court;
(g) Not to be compelled to testify against himself or to confess guilt.</td><td>Examples
- Formal justice system not able to resolve civil disputes over identity or property
- Criminal perpetrators not punished
- No compensation for unlawful property destruction during armed conflict
- No access to legal aid or advice
- Unfair criminal trials
- IDP/returnees unable to claim for lost property
- Armed groups impose death-sentences without fair trial</td></tr>
</table>

[24] ICCPR, Article 14

	(h) In the case of juvenile persons, the procedure shall be such as will take account of their age and the desirability of promoting their rehabilitation. (i) Everyone convicted of a crime shall have the right to his conviction and sentence being reviewed by a higher tribunal according to law. (j)When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him. (k) No one shall be liable to be tried or punished again for an offence for which he has already been finally convicted or acquitted in accordance with the law and penal procedure of each country.	

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of asylum policies - Weak or absence of reliance on judicial systems - Weak culture of rule of law - corruption - Lack of legal protection	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Individuals without legal status - Stateless and undocumented individuals - Children - Perceived affiliations to armed groups	*Example of Protective Factors* - Reliance on informal justice mechanisms - Reliance on community support
Outside the scope of protection case management requiring referral	For SGBV, CP, Legal: Reports of such cases should be referred to legal teams and child protection teams where necessary in the case of children	

CIVIL & POLITICAL RIGHTS		
Type of Violation *Denial of freedom of association and expression*	**Definition** Campaigning for change in their country of origin may, indeed, be the only way of increasing the chances of being able to return home eventually. In general, participation in such political organisations is guaranteed by a refugee's human rights, in particular the right to freedom of expression and association. If the situation were otherwise the "oppressive system in their country of origin would be watertight.[25]	**Examples** - Arbitrary arrest - Denial of the right to due process - Torture - Forced returns - Evictions - Interruption of access to aid
FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Journalists - Political activists - Community leaders - Young adults	*Example of Protective Factors*
Type of Violation *Denial of freedom of religion*	**Definition** Everyone has the right to freedom of thought, conscience and religion; this right includes freedom [...] either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance." [26]	**Examples** - Arrests - Deportation - Extortion - Denial of access to rights - Arranged marriages - Smuggling

[25] LEGAL AND PROTECTION POLICY RESEARCH SERIES Political Rights of Refugees Ruma Mandal
[25] UDHR

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Governance policy - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Members of religious minorities	*Example of Protective Factors* - Reliance on community support - Protective policies
Outside the scope of protection case management requiring referral		

RIGHT TO NATIONALITY, CIVIL STATUS AND DOCUMENTATION		
Type of Violation *Denial of birth registration and/or certificate*	**Definition** Birth registration is the continuous, permanent and universal recording within the civil registry of the occurrence and characteristics of birth, in accordance with the national legal requirements. It establishes the existence of a person under law, and lays the foundation for safeguarding civil, political, economic, social and cultural rights. As such, it is a fundamental means of protecting the human rights of the individual.[27]	**Examples** - Failure to issue civil documentation - Failure to register girls or boys with disabilities - Impeded right to education - Impended right to health - Risks of statelessness - Hampered durable solutions

[27] See www.unicef.org/protection/57929_58010.html.

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Government immigration policies - Lack of a Fair, functional and effective judiciary - Isolation or remoteness, including weaker infrastructure and poorer access to markets and services - Resource base, including land availability and quality - Weather (such as droughts) and environmental conditions (such as earthquakes) - Inequality (such as gender, ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Stateless individuals - Individuals from unrecognised religious sects - Child marriages - Undocumented marriages - Informal births in remote areas	*Example of Protective Factors* - Marriages registered systematically - Access to hospitals and availability of beds - Affordability of hospitals - Reliance on community support.
Type of Violation *Arbitrary deprivation of nationality*	**Definition** When a person loses or is stripped of his or her nationality or citizenship as a result of discriminatory national legislations. Also situations where there is no formal act by a State but where the authorities clearly show that they have ceased to consider a particular individual (or group) as a national (or nationals)	**Examples** - Risk of statelessness - Restriction of freedom of movement - Authorities persistently refuse to issue or renew documents without an explanation or justification being provided - Confiscation of identity documents

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Resource base, including land availability and quality - Inequality (such as ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Members of religious minorities - Members of armed groups or terrorist organisations - Deserters - Children, unaccompanied or separated children - Stateless individuals - Children born out of wedlock - Children not registered due to gender discrimination or because of a disability - Persons belonging to a minority group facing discrimination in the country - Persons living in a remote area far away from a Civil Registry - Parents of the child undocumented themselves	*Example of Protective Factors* - Reliance on community support - Officials in hospitals providing information on birth registration - Functioning complaint and feedback mechanisms relating to confiscation of documentation
Type of Violation *Denial of travel documents*	**Definition** When a person loses or is stripped of his or her travel documents as a result of discriminatory legislations or administrative restrictions.	**Examples** - Risk of statelessness - Restriction of freedom of movement

FOR ADAPTION: Examples of risk factors and protective factors in your context based on your protection analysis		
Examples of environmental risk factors - Securitisation of displacement policies - Perceived affiliations and community punishment - Weak or unavailable social protection services - Weather (such as droughts) and environmental conditions (such as earthquakes) - Inequality (such as ethnic, and racial inequality)	*Example of Individual characteristics or circumstances which, due to the context, could lead to risk factors for the individual* - Members of certain displaced nationalities and religious minorities - Members of armed groups or terrorist organisations - deserters - Stateless individuals	*Example of Protective Factors* - Economic means and resources - Availability of supports to access travel documents
Outside the scope of protection case management requiring referral		

CASE MANAGEMENT - FORM 1

INTRODUCTION & INTAKE

Form 1 Introduction & Intake Form	
When to complete	During the initial visit with a potential client.
Who to complete	Caseworker assigned to the case.
Purpose of the form	To record basic information about the client and their protection issue.
Preliminary intake information Complete these details before your meeting with the client. The client should have provided permission for an interpreter or anyone else who will be present.	
Date of session	DD/MM/YY
Location of session	
Caseworker code	
Interpreter name	
Interpreter disclosure agreement & client consent signed	☐ Yes ☐ No
Who referred/identified the person?	☐ Referral from another organization ☐ Family, neighbour or community member ☐ Internal referral ☐ Self-referral ☐ Community volunteer/focal point ☐ Government representative ☐ Other (specify):
Date of identification	DD/MM/YY
Are you already receiving support from another organization or local group?	*Explain what assistance from which organisation and how long they will receive assistance for. Insert options tailored to the context:*
If YES: Have you already shared your story with them?	☐ Yes ☐ No
IF YES: Do you want to continue or should I contact that organization to ask them for the details of your case?	☐ Yes ☐ No If yes, proceed to ask for consent to reach out to the organisation concerned.

Address any barriers
Prior to the meeting, you should have checked whether you client needs any support. Ask again at the beginning of the meeting.

Do you need any support to take part in this meeting? For example, do you need to take extra breaks, support with communication, transportation, and an interpreter present.	☐ Yes ☐ No
Note down support required and what has been put in place:	

Introduction & welcome

Introduce yourself, your role and your organisation. Create a comfortable, safe and private environment.
Hello, my name is _____and I am_____[insert position] for the _____[name of organisation]. I am glad that you contacted us. I am here to listen and to see whether we might be in a position to support you. Do you feel comfortable talking to me here? Where would you prefer to talk to me so we can speak in private and you feel safe?

Explain the case management process, this step of the process, and the client's rights.
It is important that you understand what this case management service is. Case management just means that we will talk together about what support you need and together we will put in place some goals to address them. This will mean that I have to ask you about your background and about your current situation, but you do not have to answer any questions that you do not want to and you can always ask me to stop or to slow down.

In this session, it is important for me to understand more about your situation so that we can determine whether this service may be of benefit to you. It is important before we proceed that you fully understand your rights throughout this process.

At any time during this meeting, please feel free to:
- Request support so that you can participate in our meetings, for example asking me to repeat any questions or if you need to take a break or if you want anyone to join our meeting. Just let me know.
- Request that your information not to be documented or written down.
- Not to answer any questions that you don't want to, and you can always ask me to stop or slow down.
- Ask me questions at any time, and if you feel you could work better and talk more easily to someone else other than me, maybe of a different gender or you want to work with another organisation, please feel able to tell me.
- Refuse referrals to services if you don't want them, and to stop the case management process at any time, or request your case files or other documents, as well as to ask me to make changes to them. You can also ask these documents to be removed or deleted at any time.

Explain confidentiality, its limitations and when you may have to break confidentiality.
It is important for you to know that I will keep what you tell me confidential, including any notes that I write down during our meeting today. This means that I will not tell anyone what you tell me, or share any other information about your case, without your permission.

There are a few situations where I may have to speak with someone else without asking your permission; This is in case you tell me that you want to hurt yourself, when I may have to tell my supervisor or others who could help keep you safe, or if you tell me you want to hurt someone else, when I would have to tell the relevant authorities to prevent that, and finally, in case a UN or humanitarian worker has hurt you, in which case I would need to tell my supervisor and report what this person has done so he/she cannot hurt anyone else.

Where there are safe and functioning local laws for mandatory reporting you can mention them here.

Sharing information at these times is meant to keep you safe and get you the best help you need. Other than these times, none of the information shared between us will be shared without your permission.

Do you have any questions about anything explained to you? [Allow time to answer the question].
Did I answered all your questions and do you feel that you understand this service and your rights in relation to the service? Can I ask for your permission to proceed?
-If yes, proceed to ask more questions to determine whether you should open a case file
-If no, provide information about available services to the person verbally and through information materials. Provide a hotline number to the client should they wish to receive services in the future. If a one-off service or advocacy action is needed, then proceed to conduct a quality referral for him/her.

Part A: Clients bio-data	
Case code	
Date of birth[1]:	MM/YY
Gender	☐ Male ☐ Female ☐ Other
The next questions ask about difficulties you may have doing certain activities because of a HEALTH problem. (Remember to note down exactly what the client has told you. Do not make assumptions. Disability status should be based solely on the client's answers to the below categories).	
1. Do you have difficulty seeing, even if wearing glasses? Would you say…	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know
2. Do you have difficulty hearing, even if using a hearing aid? Would you say…	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know

[1] *If the client does not know their exact birthdate, that is ok! Ask them to estimate year and month. If they are really unsure about this information, ask roughly how old they think they are and then subtract that from the current year and make the birthdate 01/01. For example, a woman who believes she was born in the spring 40 years ago from year 2020 might be 04/01/80. A man who does not know the time of year but believes he is about 80 would be 01/01/40.*

3. Do you have difficulty walking or climbing steps? Would you say...	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know
4. Do you have difficulty remembering or concentrating? Would you say...	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know
5. Do you have difficulty (with self-care, such as) washing all over or dressing? Would you say...	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood? Would you say...	☐ No, no difficulty ☐ Yes, some difficulty ☐ Yes, a lot of difficulty ☐ Cannot do it at all ☐ Refused ☐ Don't know
Disability status (case worker only): Yes/No (Cut off: Yes = one or more questions where the client has responded: Yes, a lot of difficulty/cannot do it at all)	☐ Yes ☐ No
What is your citizenship/ country of origin? (Adapt as appropriate. Note here if the person claims to be stateless)	*List relevant citizenship countries/countries of origin for your context*
What is your mother tongue?	
What is your civil/marital status?	☐ Single ☐ Married/cohabitating ☐ Divorced/separated ☐ Widowed
What is your educational background?	

Displacement status:	☐ IDP ☐ Refugee ☐ Local community ☐ Other
Are you registered with the State/UNHCR/UNWRA? *If in refugee context and unregistered, unless there are security concerns refer for registration. Some incident types responded to by UNHCR will require registration first. Record registration numbers on the consent form.*	☐ Yes ☐ No Please specify the reasons:
Do you require any identification documentation or registration with UNHCR/ UNWRA?	☐ Yes ☐ No Please explain:
Part B: For people who require a caregiver Caregiver is a person who provides direct care for a child or adult. This can be a parent, or any adult person who by law or custom is responsible for doing so.	
Do you have caregiver/s? Only ask if relevant	☐ Yes ☐ No
What is the name of the caregiver/s?	
What is your relationship to them?	
Note whether a caregiver is present during the meeting	☐ Yes ☐ No Explain:
Part C: Intake *Use **tell, explain, describe** questions to encourage your potential client to think and reflect. Make sure you facilitate their thinking by using active listening skills and healing statements. If you need more information, you can ask probing questions. These are a non-exhaustive list of question(s), which can be used to understand whether your client is at risk.*	
Background, immediate needs	
Can you tell me what brought you here today? • *Listen to the client's story, empathize, and use healing statements to respond. Depending on what you are told adjust your follow up questions to make sure you don't repeat questions.* • *To show the client that you are listening to them and have understood what they have said, it can be a useful tool to summarize their main concerns using the same language and words they used.* **Can you explain whether you have any immediate medical, physical or emotional needs?**	

Notes:

Safety and participation in the home and community

Remember, if they mention that they are in urgent need of safety, it is important to focus immediately on keeping them safe. Consider doing a safety plan with them before you leave.

Can you tell me about your background, in particular how you arrived here, where you are from?

- *Understand your potential client's displacement cycle*

Can you describe the family/community you live in and whether you feel safe at home/in your community?

- *Understand how the person perceives their living situation and whether they feel safe or whether they are concerned. Pay attention to the description words used, which may indicate whether the person feels safe, included or supported.*

Can you tell me about any people or groups that are particularly significant in your life?

- *Pay attention to people or groups mentioned. This may be a form of support that they can draw on or be a form of harm.*

Do you feel that some of these people or groups are able to support you/have supported you in the past if you have had a concern or problem? If so, how did they support you?

- *Note down people or groups mentioned and what they can support on. Does the person feel comfortable reaching out to them or having reached out to them in the past?*
-

Are you able to participate in and contribute to decisions that affect you in the home and community?

- *Understand their level of participation in family and community life. Pay attention to participation barriers (social and attitudinal, institutional, physical, information and communication) mentioned.*

Notes:

Access to work, basic needs and services

Can you tell me whether you are able to move freely and safely within and outside of your community?

- *Understand whether they face any barriers to movement in the home and free movement out of the home.*

Do you have access to a shower, a toilet, drinking water and food on an equal basis with other people in your family or in your community? Can you describe your access to those services for me?

- *Try to understand whether they have equal access to services within the home, and the socio-economic standing of the household in the community. Pay attention to the number of meals, nutrition of food, communal or family access to toilets and showers.*

Can you explain the health of you and your family at the moment?

- *Check how this impacts the family and family relationships.*

Do you or other members of the family have work or an income of any kind at the moment?

- *Understand whether they can work, currently have work or are about to find work. Understand what kind of work this is, have their or other family members' work situation changed recently.*

Notes:

Summary of key concerns and solutions

Can you please summarize the key concerns that are worrying you the most at the moment and what you need?

- *For some situations, a person may not be forthcoming about the nature of their concerns because they are fearful, so it can be useful instead to ask about their needs directly.*

What steps have you taken to try to resolve some of these concerns? *(You can ask what, who, when, where questions for more information if needed on the incident and if appropriate)* **What did you feel worked well and what did not work?**

- *Understand how the client has tried to cope with these concerns in the past, highlight what worked and what didn't so you can build on or avoid strategies mentioned.*

Notes: *Note any questions the person needs answered, or needs for follow-up (not already been accounted for above). Record barriers that have been mentioned by the client. You will need to take these into account when making referrals and in future meetings with the person.*

Part D: CASE WORKER ONLY: Violation/incident type
Based on your conversation with the individual, are they at risk of any specific rights violations?
This list of rights violations should be adapted to reflect your case management prioritisation criteria.

Type of violation	Sub-type	Contextual detail and referrals required to other case management streams
Deprivation of the right to life	☐ Killing/murder/manslaughter ☐ Summary extrajudicial execution ☐ Other	
Torture, inhumane, cruel or degrading treatment or punishment (including physical and psychological violence	☐ Torture ☐ Other inhumane, cruel or degrading treatment or punishment ☐ Physical and psychological violence, including assault or abuse	*All cases of rape, sexual assault, physical assault or abuse, forced marriage, denial of resources, opportunities or services, psychological and/or emotional abuse for women, girls and boys, should be referred for SGBV or for child protection case management*

Deprivation of liberty	☐ Arbitrary arrest, detention ☐ Arbitrary restrictions on movement ☐ Forced return (IDP only) ☐ Abduction and/or kidnapping ☐ Enforced disappearance ☐ Other	
Exploitation	☐ Extortion ☐ Forced labour (slavery) ☐ Trafficking in persons (forced prostitution, forced marriage, organ harvesting) ☐ Forced recruitment (adults) ☐ Other	*Refer for GBV and CP case management services for cases of women and children.* *For cases of child recruitment, refer for child protection.*
Forced/denied access to territory & asylum	☐ Refoulement ☐ Rejection at border/frontier ☐ Denial of access to asylum procedures ☐ Other	*Can include cases of extradition or expulsion*
Denial of family life	☐ Denied a family or relationship ☐ Denied or unable to exercise family unity ☐ Family separation ☐ Other	*Refer women and children for GBV and CP case management services*
Access to justice	☐ Denied access to judiciary/legal counsel/representation ☐ Denied fair trial, effective remedy ☐ Other	*Use for cases in need of legal counselling* *Use for cases in need of legal representation* *Use for cases in need of mediation* *Refer for legal case management services*
Denial of economic, social and cultural rights	☐ Deprived access to basic needs and services ☐ Denial of the right to work ☐ Forced eviction ☐ Destruction/loss of property ☐ Other	*Include any barriers to access that the client may face. Categories: physical barriers; information and communication barriers; attitudinal barriers faced in the client's environment; Other*
Civil and political rights	☐ Denial of freedom of association ☐ Denial of freedom of expression ☐ Denial of freedom of religion ☐ Other	

Right to nationality, civil status registration and documentation	☐ Denial of birth registration and/or certificate ☐ Arbitrary deprivation of nationality ☐ Denial of travel documents ☐ Other	

Provide a summary of the incident, as well as any barriers faced by the client to access services/ maintain resilience

Provide a summary of the violation type. Based on the Washington Group Questions and the information collected from the client, are there additional barriers that the client may face to access services or maintain their resilience.

Part E: Risk-Level determination

Remember the risk-level should be determined on a case-by-case basis and on the merits of each case. You can refer to your violation typology list for additional support and examples.

☐ **Low:** Probability of a serious risk to individual safety is low; however, an intervention to respond to individual specific needs may be required to reduce vulnerability.	☐ **Medium:** Probability of a serious risk to individual safety requiring intervention within a week. Bi-weekly follow-up required by phone and visit. The number of follow-ups will decrease in line with to the clients' needs.	☐ **High:** Serious and imminent risk to individual safety requiring immediate action within a maximum of 48 hours. Depending on situation, weekly follow-up is required by phone and visit. The number of follow-ups will decrease in line with the client's needs.

No observed need for protection case management services at this time. ☐ Provide information on available services and how to access them ☐ (If required) ask for consent to conduct a quality referral	**Do all you can to keep the person safe. Your primary focus in high-risk situations is to keep the client safe.** ☐ Ask whether he/she wishes to proceed and sign the consent form. ☐ If there are immediate lifesaving needs, take immediate action to address them ☐ Agree on an appropriate day/time to meet again and agree on any support he/she needs to participate in the next session. ☐ Provide your work contact information in case he/she needs to contact you.

CASE MANAGEMENT - FORM 2A

INFORMED CONSENT

Form 2 Informed Consent	
When to complete	At the start of case management services: • For the client to provide permission to participate in the case management process. • For the client to provide permission to collect and store their individual bio-data and information about their case through the case management process. • For the client to provide permission to the caseworker for the presence of an interpreter during the case management process/session (section 2) • For the client to provide permission to share non-identifying data for the purposes of analysis Permission to share information with other service providers (i.e. during referrals) is captured directly on the referral form.
Who should complete it	The client (caregiver for minors) supported by the assigned caseworker
Purpose of the form	To record a conversation between the caseworker and the client about the case management process, confidentiality, its limitations, and the client's data protection rights. To record the client's permission to participate in the protection case management process, including to collect, store and share the client's information and bio-data.

Part A: Important reminder

During the informed consent process, you must provide all possible information and options to the client in a way that they can understand; determine that they can understand this information and their decision, and that the decision of the client is voluntary and not coerced by others (e.g. family members, caregiver). You must ensure that the person has the capacity, maturity and adequate information to know what they are agreeing to. **Remember: You should always assume that all people with a disability (including intellectual disabilities and mental health conditions) have the capacity to provide informed consent independently. The onus is on you to (1) adjust your communication using a range of styles; (2) let the client choose someone to support communication; (3) only make a decision of vital or best interest as a last resort, and always based on the best interpretation of the individual's wills and preferences. See Form 2b Easy to Read Informed Consent.**

During your introduction and welcome with the client you should have:

- Introduced yourself, your role, your organization
- Addressed any barriers to participation
- Explained the case management process and his/her rights through the process
- Explained his/her data protection rights
- Explained confidentiality and its limitations

Check whether they would like you to repeat this information again.

Explain again that there are only three exceptions to the rule of confidentiality: Only where there are indications that a person is planning to take his/her own life, or planning to harm the safety of others, or where a child is at imminent risk of harm, can you conduct a referral without informed consent. For children, always consider the best interests of the child.

Remember: If consent is not obtained, do not proceed with the referral. Instead, explain to him/her how to access the service if they change their mind at a later stage and provide relevant contact information to do so.

CONFIDENTIALITY[1]
Consent to release information

I _____ (client name), acknowledge that the _____(service provider name) has clearly explained the case management process to me and has explained that I will guide the case management process to identify my needs and goals and that the primary purpose of this service is to ensure my safety, dignity and well-being.
I understand that my information will be treated with confidentiality and respect and that through the case management process I have the right to;

- Decide what information I share with the caseworker. They will not pressure me to share information.
- Request that my information not to be documented or written down
- Refuse to answer any questions that I don't want to, and always ask for the caseworker to stop or slow down at any time.
- Ask questions at any time of the caseworker and if I feel that I could work better and talk more easily to someone else other than the assigned caseworker or work with another organization, I can request this.
- Fully understand the purpose of referral, the way it will be done, what information will be shared and any expected consequences and I will provide consent to proceed. I can also ask for the caseworker to accompany me.
- Refuse referrals to services if I don't want them, and stop the case management process at any time, or request my case files or other documents as well as to ask for any changes to them.

My caseworker will keep my information confidential. The only exceptions to this are;

1. My caseworker may seek guidance from a supervisor in relation to my case. My caseworker would only share information as needed to support me and it will not include information that could identify me.
2. If I express thoughts or plans of committing physical harm to myself, or others (or if I am at imminent harm as a child), my caseworker will take action to protect my safety and the safety of those around me. If there is a risk of immediate danger, my caseworker would not need to seek my consent in such cases, but would do her/his best to inform me of actions taken.
3. Non-identifiable information may be used for purposes of humanitarian reporting and analysis only.

By signing this form, I authorize this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

Signature/Thumbprint of client (Caregiver for minor) _____

[1] This has been adapted from the informed consent form used in the Inter-Agency GBV Case Management Guidelines

Caseworker code: _____ Date: _____

Part B Contact Information & Other Identifying Information (to be kept separate from the rest of the case management forms)	
What is your preferred mode of communication?	☐ Phone ☐ Whatsapp ☐ E-mail ☐ In-person at home ☐ In-person at another agreed to location ☐ Through the Community Focal Point ☐ Other designated individual ☐ Other Explain:
If by phone, **who owns the phone?** *Check whether it is safe for you to contact, and get authorization to identify yourself to the contact provided.*	☐ Owned by Self ☐ Borrowed/shared
What is your preferred time and day to contact you?	
What is your contact number?	
What is your address?	
Do you have an ID? (Register the type and number)	
If registered: Can you share your UNHCR/ UNWRA/State registration number?	

Part B: Interpreter Consent Form
For the client to sign when you have agreed to use an interpreter. If it is safe and completely necessary to do so and if no other trusted support person is available and/or not preferred by the client, you can ask for permission to use a professional interpreter to facilitate understanding and communication. Only if it is safe and after you have consulted your supervisor, ask the client and watch for signs that they agree or disagree. Always consider the client's best interests. Follow the above 'important reminder' box to guide the informed consent process.

CONFIDENTIALITY
Consent to Interpreter

I _____ (client name), acknowledge that the _____interpreter name) will be present during the case management process/session for the sole purpose of translation to facilitate understanding and communication. To the best of his/her abilities he/she will not change the meaning of my words. I understand that he/she will keep my information during the case management process/session confidential and that he/she is not authorized to share any of my information. I understand that I can request for him/her to stop attending at any time.

By signing this form, I authorize the presence of the interpreter during case management sessions.

Signature/Thumbprint of client:(Caregiver for minor) _____

Caseworker code: _____ Date: _____

CASE MANAGEMENT - FORM 3

INTERPRETER NON-DISCLOSURE AGREEMENT

Form 3 Interpreter Non-Disclosure Agreement	
When to complete	As soon as requested by the client. This may be at any time during the process, but will likely be at the beginning. The client should have signed the interpreter consent form prior to this agreement.
Who should complete it	To be signed by the interpreter.
Purpose of the form	To ensure that the interpreter respects confidentiality and does not disclose anything.
Date	
Name of interpreter	
Contact information for the interpreter	
Language	☐ Language 1 ☐ Language 2 ☐ Language 3 ☐ Sign Language
Gender of the interpreter	☐ Female ☐ Male ☐ Other; Prefer not to answer

CONFIDENTIALITY

I _____(Interpreter name) understand that the sole purpose of my presence is for translation. I am not here to judge or reformulate the client's statements and should translate as close as possible to the original language used by the client. I understand that everything that will be said during that interview will be kept confidential and that I am not authorized to share this information. I understand that by signing that statement I am making myself contractually liable to the _____(organization name) and that _____(organization name) could bring legal proceedings against me if I breach the confidentiality principle.

Signature *Please sign or mark to show that you have understood.*	**Date**

CASE MANAGEMENT - FORM 4

PROTECTION RISK ASSESSMENT

Form 4: Protection Risk Assessment Form	
When to complete	Within two weeks of the client's identification. In some cases, you may conduct the risk assessment at the same meeting as the identification and registration meeting.
Who should complete it	Caseworker assigned to the case.
Purpose of the form	To record the client's risk(s), resulting needs and protective strengths and capacities. Pre-record relevant information gathered from the Introduction & intake step into this form ahead of your visit. To ensure that each client benefits from a consistent approach to evaluating their situation.
Part A: Preliminary information *(to complete prior to session)*	
Date of session	
Location of session	
Caseworker code	
Case code	
Interpreter name	
Interpreter disclosure agreement & client permission signed	☐ Yes ☐ No
Summary of key violation/incident information (For caseworker only) *Pre-fill based on information you received during the identification & intake meeting. Fill in any missing information after you have completed the assessment. Use your prioritisation reference form to support you.*	
Violation/incident type(s) *Available options to be based on your prioritisation criteria.*	☐ Right to life ☐ Torture, inhumane, cruel and degrading treatment, including violence ☐ Right to liberty & freedom of movement ☐ Exploitation ☐ Access to territory & asylum ☐ Denial of family life ☐ Access to justice ☐ Denial of economic, social and cultural rights ☐ Right to nationality, civil status, registration & documentation ☐ Denial of other civil and political rights ☐ Other

Incident sub-type *Available options to be contextualised based on your prioritisation criteria.*	
Incident occurrence: Has the incident already happened or is it at risk of occurring?	☐ Happened ☐ At risk of ☐ Both Explain:
Incident date (start/end) or estimation of:	
Risk- level *Update based on risk assessment findings.*	☐ High ☐ Medium ☐ Low
Has the incident been reported?	☐ No ☐ Yes Note down support required:
Date of report *Date when incident was first reported.*	
Reported to *Available options*	☐ Police ☐ Medical professional ☐ Community leader ☐ Other
Reported by *Person who reported the incident. Available options:*	☐ Survivor/victim ☐ Witness ☐ Partner ☐ Parent ☐ Guardian ☐ Government ☐ Other family member

Violation/Incident(s) description: Summarise the key points of the incident/risk of violation. Provide additional observations about the incident, if any. Explain whether this is a particular form of violence that is supported by some community members on the basis of tradition, culture or superstition.

Address barriers *Check whether your client needs support to participate in the meeting.*	
Do you need any support to take part in this meeting? For example, do you need to take extra breaks, support in communication (i.e. interpreter, access to adapted communication modalities, etc.)	☐ No ☐ Yes Note down support required:
Note down what support has been put in place:	

Introduction
Make sure you have filled any information previously gathered from the client into the form prior to the meeting to avoid repetition for the client. Re-explain the process, this step of the process, and their rights and ask permission to proceed. • **Create a comfortable, safe and private environment.** • **Re-explain the case management process, this step of the process, and the clients' rights.** *Explain: this session will help me to gain a full understanding of your situation and your potential needs for support, as well as your strengths and the positive influences in your life. I will be asking about your housing, health, and economic situation and about any safety and security concerns in more detail, but only what information you wish to share with me.* • **Re-explain confidentiality, its limitations and when you may have to break confidentiality.** • **Ask whether they have any questions?** • **Ask permission to proceed.** **Based on your last meeting with the client, you will have an idea of the specific risk(s) they face. It may be natural to start asking them about the risks. For details of the risks, you can use the 5WH questions *why, what, when, where, how questions.***

Nature of your client's risk, their resulting needs & protective capacity to cope

Part A: Specific risk(s) to safety & security *You want to understand the extent to which your client and their household members are facing threats to security or safety while at home, in their community or society. This can expose them to unique protection risks, such as threat to life, physical safety and/or mental and psychological wellbeing.* ***You will have to identify the circumstances in which the client is most in danger.***	
Do/did you or your family face any safety or security threat or incidents? *(Can include flight history, previous detention, torture, etc.) You need to understand what the incident is and who is perpetrating it.*	☐ No ☐ Yes Explain:
Can you please explain when and where does/did this happen?	Explain:
Why do you think this happened/is happening?	Explain:

Have you noticed anything about the perpetrator during those times? *(Is there usually a trigger, such as drinking, loss of job, and change in financial security, etc.)*	Explain:
How have you tried to address this incident in the past? If yes, please explain:	☐ No ☐ Yes Explain:
Have you reported this incident previously? (If so, when, where and to whom? If not, what is the reason why not?)	☐ No ☐ Yes Explain:
Do you face any difficulties leaving your home or community due to lack of accessibility? (This may place the client at higher risk of any of the types of violations faced)	☐ No ☐ Yes Explain:
Are there any people, organizations or local groups you can turn to to help address these risks?	☐ No ☐ Yes Specify whom:
Would you face any difficulties while trying to communicate with these people? How would you address them?	☐ No ☐ Yes Explain:
Comment/Observation *(e.g. please record any additional comments shared by the client, comments you have and/or observations of the individual's behaviour during the meeting (e.g. fearful, crying, angry, expression of hopelessness, etc.)*	
If there are threats to the client's safety & security, proceed with the safety planning form to help develop a safety plan.	
Part B: Client's household. *You want to understand with whom your client lives and the nature of their relationships as these can create unique risks for the client or provide protection.*	
Who are you living with?	☐ Living with immediate family ☐ Relatives ☐ Non-relatives ☐ Independently
<u>If not with family members:</u> Where are your immediate family members?	☐ In another country ☐ In another location in this country ☐ Don't know ☐ Other specify
<u>If separated from family:</u> Are you in need of family tracing and reunification support?	
How many people are you living with?	

<table>
<tr><td colspan="5">For each of your client's household members, try to understand the nature of your client's relationships with them (i.e. whether they have positive and supportive relationships). Use additional paper/add rows where required.</td></tr>
<tr><td>What is your relationship to them?

(Sibling, parent, relative, specify the caregivers when relevant)</td><td>What is their age? (Approximately)</td><td>What is their sex?</td><td>How would you describe the nature of your relationship with them?

(Are they supportive? Can you turn to them in case of a problem? Do they look after you when you are sick?)</td><td>Are they facing any particular problems themselves for which they may require assistance?

(Prompt for family separation, illness, barrier to access services, education, documentation, security, legal)</td></tr>
<tr><td>☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Relative
☐ Friend
☐ Other (specify)</td><td>YY</td><td>☐ Male
☐ Female
☐ Other</td><td></td><td>☐ No
☐ Yes
Explain:</td></tr>
<tr><td>☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Relative
☐ Friend
☐ Other (specify)</td><td>YY</td><td>☐ Male
☐ Female
☐ Other</td><td></td><td>☐ No
☐ Yes
Explain:</td></tr>
<tr><td>☐ Mother
☐ Father
☐ Sister
☐ Brother
☐ Relative
☐ Friend
☐ Other (specify)</td><td>YY</td><td>☐ Male
☐ Female
☐ Other</td><td></td><td>☐ No
☐ Yes
Explain:</td></tr>
<tr><td colspan="5">Comment/observation:</td></tr>
<tr><td colspan="5"></td></tr>
</table>

Part C: Client's housing situation. *You want to understand your clients living situation because living arrangements may create unique protection risks, such as violence, exploitation, neglect or isolation for them.*	
What is your housing situation? (Are you paying rent or do you know own the house?)	☐ Owned ☐ Rented ☐ Informal tenure/unpaid (collective shelter, centre, garage) ☐ Living with host family, paying rent ☐ Living with host family, not paying rent ☐ Camp or settlement ☐ Other (specify): Explain:
Do you have a written housing contract?	☐ No ☐ Yes Explain:
Do you feel safe/secure that you can stay in this shelter as long as you want to? *(Have the family been threatened with or experienced eviction, have they fallen behind on rent payments?)*	☐ Very stable ☐ Stable ☐ Insecure ☐ Very insecure Explain:
Do you have access to a toilet? *(Expand on whether the access is safe. Are they able to lock the door, distance, adequate lighting)*	☐ No ☐ Yes Explain safety & accessibility:
Do you have access to a shower? *(Expand on whether the access is safe. Are they able to lock the door, distance, adequate lighting)*	☐ No ☐ Yes Explain safety & accessibility:
Do you feel safe in your home? *(Are you comfortable with the people you live with? Do you have enough privacy? Is the home in a safe location? What makes you feel unsafe?)*	☐ No ☐ Yes Explain safety:
Comment/observation on housing situation: *Observe the condition of the housing, whether there is adequate lighting and sanitation and the smell. Can all people within the household enter, circulate and use it, privacy between families, and security of tenure.*	

Part E: Access to basic needs and services including information: *You want to understand the extent to which your client has access to basic need and services, including to information, to make informed decisions because this can expose them to unique protection risks, such as threat to life and dignity.*	
Do you experience any difficulties accessing your daily food needs?	☐ No ☐ Yes Explain:
Do you experience any difficulties accessing your daily water needs? *(Water for drinking, cooking, hygiene)*	☐ No ☐ Yes Explain:
Do you experience any difficulties accessing the services you need?	☐ No ☐ Yes Explain:
If yes, what type of challenges/barriers do you face? *(Consider the following: physical, financial, information, communication, social and attitudinal)*	Explain:
What type of information do you need and how do you prefer to receive this information?	Explain:
Comment/observation:	
Part F: Current economic situation: *You want to understand the extent to which your client can participate in decisions and choices about how money is spent and how much control they have over resources because this can expose them to unique protection risks such as neglect and exploitation. These questions should be addressed to the client confidentially, answered from their perspective not the perspective of the income earner or family decision-maker*	
Do you/your household have any income?	☐ No ☐ Yes Explain:
Do you have an idea about the source of this income or how it is generated? *(Are there adults working in the household? How many? Is money sent from abroad? etc.)*	☐ No ☐ Yes Explain:

Do you have a form of control over the use of your income and/or your household's income? *(Can you buy what you need by yourself? Do you need permission? If yes, would that conversation be easy or difficult?)*	☐ No ☐ Yes Explain:
Do you feel that your material needs are being met? (Depending on the response)	☐ No ☐ Yes If not, then why do you think this?
What are the main challenges you/your household face as a result of your economic situation?	Explain:
Has there been a sudden change in your income/financial situation in the past 30 days? *(Note if this has caused tension in the household, change in living situation)*	☐ No ☐ Yes Explain:
Comment/observation:	
Part G: Health situation: *You want to understand your client's health condition because it might impact their relationships within the family and create unique protection risks such that they lead to violence, abuse, neglect or exclusion.*	
Do you have any health concerns?	☐ No ☐ Yes (If yes, continue to ask the following questions in the health section) Explain:
Is this affecting your ability to perform your daily activities? (e.g. unable to move around easily, in pain, unable to work, inability to concentrate, confused thinking, etc.)?	☐ No ☐ Yes If yes, how?
Do you receive any treatment or support?	☐ No ☐ Yes If yes, who is providing it?
Do you need any support to take care of yourself?	☐ No ☐ Yes If so, who normally provides this support to you?
Does your household give you the support you need?	☐ No ☐ Yes Explain

Does this impact your relationships in any way?	☐ No ☐ Yes Explain:
Comment/observation: *Specify relationship with caregiver; specify what support is being provided.*	

Part H: Basic MHPSS Assessment:

You can better understand your client's mental health and psychosocial well-being by completing a Basic MHPSS Assessment. Prior to completing a Basic MHPSS Assessment, it is important for protection case managers to review potential assessment options with their supervisor; select the 'best fit' based on the client population, context, and programming goals; complete an adaptation process of the assessment tool; and complete training on tool prior to implementation to ensure protection case managers follow do-no-harm principles and are cognizant of key signs of distress to facilitate essential referrals for MHPSS services when necessary. Additional assessment tools available for review and selection are listed in the PCM Guidance in Chapter 4.

*Included here is the Patient Health Questionnaire-9 (PHQ-9), with minor adaptions; This tool can be used to support caseworkers in monitoring the severity of signs of depression and identifying clients in need of referrals for MHPSS services. Importantly, it is not a screening tool for depression. Questions should be administered through discussion, taking into account the fact that it may be challenging for your client to provide direct, immediate answers[1].

Client's level of functioning: *Ask your client in an informal discussion how they have been feeling for each of the following symptoms during the last **two weeks**? For each question, note the client's answer in the box, which will support you in doing your final assessment.*

Question	Answers
How often over the last two weeks have you...	
1. Had little interest or pleasure in doing things?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
2. Been feeling down, depressed or hopeless?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
3. Had trouble falling/staying asleep or are sleeping too much?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)

[1] This is the Patient Health Questionnaire (PHQ-9) https://www.med.umich.edu/1info/FHP/practiceguides/depress/phq-9.pdf

4. Been feeling tired or having little energy?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
5. Had poor appetite and did not want to eat, even when food was available, or overate?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
7. Had trouble concentrating on things, such as reading or watching television?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
8. Been moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
9. Had thoughts that you would be better off dead or of hurting yourself in some way?[2]	☐ Not at all (0) ☐ For several days (1) ☐ For more than half the days (2) ☐ Nearly every day (3)
Total score (0-27): *(i.e. combined total number)*	
This question looks at functionality based on the symptoms that your client identified above. Use this question as a scale to assess how affected your client is by the symptoms. **IF for the above questions the client responded 'For several days', 'For more than half the days' or' Nearly every day'; THEN complete Question 10.**	
10. You indicated that you are [insert above relevant questions…example: having trouble sleeping…]. How difficult has this problem/have these problems made it for you to do your work, take care of things at home, or get along with people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

[2] This has been modified from the original question (i) in the PHQ9 which says 'thoughts that you would be better off dead or of hurting yourself in some way'. In some contexts, this will not be appropriate to ask. If it is asked to some and not other clients it would mean that scoring is not comparable across the case load. https://www.med.umich.edu/1info/FHP/practiceguides/depress/phq-9.pdf

Note on scoring: PHQ-9 scores represent minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe depression (20-27). Where clients are categorized as moderate or above (score 10 out of 27 or above), it is recommended that protection case managers complete a referral to an MHPSS specialist. If client expresses suicidal ideation, responding several days or more (score of 1 or above) to question 9, it is essential that protection case managers immediately consult their supervisor and activate appropriate MHPSS referrals and provide support services, when appropriate and within their scope of work. Roles and responsibilities will vary by capacity of team and service providers in the area. It is vital that prior to implementing the PHQ-9 that the MHPSS service mapping has been conducted so that protection case managers and supervisors are aware of the available MHPSS referral options in the location of service delivery.

Summary MHPSS assessment (caseworker only) *Include any additional comments or observations about your client, and their appearance or behaviour, which could indicate their mental health and psychosocial wellbeing.*

Part I: Exploring strengths

Through a focused discussion with your client, brainstorm together and map the strengths of the client and the community around them. Draw from earlier conversations you have had with them about their relationships with family members as prompts.

Some questions you can ask to start the discussion:

What do you feel are you doing well? What interests you? Do you have people you can count on in your home or community when you have a problem? In what way do they support you? How have you managed to survive this far given all the challenges? Are there places that you like to go to in your community? Are you a member of a religious or community group? Do you have access to some local services? What/who are the people, ideas or experiences you have which give you hope and strength?

Individual/close relationships	Community
Examples: • *I am healthy* • *I am enthusiastic and motivated* • *I have a house* • *I have knowledge of …* • *I am educated* • *I can read and write* • *I have a good relationship with my wife/ husband* • *I am passionate person* • *I am interested in…* • *I have close friends*	*Examples:* • *I have access to health services* • *I have access to community buildings and schools* • *I often go to worship* • *My neighbours support me* • *I am part of a community group* • *I have connections with community leaders* • *I have a big family who I love* • *There are some local organisations who provide support*

Comments: Think about the client's and communities' protective capacities:

Consider what strengths (knowledge, experience, expertise) the client has and how could these be enhanced? What other skills, knowledge, experience or expertise do people directly or indirectly involved in the person's life already have or need to acquire?

Part J: Summary	
Summary for the client:	
From what we have discussed, what do you feel are the three things which are worrying you most?	
What has worked for you in the past/what have you tried? What have you learned which could be helpful moving forward?	
Do you have any suggestions for what you and I can do to help this situation?	
Summary for caseworker: You should now have a picture of what risk factors are contributing to your client's challenges and what protective factors are supporting them. It can be helpful to categorise these in terms of **environmental risk factors, individual risk factors (i.e. your clients characteristics that may increase their risk in this context)** and their **protective factors.** This is because in Step 3 for Case Action Planning you will work together with your client to manage these risks and enhance these protective capacities. **Note down:** any physical, information or communication barriers the person faces accessing services or assistance to facilitate the referral process. **Note down:** any changes to the specific risk(s) since the introduction & intake step. **Update details of the incident/risk at the top of the page** and update the risk-level for the case.	
Environmental risk factors (threats & barriers) they face	
Individual risk factors (Characteristics which may increase their exposure to these threats and barriers)	
Protective factors (strengths and capacities) in their life, including their relationships, household, community	

CASE MANAGEMENT - FORM 5

CASE ACTION PLAN

Form 5 Case Action Plan			
When to complete	Following the risk assessment, in order to address risks, barriers and resulting needs identified. To update according to progress and new information during follow-up visits.		
Who should complete it	Caseworker assigned to the case. The client should be the decision-maker of the plan. It is strongly recommended that the supervisor approves the plan.		
Purpose of the form	To record and plan agreed interventions needed to address the client's risk and resulting needs.		
Date			
Clinet code			
Caseworker code			
Date of last follow-up visit			
Is a safety plan required			
1. Specific Risk: *You may have more than one goal per risk*	**1. Goal:** *Using the client's own words as much as possible, explain the identified outcome. Note the type of goal: safety, mental health and psychosocial support (MHPSS), accessibility to basic needs and services, health care including mental health, access to justice, or other goal(s).*		
Action *Include actions to connect to services, connect to people and address barriers to services. For Referrals include: date/time of appointment, name of service provider, location of service provider, need for accompaniment*	**By Who** *Responsible person, organization*	**By When** *Time frame for completion, date for follow-up*	**Status** *To be updated based on the follow-up visit*
			Met (insert date) *In progress* *Unmet (insert date)*
			Met (insert date) *In progress* *Unmet (insert date)*

2. Specific Risk:	**2. Goal:**		
Action	**By Who**	**By When**	**Status**
			Met (insert date) *In progress* *Unmet (insert date)*
			Met (insert date) *In progress* *Unmet (insert date)*

Client signature_____ **Date**_____

Caseworker signature_____ **Date**_____

CASE MANAGEMENT - FORM 6

SAFETY PLANNING FORM (FOR SAFETY PLAN)

Form 6 Safety Planning Form (for Safety Plan)	
When to complete	At any stage during the case management process where safety concerns are disclosed.
Who should complete it	Caseworker assigned to the case. Supervisor should approve the safety plan.
Purpose of the form	Record and plan how to mitigate risk of harm for clients who are in danger.

Use this form to determine what needs to happen or to be in place for your client to be safe. Identify dangerous situations, warning signs, and activities that the client can take on their own to keep them safe. Use these questions to help you to work with the client to identify potential ways to help them plan what to do. You can make a plan for less life-threating situations and for more drastic situations.

What do you do when you are in danger? *Help them to think about alternative responses.*

Where could you go? *Help the client to think of at least one safe place they can go to in an emergency. They should arrange things with that place ahead of time. Are there any physical or financial barriers they may find while trying to reach that place? How would the client address them?*

Whom do you trust? *Think about anyone (neighbours, friends, family members, an organization) that the client can trust. For example: discuss having a signal with helpful neighbours. On seeing this signal from the client, neighbours would plan to visit in a group. Would there be any information and communication barriers the client would have in trying to communicate with these people? How would the client address them?*

What local authorities or police might you involve, and under what circumstances would you involve them? *Depending on the type of danger, this may not be relevant; for example, where a client is being targeted by the authorities themselves. However, for situations of family or community violence it may be appropriate. Would the client want to involve the authorities? Would there be any attitudinal, information and communication barriers the client might encounter while trying to communicate with these people? How would the client address them?*

Is the perpetrator known (i.e. government body in general or a specific person)? Is there anyone who can talk to the perpetrator to try to discourage them? *There may be someone whom the perpetrator respects that could talk to them. Through advocacy with authorities, the client may be able to counter the risk.*

Who already knows about your situation/what has and/or is happening to you? *The client may not be embarrassed to enlist the help of these people.*

Do you experience difficulties moving around your home, or leaving it if required for your own safety?

If you have to leave, what will you bring? *Consider important documents, clothing, food, and money and how it will be moved.*
How can you involve your family and children? *If the client has family and/or children. What do your family and children do when you or they are in danger? How do you, your family and your children plan safety together?*
If you have to leave, what will happen to your family? *If the client has family and/or children, what will be their role in the escape? Be aware of their safety and how much they are able to handle.*
Who else might be in danger if you had to leave?

CASE MANAGEMENT - FORM 7

REFERRAL FORM

Form 7 Referral Form		
When to complete	During the case management process: • For clients to provide permission to share their information with other service providers for each referral conducted or case transfer. Use the interagency form in operation in your area.	
Who should complete it	Caseworker assigned to the case.	
Purpose of the form	Record the client's permission to share information with other service providers. Record minimum information required for the receiving agency to respond.	
Priority	**Date of identification**	**Referral date**
Indicate the priority of the case so that the receiving agency knows the timeframe for response. Consider if there are indications of immediate risk to personal safety.		
☐ High risk (48 hours) ☐ Medium risk (1-7 days) ☐ Low risk		

Referred by	**Referred to**
Insert the contact information of referring agency	*Insert the contact information of receiving agency*
Sector **Agency** **Location** **Focal Point name** **E-mail** **Phone**	**Sector** **Agency** **Location** **Focal Point name** **E-mail** **Phone**
Client information (only include if consent has been obtained)	
Insert the person's individual bio data and contact. Check your service mapping to see whether additional information requirements are needed to access the service. Only include the identifying information required for the receiving agency to provide the service.	
Name: **Address:** **Phone:** **Phone belongs to whom:** **Preferred method of contact:** **Preferred date/time for contact:**	**UNHCR Registration no. (if applicable)** **Age:** **Sex:** **Disability status** *(based on the outcome of your Washington group questions in the identification & intake form): Y/N*

Caregiver information (for minors under 18 years)

Name:
Relationship to the child:
Address:
Phone:
Caregiver informed of referral: Y/N
Explain if No:

Indicate the service(s) you are referring for. Please refer to the service mapping to ensure the service is available and the case meets the eligibility requirements for the service. Update explanations of services available in your context. See examples for CP, GBV and MHPSS.

☐ **Child protection:** *This may include children at risk of exploitation, violence and abuse, children engaged in the worst forms of child labour, unaccompanied and separated children*
☐ **Gender-based violence:** *Women at risk of gender-based violence who can benefit from prevention and response services, including case management, safe spaces, early marriage cases*
☐ **Health:**
☐ **Mental health and psychosocial support (MHPSS) services:** *This may include service providers in health, protection, and beyond; depending on the referral needs of the client and available MHPSS services providers in the area.*
☐ **Legal:**
☐ **Basic needs (food, nutrition)**
☐ **Shelter**
☐ **Water, sanitation and hygiene**
☐ **Education**
☐ **Livelihood**
☐ **Other**

Case narrative

Describe the minimum information required for the receiving agency to respond. For example, problem description, whether the client receives other assistance, number in the household. Also include what accessibility/reasonable accommodation measures should be in place/put in place by the receiving organisation to support access to the service. For example, temporary ramp, interpreter. Remember, for referrals to SGBV, CP and Legal case management services do not provide details of the incident or case.

Consent to release information

Read the disclosure with the individual. Inform the individual of how the service provider will use their data and answer any questions they might have before they sign the disclosure. For children under the age of 18 where the caregiver may be implicated in the abuse, informed assent should be sought instead. Explain to the individual that they have the right to request that their information not be documented and can request retrieval of the information at any time. They have the right to refuse to answer any questions they prefer not to and the right to ask questions or for explanations about the referral process at any time.

I _____ (clients name), acknowledge that the service provider, _____ (service provider name) has clearly explained the procedure for the referral to me and has listed the exact information that is to be disclosed. I understand that my information will be treated with confidentiality and respect, and will only be shared as needed to provide assistance and may be used for the purposes of humanitarian analysis. By signing this form, I authorize this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

Signature of client: **Date:**

CASE MANAGEMENT - FORM 8

FOLLOW-UP & MONITORING

Form 8 Follow-up & Monitoring	
When to complete	Whenever a follow-up is conducted at any point during the case management process from the opening of the case until case closure. The frequency of follow-up visits is linked to the client's needs and risk level.
Who should complete it	Caseworker assigned to the case.
Purpose of the form	To track progress made towards the goals set in the initial action plan. To record new developments or information received during the follow-up visit.
Case code	
Caseworker code	
Date	
Risk level *Update the risk level based on progress of the case action plan*	☐ High ☐ Medium ☐ Low

Reminder

During the case follow-up, monitor the progress you are making with the person to reach their goals, with making sure the person is safe and getting the support they need, and identifying any new barriers and solutions. Remember not to rush your visit with the client. Be conversational and do not be distracted by your form. Engage in active listening. Follow-up visits should aim to continue to build a rapport with the client as this is supportive of building trust and facilitating a relationship that leaves the client feeling safe and respected.

- Reassess the client's safety and mental health and psychosocial wellbeing.
- Review the case action plan and update it as necessary, including the risk level (check progress, new barriers)
- Agree on follow-up actions

Re-assess safety and mental health and psychosocial wellbeing	**Notes:** Type of new service received by client, date that service received, changes to physical and/or mental health and psychosocial wellbeing.	**Changes to the Action plan** Update the new services needed, or the date of receipt of the service, add new actions required and update the action plan.
Do you have any new developments or concerns related to your personal safety?	**Yes** **No** **Explain:**	

How have you been feeling since the last time we met? *To re-assess mental health and psychosocial wellbeing, use the PHQ-9 questions in section H of Form 5 Protection Risk Assessment (or selected tool)*		
Progress made towards goals These goals are linked to the goals laid out in the action plan. You will need to update them accordingly and insert any details needed about actions to achieve them. • Update the client on developments you see seen with regard to their action plan since the last time you met. • Where appropriate, also ask the client to update you on developments with regard to their action plan. • Agree on how you are progressing towards the goals, including any challenges • Agree on changes you need to make to the action plan and the next steps		
Safety goals Progress towards safety goals: ☐ N/A ☐ In progress ☐ Met	Explain progress towards safety goals:	
Accessibility goals for basic needs and services Progress towards accessibility goals: ☐ N/A ☐ In progress ☐ Met	Explain progress towards accessibility goals:	
Health care goals (including mental health) Progress towards health care goals: ☐ N/A ☐ In progress ☐ Met	Explain progress towards health care goals:	
Mental health and psychosocial support goals Progress towards psychosocial support goals: ☐ N/A ☐ In progress ☐ Met	Explain progress towards psychosocial support goals:	

Legal/justice goals Progress towards legal/justice goals: ☐ N/A ☐ In progress ☐ Met	Explain progress towards access to justice goals:
Other goals (list here) Progress towards other goals: ☐N/A ☐ In progress ☐ Met	Explain progress towards goals:
Changes to the action plan Update new services needed, or date of receipt of the service, add new actions required. Note down any justification for changes made to the action plan, clearly noting the date.	
Agree on any revisions you need to make to the action plan. *Update the action plan with the client.*	**Notes:**
Agree on what you each want to achieve by the next visit *On your next visit, you can start by checking with each other on whether you met these goals*	**Notes:**
Agree on the need for the next follow-up visit, including the location, time and day. *Check whether you need to make any adjustments to ensure the clients full participation in the next meeting. (i.e. organizing an interpretation, meeting in a more accessible place)*	**Follow-up meeting:** **Yes** **No** **Location:** **Date:** **Time:** **Adjustments for full participation needed:**

CASE MANAGEMENT - FORM 9

CASE CLOSURE

Form 9 Case Closure	
When to complete	When the goals of the case action plan have been met, in discussion with the client. Also, for reasons of: loss of contact, death of client, at request of client, client leaves the country/region.
Who should complete it	Caseworker assigned, with the approval of the supervisor.
Purpose of the form	To record information on the closure of the case.
Case closure date	
Caseworker code	
Case code	
Case closure	
Was the action plan met? Summarize progress towards the goals in the action plan.	☐ Yes ☐ No **Summary of progress with regard to the goals:**
Explain the reasons for closing the case.	**Select reasons for closing case** ☐ Client's needs have been met to the extent possible ☐ No contact with the client for more than [inserts duration] ☐ Client requested that the case be closed ☐ Client left the area ☐ Case was transferred to another service provider for case management ☐ Case closed/transferred due to funding constraints ☐ Death of client **Explain:**
Provide summary information for any agencies/community focal points who will assist the client in the future	
Closure checklist for caseworker	
The client has been informed of information on available services, how to access them and how to contact the hotline should future services be required	☐ Yes ☐ No

The client is aware of the case closure and, to the extent possible, the client has provided their informed consent to closure of the services	☐ Yes ☐ No Explain:
Case supervisor has reviewed case closure/exit plan	☐ Yes ☐ No Explain:
Has the client given consent to participate in the client feedback survey (to be administered by a staff member other than the caseworker)	☐ Yes ☐ No Explain:
Client signature:	**Date:**
Caseworker signature:	**Date:**
Supervisor signature:	**Date:**

SUPERVISION - FORM 1

CASEWORKER CAPACITY ASSESSMENT FORM[1]

Purpose of the form: This helps supervisors to understand the extent of a newly recruited caseworker's attitudes, knowledge and skills. It contains minimum competency standards for all caseworkers providing client-centred case management services. The results of the assessment should inform the capacity building and development actions that a supervisor provides in individual and group supervision sessions.

How to administer the form:

Before

The supervisor should
Step 1: Organize an individual supervision session in a comfortable and private space. The supervisor should set aside between 2-3 hours for this assessment or, if preferred, this process can be broken down into 2 or 3 separate sessions.

During

The supervisor should
Explain the purpose of the assessment to staff and ask staff to answer honestly and be self-reflective. This will be most helpful in identifying areas where staff can benefit from further coaching and staff development. **Supervisor can say:** *"This form has been developed to capture some of the key standards that are expected of a protection caseworker. We don't expect you to be an expert and have perfect answers from the very beginning. It takes time to understand protection case management guiding principles and how to apply them with clients. During our first weeks together, this assessment will determine the areas where we can provide you with more technical support. After the assessment, we will continue working together to build your knowledge and skills. After a few months, we will revisit the assessment to see how you are progressing."* Step 3: Explain that the form is divided into three sections (attitudes, knowledge and skills). Explain that **the attitude assessment is a self-administered assessment** where the caseworker will be given 20 minutes alone to answer these questions. Once this has been completed, **the knowledge and skills assessment will be administered through a verbal interview with the supervisor.** Explain that you will be taking notes in order to remember her/his responses. Invite the caseworker to raise any questions about the form or the process to ensure s/he feels comfortable. **The supervisor should ask the questions on the questionnaire in order and give the caseworker time to explain/describe their answer.** Allow the caseworker to speak openly and ask clarifying questions. Supervisors are encouraged not to provide answers, but should respond if there are some alarming issues that require immediate discussion and direction. For the attitude scale, simply mark the scoring and don't ask for further elaboration. Once the assessment is complete, the supervisor and caseworker should discuss what are the suggested priorities in each area for technical capacity building and development. If the staff member does not meet, or only partially meets the required attitudes, knowledge and skills it may not be appropriate for them to work with persons at heightened risk until s/he undergoes personal reflection of the harmful values and/or beliefs, or reviews the way case management services should be delivered. If this is the case, supervisors will need to handle this conversation carefully and sensitively.

[1] This form has been adapted from the Child Protection Case Management Supervision Package developed by the Child Protection Case Management Task Team

After

The supervisor should
During regular individual supervision sessions, the supervisor should refer back to the capacity assessment in order to provide ongoing coaching to the caseworker. If several caseworkers need guidance in the same area, the supervisor can organize a training or development session during group supervision. The supervisor should also arrange shadowing sessions for the caseworker to observe the application of guiding principles in practice. After approximately 3-6 months, the supervisor should re-assess the caseworker to determine her/his progress and continuous development needs.

Caseworker Capacity Assessment

Date	
Caseworker	
Supervisor	

Part One: Protection attitudes and scoring

This is made up of 15 statements to assess personal beliefs and values. The scale can measure their attitudinal readiness for working directly with persons at heightened risk and highlight areas for further learning and training.

Statements	**Does the caseworker:**				**Caseworker's response and notes from discussion**	**Development priority?**
	Strongly agree	**Agree**	**Disagree**	**Strongly disagree**		
1. People with developmental disabilities and mental health conditions have something to offer the community and should be able to move freely	**4**	**3**	**2**	**1**		
2. Violence can sometimes be a person's own fault and is justified	**1**	**2**	**3**	**4**		
3. People of all political and religious beliefs and values have the right to express them and live in safety and dignity	**4**	**3**	**2**	**1**		

3. People of all political and religious beliefs and values have the right to express them and live in safety and dignity	**4**	**3**	**2**	**1**		
4. People who experience traumatic events cannot recover or become productive members of society	**1**	**2**	**3**	**4**		
5. A caseworker should always consider a person's opinion and wishes when making a decision that will affect them	**4**	**3**	**2**	**1**		
6. It is acceptable for caregivers to make decisions and provide consent on behalf of a person with a developmental disability or/and older person because they know best	**1**	**2**	**3**	**4**		
7. Violence within a household is a family matter and should be handled within the family	**1**	**2**	**3**	**4**		
8. Services should always be designed with persons with permanent disabilities in mind	**4**	**3**	**2**	**1**		
9. Retaliation from community members against former combatants is acceptable	**1**	**2**	**3**	**4**		
10. Men do not experience mental health concerns	**1**	**2**	**3**	**4**		

11. It is my job to determine whether a client is telling the truth	**1**	**2**	**3**	**4**		
12. Poor people often say that they have been excluded from assistance or do not have support so that they can get attention or money	**1**	**2**	**3**	**4**		
13. If a person cannot answer a question properly or needs time, he/she is making up the case	**1**	**2**	**3**	**4**		
14. Locking someone up with a disability or mental health concern is normal in some situations	**1**	**2**	**3**	**4**		
15. A former member of an armed group should not be accepted for protection case management	**1**	**2**	**3**	**4**		
Total Score (Supervisor should sum the total score in each column and then add these together for the total score)						

The below scores should be used as a guide, but are not definitive.
50-60: Scores in this range indicate that the caseworker has a person at risk friendly attitude – He/she has positive beliefs and values for working with people at heightened risk. However, you can still consider supporting the caseworker on certain issues as needed.
35-50: Scores in this range indicate some troubling attitudes that may be harmful to clients. Managers and supervisors should use their discretion in allowing staff to work on cases and may want to consider "coaching" the staff person before they work independently with person at risk.
34-0: Scores in this range indicate that an individual is not ready to work with persons at risk. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes and identify immediate actions to address these gaps.

Actions to be taken	**Supervisor:**	**Caseworker:**	

Part Two: Case management knowledge

Knowledge questions	Possible correct responses	Caseworker's response and notes from discussion	Development priority?
1. What are the Guiding Principles for working with people at heightened risk?	1. Respect confidentiality and its limitations 2. Promote client safety and security 3. Everyone is entitled to human rights equally and without discrimination 4. Participation: Clients should be supported to make their own decisions; their views and opinions should be respected 5. Empowerment: I should look to enhance a person's strengths and capacities for coping 6. Do not harm 7. Client-centred approach		
2. What can be possible consequences of violence for a person?	1. Physical harm, such as injury or disability 2. Psychological harm, such as mental health problems (depression, anxiety, low self-esteem, isolation, hopelessness) 3. Difficulty in trusting people and maintaining relationships 4. Difficulty accessing services 5. Stigma		
3. What are the limits to confidentiality when working with persons at heightened risk?	1. If there are mandatory reporting laws in place 2. If the client is at risk of harming themselves 3. If the client is at risk of harming another person (possible homicidal) 4. If a person has been legally assessed as lacking the capacity for consent and all possible steps have been taken to support the informed consent process with him/her 5. Where the client is a child and is at risk of harm, we must act in the child's best interest		

4. Why might it be difficult for someone to leave an abusive situation?	1. Has nowhere safe to go 2. No economic resources of their own. Dependant on the abuser economically 3. Has hope that things will change 4. Is scared no one will provide care or support 5. Worried about breaking up the family 6. Worried about what people in the community will say (stigma) 7. Unable to move independently or voice their concerns due to barriers		
5. When and how should a caseworker obtain informed consent/assent?	<u>When:</u> 1. Before the identification meeting prior to intake into case management services for permission to hear the persons story, record and take notes 2. After the identification meeting prior to intake into the case management services to request permission to participate in services 3. For referrals to other services providers <u>How:</u> 1. Address any barriers identified for informed consent with the client 2. Ensure that the client fully understands the case management process 3. Ensure that the client fully understands confidentiality, including how their information will be collected, stored and shared 4. Ensure that the client fully understands the limits to confidentiality 5. Ensure the client fully understands their options and the potential risks and benefits thereof 6. Provide time for any questions 7. Ask the client whether he/she wishes to proceed by signing or giving verbal consent		

6. What are the possible consequences of sexual violence against men?	1. HIV/AIDS or other STIs 2. Mental health problems (depression, anxiety, other) 3. Stigma 4. Relationship problems 5. Isolation in the community		
7. What are some of the reasons why a client may not want to report violence or tell you their story?	1. Fear of retaliation from the perpetrator 2. Fear or worry that no one will believe them 3. Shame 4. Self-blame 5. Lack of transportation 6. Lack of money to pay service fees 7. A lack of trust in the authorities or service providers 8. Believe agencies only support certain people, such as children		
8. What are the steps in case management?	1. Identification and registration 2. Risk assessment 3. Case action planning 4. Safety planning 5. Implementation of the case action plan 6. Follow up and monitoring 7. Case closure 8. Case management service evaluation		
9. What body language can you use to make the client feel more comfortable (for example, how you are sitting)?	1. Sit face to face with client, but not at a desk 2. Make eye contact appropriately according to local customs 3. Keep a calm and relaxed body posture 4. Lean in toward the client as she/he speaks 5. Nod your head to show understanding 6. Keep a warm and friendly disposition		

10. What are some of the things you can do to create trust and show respect to a client during your meeting?	1. Give full attention to client (do not take phone calls, etc.) 2. Do not interrupt; give time to talk and do not be in a rush 3. Use respectful language which mirrors the clients 4. Do not promise anything you cannot do 5. Give complete and honest information 6. Follow through - do what you say you will do 7. Do not tell them what they "should" do; give information to help them make their own choice.		
11. Describe how you should start your first meeting with the client (introduction, identification)	1. Greet the client 2. Introduce yourself, your role and the agency, as well as anyone else present 3. Create a private and safe space 4. Assess any immediate risk to personal safety and security 5. Address any barriers to participation 6. Explain the case management process and the person's rights (they can stop, refuse to answer, ask questions) 7. Explain confidentiality and its limits, including data protection 8. Explain any potential risks or benefits 9. Understand the person's general situation 10. Identify whether the person is at risk of/has experienced a rights violation 11. Determine the risk-level 12. Ask permission to proceed either to intake into case management services or to conduct a quality referral only		

12. What are some key considerations when developing a case plan?	1. Develop within two weeks of the risk assessment 2. The client should drive the process of setting their goals 3. We should build on the client's strengths 4. The content of the case plan should reflect the client's risk assessment 5. Set specific, time-bound actions outlining who is responsible for what		
13. How can a caseworker support a client-centred approach to case management ultimately supporting the client's empowerment process	1. View people as rights claimants and support them in accessing their rights 2. Listen to the client's opinions and requests without judgment and action their wishes 3. Assess a person's individual and environmental risk factors and protective factors as regards a violation and address these 4. Support clients in drawing on their protective factors, such as the resilience, strengths and resources inherent within them and their household or community to build the action plan 5. Provide full information to the client of the types of services available, how to access them and possible risks 6. Where appropriate, safe and requested by the client, support the families/household's commitment to the outcomes, goals and tasks outlined in the case plan		
14. What are key healing statements you can use with clients	1. I believe you 2. You are not to blame 3. I am here to support you 4. What you are feeling is a very normal reaction to this situation 5. I am sorry you are in this situation/this has happened to you		

15. What are the main criteria for knowing when to close a case?	1. Goals within the case plan have been met as much as possible and follow up is complete 2. The client explains that they are able to address on-going challenges now themselves 3. The child and family relocate and the case file can be closed or transferred as appropriate 4. The client is transferred to another case management stream or relocates 5. No client contact for more than a specific period (i.e. 2 months) 6. The death of a client		
Where a caseworker is able to answer most of these questions with the possible correct responses or similar responses (such as 5 criteria per answer), it indicates that the member of staff meets the core case management requirements and is able to work independently with persons at risk, with ongoing supervision. Where they were consistently below this level of response, only providing 3 criteria or less and/or completely unable to answer some of the questions, this indicates that a capacity building plan should be in place as there is not sufficient knowledge and one-on-one mentorship as well as training sessions and shadowing staff may be necessary.			
Overall final evaluation			
Actions to be taken	**Supervisor:**	**Caseworker:**	

Part Three: Case management skills

This form is intended to guide a process of learning, allowing a case worker to put their knowledge and attitudes into practice. It is not an evaluation of the caseworker's performance. These questions can guide a discussion or role play. It lists skills associated with good case management practice and describes the correct answers/approach to look for. The form is for the supervisor only and is intended to help the coaching process because it provides a structured method to identify in which topics/issues caseworkers most need support.
Please note: It is very important that the form itself and the written comments are not shown to the caseworker (so as not to make them nervous). The supervisor should take notes separately and, once the supervision session is finished, document the feedback on the form

Skills questions	**Listen & look for responses**	**Caseworker's response and notes from discussion**	**Development priority/ continued support needed?**
1. Show how you would introduce yourself to a potential client in your first meeting.	1. Introduce themselves warmly, as well as their role and agency 2. Ask the person what their name is 3. Check the space and ask whether the client feels comfortable, private and safe 4. Check whether there are any immediate safety concerns 5. Ask whether they need any support to fully participate in the meeting		
2. Show how you would use your body language to help a client feel safe and comfortable	1. Uses appropriate eye contact 2. Mirrors the words and phrases you use 3. Stays calm and comforting throughout the interaction 4. Using a short and gentle voice 5. Friendly facial expressions 6. Leans towards you when speaking		
3. Show how you would explain confidentiality and its limits to the client?	Explaining that confidentiality means that *"I won't tell anyone what you tell me"* Exceptions when confidentiality has to be broken. *"There are a few situations in which I may have to tell someone else what you share with me but it is only for safety reasons - if I think you may hurt yourself, or hurt someone else."* Ask if the client has any questions		

4. Explain what you would do if a client walks-in and starts to talk about what happened to him/her immediately	1. Let the client finish what she/he is saying. But do not ask further questions. 2. Politely let them know that you understand that she/he is in distress and that you would like to listen and help 3. Explain that before you can do that, you need to explain a few things which are important for her/him to know.		
5. How should a caseworker respond if a client becomes hostile or angry during an interview?	1. Remain composed and calm 2. Do not raise your voice 3. Attempt to calm the person down; try determining what is causing the anger and recognize their feelings 4. Give the person space and time to think 5. Be alert for possible aggression and leave the situation if it feels unsafe 6. Carry a cell phone and use it (where appropriate) 7. Conduct interviews with a colleague to mitigate risks if needed and as advised by your supervisor		
6. What are some important considerations when interviewing a client who has experienced abuse?	1. Do not push the client to speak about their experience 2. Tell the client they can take their time 3. Do not ask heavy questions that might re-traumatize the client; they will speak to you about these issues of their own accord 4. Tell the client that you are here to help		

7. How can a you demonstrate empathy and respect for clients	1. Pay attention to verbal and non-verbal cues 2. Determine what is important to the client 3. Show a genuine desire to understand their situation 4. Keep an open mind 5. Create an environment of respect and acceptance 6. Listen for and acknowledge difficult feelings and encourage honest discussion		
8. Can you demonstrate with a few questions how you would start a discussion with a client about what happened to him/her?	Tell me about what brought you here today/I'd like to hear about what brought you here today. Would you like to tell me about what happened? Use an open tell, explain or describe question.		
9. Can you show me how you would assess safety and do a safety plan?	1. Ask the client how safe they feel at home or in the community 2. With the client identify strategies and resources in the client's life that can help reduce the risk for harm 3. Use safety assessment or suicide assessment as needed		
11. Can you explain to me how you would come up with a coping skills plan with a client?	1. Ask the client 'when you feel sad or lonely or scared, who can you talk to?' Have the client (or write down yourself) list the people they feel comfortable with. 2. Identify the activities the client enjoys and the feelings associated with those activities. Build on the information you gathered from the psychosocial assessment. 3. Based on the client's answers, help them come up with a plan to talk to, spend time with the people they have identified and to do the activities that make them feel better. Explain that they can use this plan whenever they feel [insert appropriate feeling]. 4. Ask the client if there is anyone they would like to share their plan with who can help remind them of it.		
Actions to be taken	**Supervisor:**	**Caseworker:**	

SUPERVISION - FORM 2

OBSERVATION FORM[1]

Purpose of the form: This should be used as a guide for the supervisors when observing the provision of case management services by a caseworker. This form is part of the regular coaching and feedback and should be provided in individual supervision sessions.

Before

The supervisor should	The caseworker should
• Discuss the process with the caseworker so that they feel reassured about the exercise, allowing the caseworker to ask any questions and raise any concerns they have in advance of the scheduled observation exercise. • Schedule an observation with an appropriate case in advance with the caseworker. • Be familiar with the client's case file ahead of joining a meeting and any issues that may arise. • Ensure that consent has been obtained for the visit.	• Schedule the interviews or meetings with a client with an appropriate case. The caseworker should obtain the clients informed consent/ assent. • Eventual risks or concerns associated with the observation should be discussed with the client. If no concern is underlined and the client provides consent, then the observation can take place.

During

The supervisor should	The caseworker should
• Allow the caseworker to take the lead. • Don't interrupt the caseworker unless it is necessary. • Explain that you will be taking notes about the caseworker's practice and let the client see the notes if they are interested. • Take notes according to the observation tool, highlighting specific examples for areas of improved or good practice that can be praised afterwards. • Fill in the Observation Tool, making sure that concrete examples are noted.	• Introduce the client to the supervisor and remind them why the supervisor is joining the visit. • Lead the session with the client as though the supervisor is not present.

After

The supervisor should	The caseworker should
• Complete the Observation Tool, including constructive and positive feedback. • Shortly after the session, have an individual supervision session with the caseworker to provide feedback from the observation.	• Participate in an individual supervision session with the supervisor and share reflections/ feelings about the observation. • Ask any questions that may arise from this specific session or technical areas that the supervisor can provide more guidance on.

[1] This form draws heavily from the Observation Form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force

Case Management Session Observation

Case number	
Date	
Caseworker	
Supervisor	

Mark which stage of the CM process you are observing:

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

Areas of observation	Examples (Did the caseworker...)	Examples observed and comments for the caseworker
1.PREPARATION Demonstrate proper planning and organization for the session, including making any adjustments for participation	• Ensure the available background information was gathered and adjustments/considerations were made prior to the session to ensure full participation of the client • Select an accessible, comfortable, safe and private location based on the client's preference • Have a clear objective/goal for the session	
2. INTRODUCTION Introduce the session appropriately to the client, create a comfortable and safe space	• Introduce themselves by name, role and organization in a way that the client could understand • Explain to the client the purpose of the interaction in a simple and clear way	
3. ADDRESS BARRIERS Makes adjustments to overcome barriers, if not already done so/new barriers identified	• Assess any barriers to the client's full participation, including for informed consent • Involve the client to agree ways to address barriers, including for communication	

4. CONFIDENTIALITY Protect the client's confidentiality through data protection and their informed consent	• (If completing an intake or referring the case) Obtain the clients informed consent/assent by explaining the case management/referral process and the client's rights, confidentiality including data protection protocols, limits of confidentiality including mandatory reporting policies, potential risks and benefits • Keep all documents secure • Take notes and document the case only on having obtained informed consent	
5. COMMUNICATION Engage using effective communication techniques that are age, gender, disability and diversity appropriate	• Ensure body posture remains open and facing the client, keep eye contact but remain respectful of local customs. • Use active listening skills • Mirror language used by the client and keep eye contact • Stay calm and comforting throughout the interaction • Ask open-ended questions • Use reframing and summarizing • Reflect on what the client has shared • Check regularly with the client to ensure that s/he is understanding accurately	
6. TRUST Seek to establish or maintain trust, create a healing relationship	• Greet the client warmly • Give full attention • Use healing statements, such as thank you for sharing your story with me, you can take your time, I understand you are feeling (frustrated, angry, sad, etc.); it is a very normal reaction for someone in your situation • Avoid interrupting the client • Listen before asking questions • Provides relevant and accurate information in response to questions • Avoid making promises that cannot be fulfilled • Not distracted by using forms and note taking	

7. CLIENT-CENTRED Seeks to draw on the client's strengths, promotes client's participation and seeks to understand their wishes	• Give full attention • Invite the client to express their own opinions and feelings throughout the session • Communicate with the client using non-judgmental language • Respect the clients wishes • Support the client's strengths and capacities through development of the action plan and its implementation • Be sensitive when arranging services, speaking and listening, acknowledging the client may have experienced trauma • Give the client time to make decisions and allow them to pause or stop the session at any time • Develop the action plan together	
8. SAFETY Assess the client's safety and other immediate needs	• Assess the immediate safety needs (if applicable) • Assess the client's sense of personal safety in the home and community • Review the safety plan (if applicable) with the client	
9. CLOSING Close the session appropriately	• Summarize what happened during the session with the client and thank them for their participation • Ask if the client has any questions • Agree with the client in a simple and clear manner what will happen next and when • Ensure that the client is aware of how to contact the caseworker, if necessary	
Actions to be taken	**Supervisor:**	**Caseworker:**

SUPERVISION - FORM 3

SHADOWING FORM[1]

Purpose of the form: To be used by a caseworker as a guide while watching an experienced caseworker/ supervisor interact with a client. Reflections and discussions of shadowing sessions should occur in individual supervision sessions.

Before

The supervisor should	The caseworker should
• Discuss the shadowing process with the caseworker so that they understand the purpose of the exercise, allowing the caseworker to ask any questions and raise any concerns they have in advance of the scheduled shadowing exercise. • Arrange a shadowing visit with an appropriate case and ensure that informed consent occurs with the client. • Ensure that consent was obtained for the visit.	• Attend protection case management training. • Be familiar with the client's case file ahead of joining a meeting.

During

The supervisor should	The caseworker should
• Introduce the client to the caseworker and remind the client of why they are joining the visit • Explain that the caseworker might be taking notes about the supervisor's practice and let the client see the notes if they are interested.	• Not interrupt the supervisor/senior caseworker. • Take notes to apply theory to practice. • During the sessions, the caseworker should fill in the shadowing tool, making sure that concrete examples are noted.

After

The supervisor should	The caseworker should
• Shortly after the session, have an individual session with the caseworker to discuss the shadowing session • Some of the questions that the supervisor should ask include: "What did you observe during the session?" "What did you learn?" "What went well?" "What might you do differently?" "Do you have any questions?" etc.	• Complete the shadowing tool, including questions for the supervisor. • Participate in an individual supervision session with the supervisor, and share reflections and observations from the shadowing session. • Ask any questions that may arise from this specific session or technical areas that the supervisor can provide more guidance on.

[1] This form draws heavily from shadowing form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force

Case Management Shadowing

Date	
Caseworker	
Supervisor	

Mark which stage of the CM process you are observing:

Identification & registration	
Risk assessment	
Action plan	
Implement action plan	
Follow up, monitoring	
Closing	

Areas of observation during the meeting	**List examples observed and questions for the supervisor**
1.PREPARATION Demonstrates proper planning and organization for the session, including making any adjustments for participation	
2. INTRODUCTION Introduces the session appropriately to the client, create a comfortable and safe space	
3. ADDRESS BARRIERS Makes adjustments to overcome barriers, if not already done so/new barriers identified	
4. SAFETY Assesses the client's safety and other immediate needs	
5. CONFIDENTIALITY Protects the client's confidentiality through data protection and their informed consent	

6. COMMUNICATION Engages using effective communication techniques that are age, gender, disability and diversity appropriate	
7. TRUST Seeks to establish or maintain trust, create a healing relationship	
8. CLIENT-CENTRED Seek to draw on the client's strengths, promote the client's participation and seek to understand their wishes	
8. CLOSING Closes the session appropriately	
Actions to be taken	**Caseworker:**

SUPERVISION - FORM 4

CASE FILE CHECKLIST TOOL[1]

Purpose of the tool: This tool should be used as a guide for supervisors to review a single protection case. This tool is part of regular coaching, and feedback should be provided in individual supervision sessions. It can also be used to review multiple case files independently and where common trends are observed (i.e. mistakes or misunderstandings), these can be addressed in group sessions together.

Case File Checklist

Case number	
Date	
Caseworker	
Supervisor	

General documentation	Y/N/NA	Comments/recommendations
1. Paper documentation for each case is stored in its own individual file 2. Case files are clearly labelled with the individual case code 3. Each step in the case management process that occurred thus far has a corresponding form 4. All relevant sections of the forms are filled out completely and accurately according to the status of the case		
Identification	**Y/N/NA**	**Comments/recommendations**
1. The client's age, gender and disability bio-date have been correctly captured 2. Barriers to participation have been assessed and measures are in place to address these 3. Information captured in the identification demonstrates correct identification of the violation type(s) 4. The risk level determination appears correct 5. Informed consent/assent to collect, store and share information has been obtained from the client		

[1] This form has been adapted from the case audit file in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task

Assessment	Y/N/NA	Comments/recommendations
1. The risk assessment was carried out within 1 week of the identification (or based on the risk level or in accordance with timelines agreed on in country) 2. The assessment comprehensively described the risk factors and protective factors for the client 3. Both immediate risks and longer-term needs are captured		
Case action planning and safety planning	**Y/N/NA**	**Comments/recommendations**
1. The case plan was completed within 2 weeks from the completion of the assessment (or based on risk level or according with timelines agreed on in country) 2. The actions within the case plan are realistic and address the identified risks in the assessment 3. The case plan was developed with the client 4. Goals are specific, measurable, action-oriented and time-bound (SMART), as much as possible 5. The roles and responsibilities of the different players required to reach the goals in the case plan are clearly defined 6. If a client indicates they are at risk currently, there is a complete safety plan 7. The safety plan was realistic and aligns with identified risks 8. The safety plan was complete within 24-48 hours of the risk being identified		
Implementation of the case plan	**Y/N/NA**	**Comments/recommendations**
1. Client has been linked with relevant and available services according to their case plan and informed consent/assent has been obtained 2. Appropriate steps have been taken to ensure referrals are safe and only include 'need to know' information 3. Where required, mental health and psychosocial support (MHPSS) has been provided and referrals have been completed		
Follow-up and review	**Y/N/NA**	**Comments/recommendations**
1. Follow-up was conducted regularly according to case plan 2. Review of the case plan was carried out at least once every three months with client 3. Based on the review, the case plan appears to have been adjusted accordingly		

Case closure	Y/N/NA	Comments/recommendations
1. The reason for the closure is clearly documented 2. The documentation indicates that: • The client discussed readiness and agreed to close the case • Contact information was given in the event that the client wants to re-access services 3. Approval of the supervisor was sought prior to closing the case 4. A client feedback survey was requested/ conducted 5. A follow-up visit was planned with the client to conduct a visit within 3 months of the case being closed		

Actions to be taken	Supervisor:	Caseworker:

SUPERVISION - FORM 5

CASE DISCUSSION FORM[1]

Purpose of the tool: This should be used by a supervisor to facilitate a collaborative dialogue with a caseworker during an individual or group supervision session to analyse a case and explore potential options and ways forward.

If a case is discussed in a group setting, it is important that the supervisor ensures the caseworker is prepared and comfortable sharing in front of her/his peers. In order to maintain confidentiality, the discussion should occur in a private space without using identifying information and according to the "need to know" principle. No details related to the case should be discussed externally.

The questions under each header are suggested, but can be adapted. At times, it can be helpful to use a flipchart to draw out the client's situation as presented by the caseworker.

Case Discussion

Case number	
Date	
Caseworker	
Supervisor	

Background client information – prompts	Notes from discussion
• Referral source and date • Client's gender, age, nationality, disability status • Protection status (IDP/Refugee) • Type of residents (i.e. urban/rural) • Living arrangement (living with whom)	
Current situation/protection concerns	
• Describe the main protection issue in the case, including any specific abusive or violent incidents, if applicable. • Are there immediate safety concerns? If yes; from where/ who? Who can provide immediate protection to the client (explore network and resources)? • How does the client view their situation? What are the client's priorities? • What are the roles and attitudes of their close social circle? Are they supportive? How is the relationship with the client? Is anyone implicated? • Is the client at risk of further abuse or violence?	

[1] This form is adapted from the case discussion form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force

• Are other household/community/group members experiencing or at risk of abuse? • Does the client have other needs that make the case higher risk (i.e. other risk-factors)? • What are the strengths or resources that the client has access to, either internally or through their family, or broader community? • What does the client see as possible ways forward?	
Actions taken/challenges	
• Briefly describe the work done on the case so far. • Describe the safety plan. What measures have been put in place? What personal, societal measures are in place? • What services have been provided directly? • What referrals have been made? Has the client received those services? What was the quality of those services? • What have been some of the particular challenges (e.g., concerns, referrals, engagement)?	
Questions to open a discussion – supervisor questions	
• What are the possible options for responding to the challenges in this case? • What are the potential positive and negative effects of the options? • Are there contingencies that we should consider? • What ideas and tips are there for bringing in people involved in the client's life, if consented to, to lead to a positive change?	
Good practices/learning points	
• Highlight any particular good practices or successful approaches (e.g., client-centred, finding ways of enhancing collaboration and motivation to change) • Highlight similar cases and responses taken	
Identify next steps	
• Agree on a way forward, including any services to be provided, discussions to hold with the clients, or follow-up to be conducted by agencies: person responsible and timeline • Highlight any broader advocacy issues	

Actions to be taken	**Supervisor:**	**Caseworker:**

SUPERVISION - RECORD 1

INDIVIDUAL SUPERVISION MEETING RECORD[1]

Purpose of the form: This should be used by a supervisor to track the progress made by the caseworker over the course of each period. The form assists the supervisor in facilitating a constructive dialogue with the caseworker about the functions of supervision.

Guidance: Case management supervisors and caseworkers are both responsible for preparing information to share based on the week's activities, as well as any pre-determined topics (as discussed in a previous meeting and/or as decided within a capacity building plan). This may include cases, questions from the caseworker and feedback or guidance from the supervisor. Supervisors should create an environment of openness where caseworkers are encouraged to reflect honestly.

Individual supervision meetings should be held in a private location to ensure confidentiality. Identifying information about the case can be discussed openly with the supervisor in this space so that appropriate guidance and support can be offered.

Individual supervision meeting

Date	
Caseworker	
Supervisor	
Supervision Period (dates)	

Supervision practices conducted this period		
# Shadowing visits	**# Observation visits**	**# Case files reviewed**
Agenda	**Sample discussion questions**	**Notes from discussion**
<u>Opening and check-in:</u> • Review action points from the previous meeting and any challenges faced • Set and agree the agenda	• *How was the week/period for the caseworker? Are there issues that s/he would like to add to the agenda?* • *What are the caseworker's priorities within the next hour?*	

[1] This form is adapted from the case discussion form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force

Administrative: • Review of current caseload ***If appropriate use the Case Discussion tool** • Other logistics, human resources, operational points for discussion.	• *Are there any personal HR issues that should be discussed?* • *How many new cases has the caseworker registered and the number of high-risk cases or cases requiring intensive actions or response?* • *Are there are any operational or logistical challenges that need to be addressed?* • *What are some of the particular challenges the caseworker is facing and on which would he/she like some feedback or guidance?* • *What are some of the accomplishments with cases to be celebrated?*	
Development: • Attitudes • Knowledge • Communication Skills ***Refer to Capacity Building Assessment**	• *Application of CM knowledge/ skills from training or coaching in your daily work?* • *Are there any skills or information that the caseworker would like to work on?*	
Supportive: • Check in with caseworker • Explore possible self-care strategies or support needed	• *How is the caseworker feeling in his/her work?* • *Are there any triggers/red flags that may be an indication of needing extra support or of potential burnout?* • *Any impact on self or personal life related to specific, high risk cases in particular?*	
Discussion of supervision practices used in the past week/period: • Concrete and detailed (positive and constructive) feedback for the caseworker during the exercise	• *What does the caseworker think about the shadowing, observation session or the case files selected and reviewed?* • *Does the caseworker have any questions or concerns?*	

Closing and action points: • Agree on the main action steps to be taken following the meeting and the time frame for accomplishing these tasks	• *What are the caseworker's main priorities for improving practices and outcomes for the clients?* • *What are the supervisor's main priorities for the caseworker to improve practice and outcomes for the client?*	
Actions to be taken	**Supervisor:**	**Caseworker:**

SUPERVISION - RECORD 2

GROUP SUPERVISION MEETING RECORD[1]

Purpose of the form: The supervisor can use this form to take minutes of meeting and to track progress made with caseworkers during group supervision meetings. It also assists the supervisor in facilitating a discussion with caseworkers about the functions of supervision.

Group supervision meeting

Date	
Caseworker	
Supervisor	

Agenda	Notes from discussion
Welcome, opening and check-in • Supervisor greets the team (can use an icebreaker or energizer). • Agenda is reviewed and agreed on by the team. • Establish or briefly review meeting "agreements", especially those relating to sharing information.	

Administrative
• Supervisor shares reflections from the past week and provides updates on logistics, reporting, recruitment, etc.
• Supervisor invites caseworkers to ask questions or share any administrative or operational challenges they are facing in their work.
• Caseworker check-in (each team member shares the following):
  • A success or positive experience from the week
  • Challenges that s/he has been experiencing
  • Anonymous review of:
  • Number of open cases
  • High-risk cases and some medium-risk cases [stagnating cases, complex protection issues, etc.	

[1] This form is adapted from the case discussion form in the Child Protection Case Management Supervision and Coaching Training Package, 2018, The Alliance for Child Protection in Humanitarian Action, Case Management Task Force

Development • Based on the capacity building plans of the caseworkers, the supervisor can suggest potential topics for a team learning event, such as a teach-back, guest speaker, or special events. • Caseworkers should be asked to share any learning opportunities they are aware of or if they have a topic on which they wish to have a teach-back for the team.	
Supportive • Track progress towards the goals; discuss whether the goals are still relevant. • Supervisor or caseworker can propose team-building activities or address any team wellness issues they have noted since the last meeting.	
Closing and action points • Summary of the meeting, highlighting the action points raised and the expected timeframe. • Schedule for the following week.	
Actions to be taken by the supervisor:	**Actions to be taken by the caseworkers:**

MEAL - FORM 1

CLIENT FEEDBACK SURVEY

Form 1 Client Feedback Survey	
When to complete	This form should be completed at the end of the case management process, or after a number of sessions.
Who should complete it	Not the caseworker assigned to the case. Either, another caseworker, the supervisor, MEAL staff or another person who is appropriately trained in protection principles, psychological first aid and data-protection principles.
Purpose of the form	To record the client's feedback on the level of satisfaction with the quality of services provided and to identify areas for improvement.

Instructions for staff using paper forms or tablets:

1. Identify who on your team is going to administer the feedback form.
2. Ask for informed consent following these steps:
   - Explain the purpose of the survey. Inform the client that you will ask them some questions but will not write their name on the form and that the survey will remain anonymous.
   - Remind the client that you will not ask them any questions about their actual case, but are just interested in the services they received throughout the case-management process.
   - Ask for their permission to proceed (read the client consent section aloud to the person, as noted below). If the client declines, tell the person that it is ok and if they change their mind, they can contact you.
3. In the case of staff administration of the form, the staff member asks the questions and records on paper or on a tablet. In the case of self-administration by the client, a staff member will provide the client with a paper/pen or tablet and leave the room.

We would like to know how you feel about the case management and counselling services you received. In order to understand your experience, we would like to ask you a few questions about the services you received from us. This survey is voluntary. Its purpose is to collect information about the services that have been provided to you and to help us make improvements in the quality of care that our clients receive in this community. Please let us know whether you require any support to participate in the survey, for example whether it is easier for me to read the questions to you, whether you understand me well, or if you require an interpreter.[1]

These questions are only to help us improve our services and in no way are related to your actual case. ***Your name and responses will remain anonymous and will not affect your services or support in any way.***

Do you agree to provide us with feedback through this questionnaire?

Yes *No*

If the consent is given, continue on to the survey.

Thank you for taking time to answer this survey! It will help us understand your satisfaction with our services. Please answer the questions by yourself and honestly. If you have any questions please ask me.

[1] Refer to the Protection Case Management Guidance, page X for support on making modifications to support participation for clients.

Date survey conducted:	DD/MM/YY
Survey administered by:	[Open ended]
Client gender	☐ Male ☐ Female Other
Client age[2] *If the client does not know their exact birthdate, that is ok! Ask them to estimate the year and month. If they are really unsure about this information, ask roughly how old they think they are and then subtract that from the current year and make the birthdate 01/01. For example, a woman who believes she was born in the spring 40 years ago from year 2020 might be 04/01/80. A man who does not know the time of year but believes he is about 80 would be 01/01/40.*	[Include birthdate] MM/YY
Client displacement status	☐ IDP ☐ Refugee ☐ Local Community ☐ Other
Preferred spoken language	[Context-specific list]

Disability status-WG-SS: The next questions will ask if you have difficulties doing certain activities	
1. Do you have difficulty seeing, even if wearing glasses? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all
2. Do you have difficulty hearing, even if using a hearing aid? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all
3. Do you have difficulty walking or climbing steps? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all
4. Do you have difficulty remembering or concentrating? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all

[2] It is recommended that the birthdate of the client be collected if possible. The reason for doing this is: if you are collecting data over time, you will not have to re-collect the year, whereas an age or age group would change. Different donors have different requests around groupings. Having the exact year or age allows for flexible data disaggregation.

5. Do you have difficulty (with self-care, such as) washing all over or dressing? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all
6. Using your usual (customary) language, do you have difficulty communicating, for example understanding or being understood? Would you say…	☐ No, no Difficulty ☐ Yes, some Difficulty ☐ Yes, a lot of Difficulty ☐ Cannot do it at all
Disability status (for case manager only): Yes/No (Cut off: Yes = one or more questions where the client has responded: Yes, a lot of difficulty/cannot do it at all) **Caseworkers should only use this for analysis purposes and should not read this outcome to the person.**	☐ No ☐ Yes
How did you find out about our service(s)?	☐ Family or friend ☐ Referral from another organization ☐ Neighbour or community member ☐ Community discussion ☐ Flyer or pamphlet you saw or received ☐ Other (specify):
Meaningful access without discrimination	
How many times have you met with the caseworker since you started services with us?	[Numerical data]
Did you ever have any difficulties reaching, entering, circulating or using our services?	☐ Yes ☐ No Please explain: (consider physical, information/ communication or attitudinal barriers)
If YES is answered: Did you share this information with your caseworker?	☐ Yes ☐ No
If YES is answered: Was any measure put in place to facilitate your access?	☐ Yes ☐ No Please explain the measure:
Was this measure effective?	☐ Yes ☐ No If no, please explain why not:
How long did you have to travel (in minutes) to receive our services?	☐ Less than 15 minutes ☐ 16-30 minutes ☐ 31 minutes – 1 hour ☐ More than 1 hour Please explain:
Did you pay for travel to our services?	☐ Yes ☐ No

If yes, did it seem affordable?	☐ Yes ☐ No ☐ Not applicable – did not pay for travel If yes, please explain:
Were services available at times when you were able to attend?	☐ Yes ☐ No ☐ Not applicable Please explain:
Has your knowledge about the services available to you in the area improved since joining case management services?	☐ Yes ☐ No ☐ Not applicable Please explain:
How satisfied were you with your caseworker's knowledge of the information you needed?	☐ Completely satisfied ☐ Somewhat satisfied ☐ Not at all satisfied Please explain:
Did you ever have any difficulties reaching or using any services you were referred to?	☐ Yes ☐ No Please explain: (consider physical, information/ communication or attitudinal barriers)
If YES is answered: Did you share this information with your caseworker?	☐ Yes ☐ No
If YES is answered: Did the caseworker support you to put any measure in place to facilitate your access?	☐ Yes ☐ No Please explain the measure:
Was this measure effective?	☐ Yes ☐ No If no, please explain why not:
Safety, dignity and avoiding causing harm	
Did the service meet your expectations?	☐ Yes, completely ☐ Yes, somewhat ☐ No, not at all Please explain:
Did you feel comfortable talking to the caseworker?	☐ Yes, completely ☐ Yes, somewhat ☐ No, not at all Please explain:
Did you feel the caseworker supported your decisions?	☐ Yes, completely ☐ Yes, somewhat ☐ No, not at all Please explain:

Did you feel pressured at any time by your caseworker?	☐ Yes, completely ☐ Yes, somewhat ☐ No, not at all Please explain:
Participation and empowerment	
How satisfied were you with your caseworker's communication skills?	☐ Completely satisfied (2) ☐ Somewhat satisfied (1) ☐ Not at all satisfied (0)
Do you feel that the caseworker was able to help you with your problem?	☐ Yes, completely ☐ Yes, somewhat ☐ No, not at all Please explain:
Did you feel welcomed by staff members during the provision of services?	
Was there any issue in your caseworker's attitude towards you that you would like to share?	
Of the services you received, which one did you find most helpful?	[Open ended]
Accountability	
Did the caseworker explain to you how to provide a complaint or feedback if you wanted to?	☐ Yes ☐ No
Did the caseworker explain your rights at the beginning?	☐ Yes ☐ No
Did the caseworker follow up with the services you agreed to contact?	☐ Yes ☐ No If yes, please explain:
Overall satisfaction	
To what extent has your problem been addressed?	☐ Completely ☐ Somewhat ☐ Not at all Please explain:
Please complete the sentence. Through my participation in case management services, my ability to solve this/other problems has…	☐ Increased ☐ Not changed ☐ Decreased
Overall, how satisfied were you with the services that you received from IRC protection staff?	☐ Completely satisfied ☐ Somewhat satisfied ☐ Not at all satisfied Please explain:

What improvements can we make to our services for other clients?	[Open ended]
Would you recommend to a friend who has experienced something similar that they come here for support?	☐ Yes ☐ No Please explain:
Thank you for taking the time to take this survey. We will use your honest feedback to help us improve this service.	

MEAL - FORM 2

PROTECTION CASE MANAGEMENT INDICATORS

Form 2 Indicators	
When to complete	To be collected and reported during the implementation of the project to monitor progress and effectiveness and at the end of the project cycle.
Who is to use it	Protection Manager, MEAL Staff.
Purpose of the form	The following list contains a list of custom indicators that can be used to evaluate the quality and outcome of your protection case management services. It is a non-exhaustive list and you are not expected to use all the indicators. These indicators have been designed based on the protection case management theory of change in Chapter 1.

Outcome/output	Indicator	Source/means of verification
Outcome 2A	A context-specific protection analysis	A context-specific protection analysis
Outcome 2B	% of cases that are satisfied with the case management services	Client feedback form
Outcome 2B	% of caseworkers whose knowledge assessment score is at least 70%	Supervision knowledge assessment
Outcome 2B	% of caseworkers whose attitude score is at least 80%	Supervision attitude assessment
Outcome 2B	% of clients that report their ability to solve problems has increased	Client feedback form
Outcome 2C	% of clients reporting actions taken to address barriers were effective	Client feedback form
Outcome 2C	% of planned actions from the protection mainstreaming actions plans that have been implemented	Protection mainstreaming action plan
Output (link to O2A)	No. of cases registered for protection case management.	Case intake form
Output (link to O2B)	No. of successful referrals	Action plans, referral form
Output (link to O2B)	No. of caseworkers trained on protection case management	Training participant list
Output (link to O2B)	No. of case files reviewed with a case file checklist	Case file check list

*All indicators should be disaggregated by age, gender and disability. Disability should be captured using the Washington Group Questions.