STANDARD OPERATING PROCEDURE FOR GENDER BASED VIOLENCE PREVENTION AND RESPONSE

National Commission for Women and Children
Royal Government of Bhutan
January 2020

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ROYAL GOVERNMENT OF BHUTAN
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NATIONAL COMMISSION FOR WOMEN AND CHILDREN

MESSAGE FROM THE CHAIR

It gives me immense pleasure to present the Standard Operating Procedure (SOP) on Gender Based Violence (GBV) - a procedure for organizations and individuals working on GBV. The SOP is developed based on a series of consultations with relevant government and non-government stakeholders and developed within the framework of existing legal and policy provisions. It is the first of its kind in the country and brings together existing international and national GBV related legislation, policies and procedures to provide a functional guide for stakeholders including their roles and responsibilities.

GBV is a widespread violation of human rights and an estimated one in three women experience physical or sexual abuse in her lifetime worldwide. GBV undermines the health, dignity, security and autonomy of victims, yet it remains shrouded in a culture of silence. Victims of violence suffer sexual and reproductive health consequences, including unwanted pregnancies, unsafe abortions, traumatic fistula, sexually transmitted infections including HIV, and even death. It also acts as an impediment to achieving gender equality and prevents the survivors/victims from exercising their social, economic and political rights.

Bhutan is no exception to such issues and the Study on the Prevalence of Violence Against Women and Girls, 2017 showed that two in every five women experienced one or more forms of partner violence in their lifetime. Therefore, the development of this SOP is timely and I am hopeful that it will strengthen our efforts to effectively prevent and respond to GBV through a multisectoral and coordinated approach.

Tashi Delek!

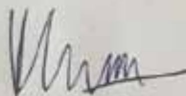
(Dr. Tandi Dorji)
CHAIRPERSON
National Commission for Women and Children

FOREWORD

The Constitution of the Kingdom of Bhutan 2008 reflects commitments of the country towards eliminating all forms of discrimination and exploitation against women and children. The ratification of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) reaffirms the country's commitment to promote and protect the rights of women in the country. The Domestic Violence Prevention Act (DVPA) was enacted in 2013 to ensure the provision of effective and appropriate services for the domestic violence victims. The National Commission for Women and Children (NCWC) is designated as the Competent Authority for the implementation of the DVPA and various initiatives have been taken to strengthen the protection mechanism for women and children. However, women and children continue to be victimized and subjected to Gender Based Violence (GBV).

In response to this, the NCWC developed the Standard Operating Procedure (SOP) on Gender Based Violence (GBV) with the objective of ensuring effective, appropriate, systematic and timely services to prevent and respond to GBV. The SOP will provide clear guidelines on multi-sector response to and prevention and mitigation of GBV in the country. It covers the provision of a continuum of care and support services at every stage and for every GBV case. Therefore, the SOP will help in strengthening a coordinated approach amongst all the relevant stakeholders as well as governance and accountability mechanisms in dealing with the GBV cases.

The NCWC would like to acknowledge the support and contribution of all the stakeholders towards the development of this SOP and we look forward to the same support in its implementation.



(Kunzang Lhamu)

Director

National Commission for Women and Children Secretariat

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Acronyms

BMHC	Basic Medical and Health Council
CA	Competent Authority
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CBSS	Community Based Support System
CCPA	Child Care and Protection Act of Bhutan 2011
CIDC	Child in Difficult Circumstances
CMSOPs	Standard Operating Procedures on Case Management for Women and Child in Difficult Circumstance
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
D/TWCC	Dzongkhag/Thromde Women and Child Committee
DVPA/RR	Domestic Violence Prevention Act of Bhutan 2013/ Rules and Regulations
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender Based Violence
HRT	Helpline Response Team
ICP	Internal Complaints Procedure
IPV	Intimate Partner Violence
JDWNRH	Jigme Dorji Wangchuk National Referral Hospital
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex persons
MHPSS	Mental Health and Psychosocial Support
NCWC	National Commission for Women and Children
OSCC	One Stop Crisis Centre
PFA	Psychological First Aid
PO	Protection Officer
PSS	Psychosocial Support
PWD	Persons with Disabilities
RBP	Royal Bhutan Police
RGoB	Royal Government of Bhutan
SV	Sexual Violence
SWO	Social Welfare Officer
SOPs	Standard Operating Procedures
VAWG	Violence Against Women and Girls
WCPU/D	Women and Child Protection Unit/ Desk
WIDC	Women in Difficult Circumstances
WCWC	Women and Children Welfare Committee

1. Introduction

1.1. Background and Context

Gender Based Violence (GBV) is widespread human rights violation. As elsewhere, GBV is common in Bhutan with studies suggesting two in every five women experience one or more forms of partner violence in their lifetime with few survivors ever reporting the case of violence, seeking assistance or receiving care[1]. In response to this, the Royal Government of Bhutan (RGoB) has supported various initiatives to promote and protect the rights of women and children including but not limited to the enactment of the Child Care and Protection Act of Bhutan 2011 (CCPA), the Domestic Violence Prevention Act of Bhutan 2013 (DVPA) and the introduction of the Standard Operating Procedures on Case Management for Women and Child in Difficult Circumstance (CMSOPs). These along with other relevant legislation, policies and procedures have strengthened the response to and mitigation and prevention of GBV. However, there remains a need for multi-sector SOPs on GBV to ensure effective coordination and delivery of quality services. Accordingly, the National Commission for Women and Children (NCWC), as the designated Competent Authority in coordination with UNICEF and UNDP initiated the development of a GVB SOPs in September, 2019. This process included a desk review of relevant literature, consultations with relevant stakeholders and training for service providers on the SOPs to support their finalization and roll-out. The following document represents the final outcomes of this effort.

1.2. Purpose and Audience

The purpose of the GBV SOP is to provide clear and comprehensive guidance for the multi-sector response to and prevention and mitigation of GBV in Bhutan. It sets standards for these actions and related services in line with international best practice. It brings together existing international and national GBV-related legislation, policies and procedures to provide a functional guide for stakeholders on their roles and responsibilities. It outlines procedures for the effective coordination of service delivery as well as related governance and accountability mechanisms.

The SOP is intended for the following distinct audiences:

- Case management actors/case workers providing case management services;
- Specialized GBV service providers across health, safety and security, mental health and psychosocial support (MHPSS), justice and social sectors;

1 NCWC, UNDP (2017). National Study on Women's Health and Life Experiences 2017: A Study on Violence Against Women and Girls in Bhutan

- Front-line workers and non-specialized services providers;
- Agencies responsible for the coordination and governance of GBV multi-sector services, including the Competent Authority;
- Actors involved in the prevention of GBV including information, awareness and social norm change actions/interventions.

See Glossary section for further definitions of these key actors.

1.3. Scope and Limitations

The SOP is limited to GBV; GBV constituting "any harmful act perpetrated against a person based on socially ascribed (i.e. gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty[2]". This includes GBV against children and adolescents, for example early marriage. Other types of violence, including non-GBV violence against children and adolescents are not covered however where relevant, reference to complementary resources for guidance have been included.

It is also important to note that currently survivors in Bhutan face challenges in accessing survivor-centered care. These barriers also present potential limitations for the implementation of the SOP. This includes:

- Lack of adequate services in remote, and often underserved areas;
- Lack of adequate personnel in dealing with survivors of GBV;
- Limited infrastructure and long distances between service providers in rural areas;
- Limited community awareness of GBV particularly in remote locations.

Where possible, the SOP have sought to provide guidance in order to address these barriers however it is anticipated that they will continue to challenge its full implementation. This document seeks to remain functional. As such, it will require revisions subject to changes in operating context with its applicability dependent on this. This document is based on the recognition that the overwhelming majority of persons who experience GBV are women due to society-wide structures of inequality and discrimination against them. Accordingly, this document uses the pronouns she/her to refer to survivors. This does not deny the existence of male survivors and includes guidance on responding to the needs of male survivors.

2 Inter-Agency Standing Committee (2015). Guidelines for Integrating GBV Interventions into Humanitarian Action

1.4. GBV Definitions and Incident Classification

The SOP are based on the following foundational definitions:

Gender[3]: Refers to the social differences between men and women that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures.

Gender-Based Violence[4]: Is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. The term gender-based violence is most commonly used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. It is important to note, however, that men and boys may also be survivors of GBV, and as with violence against women and girls, this violence is often under-reported due to issues of stigma for the survivor. GBV is a violation of universal human rights protected by international human rights conventions, including the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment; and the right to life.

The SOP recognize the four main types of GBV within which there are distinct incident classifications. These incident classifications are based on international GBV data management best practice and support clear assessment, service delivery and reporting. A legal analysis comparing type, incident classification and national legal definition has been included for clarity.

Intimate partner violence may encompass one or more types of GBV and involve one or more incident types. While it is not included as a distinct category because of this, data collection in cases of IPV can be done through summary sections in assessment, intake and other relevant forms. Further guidance on this is included in the **Case Management** section.

3 Adapted from Inter-Agency Standing Committee (2015) Guidelines for Integrating GBV Interventions in Humanitarian Action

4 Ibid

GBV Types	Incident Classification	Definition	Relevant definitions as provided in national legislation
Physical Violence	Physical Assault	An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include Female Genital Mutilation/ Cutting (FGM/C).	Physical abuse within a domestic relationship (Domestic Violence Prevention Act (DVPA)) includes acts that (a) Causes bodily injury, pain, harm, or danger to life; (b) Impairs the health or development of the victim; or (c) Otherwise violates the dignity of the victim (Sec 4.1). Physical assault (Penal Code) not specific to relationship status includes acts where defendant purposely knowingly, recklessly, or negligently causes apprehension of bodily injury to another person (Sec. 165). Battery (Penal Code) not specific to relationship status acts that involve the purposeful use physical force of an adverse nature on another person (Sec. 158). Assault of a child (Child Care and Protection Act (CCPA)) considered to be act where the person purposely or knowingly assaults the child (Sec.212). Homicide (Penal Code) includes acts where a person commits a homicide knowingly and deliberately (Sec. 137). Voluntary manslaughter (Penal Code) includes acts where a person: (a) Possess the intention to kill but without premeditated malice, acts under the violence of sudden passion occasioned by some great provocation such that a reasonable person would be induced to cause the death of other person; or (b) With vicious intent to cause serious bodily injury to a person causes the death of the person (Sec 140). Involuntary manslaughter (Penal Code) includes acts where a person's actions:(a) lead to the death of the victim is committed during the person's commission of a reckless act; (b) the person's conduct that leads to the death of the victim is committed during the commission of another unlawful act other than a felony; or (c) A homicide that would otherwise be murder is committed under the immediate influence of extreme mental or emotional distress for which there is reasonable explanation or excuse (Sec. 142).

Sexual Violence	Rape	Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.	Sexual abuse (DVPA) in context of domestic relationship includes any conduct of sexual nature that humiliates, degrades or otherwise violates the dignity of the victim (Sec. 4.2). Marital Rape (Penal Code) includes act where individual engages in sexual intercourse with one's own spouse without consent or against the will of the other spouse (Sec.190). Rape (Penal Code) includes any acts of sexual intercourse of whatever its nature against any other person (Sec. 177). Rape of a married person (Penal Code) covers the rape of a married persons according to the above definition of rape (Sec. 180). Rape of a pregnant woman (Penal Code) covers the rape of a pregnant woman according to the above definition of rape (Sec. 185). Gang rape (Penal Code) refers to acts where two or more persons engage in raping another person (Sec. 188). Gang rape of a pregnant woman (Penal Code) includes acts where two or more persons engage in raping a pregnant woman (Sec. 195). Gang rape of a married person (Penal Code) includes acts where who or more persons engage in raping a married person (Sec. 189). Statutory rape (Penal Code) includes acts where a persons engages in sexual intercourse with a child below twelve years, or an incompetent person, either with or without knowledge of the other person being a child or incompetent person (Sec. 181). Rape of a child above twelve years of age (Penal Code) includes acts where a person has sexual intercourse with a child between the age of twelve to eighteen years (Sec. 183). Gang rape of a child (Penal Code) below twelve years of age includes acts where two or more persons engage in a sexual intercourse with a child below the age of twelve years (Sec 191).

			Gang rape of a child (Penal Code) above twelve years of age includes acts where two or more persons engages in raping or indulging into a sexual intercourse with a child between the age of twelve and eighteen years (Sec. 195).
	Sexual Assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. FGM/C is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.	Sexual harassment (Penal Code) includes acts where a person makes unwelcome physical, verbal or non-verbal abuse of sexual nature (Sec. 205). Indecent exposure (Penal Code) includes acts where one exposes one's private parts to another person or does any obscene act in a public place under circumstances, which the defendant knows or should know that it is likely to cause affront or alarm (Sec. 209). Child molestation (Penal Code) includes acts where a person molests a child (Sec. 203).
Economic Abuse	Denial of Resources, Opportunities and Services;	Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.	Economic abuse in the context of a domestic relationship (DVPA) includes: (a) Unreasonable deprivation of economic or financial resources and facilities which the victim is entitled to use or enjoy, which results in emotional distress or hardship; (b) Disposal of household effects, any alienation of assets whether movable or immovable, valuable shares securities, bonds and the like or other property in which the victim has share or is entitled to use by virtue of the domestic relationship or which may be reasonable required by the victim or children or any other property jointly or separately held by the victim; Or (c) Prohibition or restriction to continued access to resources, accounts or facilities which the victim is entitled to use or enjoy by virtue of the domestic relationship (Sec. 4.4).

Emotional Abuse	Psychological/ Emotional Abuse;	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/ or menacing nature, destruction of cherished things, etc.	Emotional abuse in the context of a domestic relationship (DVPA) includes distress caused by: (a) Intimidation; (b) Harassment; (c) Damage to property; (d) Threats of physical abuse or sexual abuse; (e) Degrading or humiliating verbal conduct; or (f) Any other conduct that violates the dignity of the victim (Sec 4.3). Sexual harassment (Penal Code) includes acts where a person makes unwelcome physical, verbal or non-verbal abuse of sexual nature (Sec. 205). Indecent exposure (Penal Code) includes acts where one t exposes one's private parts to another person or does any obscene act in a public place under circumstances, which the defendant knows or should know that it is likely to cause affront or alarm (Sec. 209). Prowling (Penal Code) includes acts where a person loiters or prowls at a place and in a manner not usual for a law-abiding individual under circumstances that cause alarm for the safety of another person or property in the vicinity (Sec 464).
Harmful Practices	Forced Marriage	The marriage of an individual against her or his will. A formal marriage or informal union before age 18. Child marriage is a reality for both boys and girls, although girls are disproportionately the most affected. It is widespread and can lead to a lifetime of disadvantage and deprivation. Child/ early marriage is one of the forms of forced marriage and is a harmful practice.	Where a child marriage is performed and there is realization of expenses incurred for performing the marriage and exchanges of any properties, the person who has given such properties shall be returned, and the parent or guardian performing child marriage shall be punished with a fine at national daily wage rate of three months to one year calculated in accordance with the *Chhatrim* for National Wage rate (Marriage Act) (Kha 8-20)

1.5. Other relevant definitions

Actor(s) : Individuals, groups, organizations and institutions involved in preventing and responding to GBV.

Adolescent: Any person between the ages 10 – 19 years old. Early adolescents are 10 – 14. Later adolescents are 15 – 19.

Adolescent Survivor: A person who has experienced GBV between the ages of 10 to 18.

Adult: Any person over the age of 18 years and older.

Advocacy: The deliberate and strategic use of information to bring about change. Advocacy work includes employing strategies to influence decision makers and policies, and to change attitudes, power relations, social relations and institutional functioning.

Assessment: The set of activities necessary to understand a given situation which can include the collection, updating and analysis of data pertaining to a population of concern (needs, capacities, resources etc.), or the general socio-economic conditions in a given location/area.

'At Risk' Group(s): Group(s) of individuals more vulnerable to harm than other members of the population because they hold less power, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized.

Awareness Raising: Activities conducted with the affected community to increase their knowledge of GBV.

Best Interest of the Child: Refers to the totality of the circumstances and conditions which are most congenial to the survivor, protection and feelings of security of the child and most encouraging to a child's physical, psychological and emotional development. It also includes the least detrimental available alternative for safeguarding the growth and development of the child. (For ways to determine the best interest of the child, see the CCPA R&R 2015).

Case Management: GBV case management is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed about all the options available to them, and that issues and problems facing a survivor are identified and followed up in a coordinated way. It has unique characteristics that distinguish it from other approaches to case management. The approach is called "survivor-centred."

Case Management Actor: Specialized case management Case managers/ managers who have received required training and capacity building in GBV case management including psychosocial support. They provide specialized case management services under a system of structured supervision. This may include Protection Officer, Social Welfare Officers and others as relevant[5].

Case Manager: This term describes an individual working within a service providing agency, who has been tasked with the responsibility of providing case management services to survivors. This means that case managers are trained appropriately on survivor-centered approach. They are supervised by senior program staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. In this SOP, case managers are commonly referred to as Protection Officers and Social Welfare Officers, acknowledging that as the case management system develops other actors may also provide case management services.

Child: Is any person under the age of 18 (CCPA). The Convention of the Rights of the Child defines a 'child' as a person below the age of 18.

Child Labor: Child labor includes work that is mentally, physically, socially or morally dangerous and harmful to children; and work that interferes with their schooling. Child labor generally includes all children below 12 years of age directly involved in any economic activity, and children below the minimum age for work (between 14 and 16) engaged in more than light work (i.e. work that does not threaten a child's safety or health, does not interfere with the child's education, does not take them away from their families, does not use up time for play or recreation or does not hurt them physically, mentally or emotionally).

Child Sexual Abuse: Refers to any sexual activity between a child and closely related family member (incest) or between a child and an adult or older child from outside the family. It involves either explicit force or coercion or, in cases where consent cannot be given by the survivor because of his or her young age, implied force.

Child Survivors: A GBV survivor under 10 years of age (as above, adolescent survivors considered to be survivors between the age of 10 to 18 years of age).

Competent Authority: Government agency, namely National Commission for Women and Children responsible for the effective implementation of the DVPA and CCPA including overall management of GBV response and prevention services.

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5 At the time of writing, the case management system was being revised. Guidance is included as an annex for this interim period on the role of case management actors other than Protection Officer and Social Welfare Officers.

Confidentiality: Confidentiality is an ethical principle that requires service providers to protect information gathered about survivors and agree only to share information about a survivor's case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files. All electronic information should be password protected.

Coordinating Agencies: The organizations that take the lead in chairing GBV coordination groups and ensuring that the minimum prevention and response interventions are put in place.

Disability: An evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.

Disclosure. The term disclosure refers to an adult survivor's choice to share with someone they have experienced GBV. Survivors have the right to disclose an incident to anyone. They may disclose their experience to a trusted family member or friend or seek help from an individual or organization in the community. They have the right to disclose as little or as much of what happened to them, and to choose when to disclose information.

Domestic Violence: Used to describe violence that takes place within the home or family, between intimate partners as well as between other family members.

Front-Line Responders: Anyone who may receive a disclosure or report of GBV who is not trained to provide a specialized GBV service. This may be due to their work, position in a community or relationship with women and girl at-risk of violence. There are no set criteria for front-line responders; the term encompasses a broad range of people.

Harmful Traditional Practice: is defined by the local social, cultural and religious values where the incident takes place. For example, "booking" girls for marriage but never marrying her, honour killing, female genital mutilation/ cutting/circumcision, polygamy, forced marriage to settle a debt, forced marriage to perpetrator, forced marriage to settle a dispute, forced marriage because of killing, marriage exchange of women, forced marriage for financial reasons.

Identification. The term identification refers to the situation where other people (e.g., friends) inform a service provider that another person has experienced GBV.

Informed Assent: The expressed willingness to participate in services. This applies to younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services. Informed assent is the expressed willingness of the child to participate in services.

Informed Consent: Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent, and who exercises free and informed choice. To provide informed consent the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent.

Intimate Partner Violence (IPV): Occurs between current or former intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours, as well as denial of resources, opportunities or services

Mandatory Reporting: Law, policies and/or practices which mandate the reporting of types of GBV to police and other Government agencies.

Non-Specialized Service Provider: Service providers who do not provide specialized GBV services nor have expertise in GBV.

Psychological First Aid (PFA): is an evidence-informed approach that is built on the concept of human resilience. PFA aims to reduce stress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or even a personal crisis.

Psychosocial Support: Helps individuals and communities to heal the psychological wounds and rebuild social structures after an emergency or a critical event. It can help change people into active survivors rather than passive victims.

Perpetrator: Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.

Service Provider: Refers to all actors, including UN, NGO and governmental actors, providing services that are not specialized in GBV and who may not be involved in direct care for survivors.

Separated Child: A child who is separated from both parents/caregivers or from his/her previous legal or customary primary caregiver, but not necessarily from other relatives. Compare with definition for unaccompanied child.

Sexual Exploitation/Transactional Sex: The term ‘sexual exploitation’ means any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category

Sexual Slavery: An incident of sexual abuse perpetrated while the survivor was being forcibly transported (i.e., being trafficked), being forced to join an armed group (i.e., forced conscription), or being held against their will including abduction and kidnapping.

Sexual Violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work. Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion.

Specialised GBV Service Provider: Service providers across health, justice, social services, mental health and psychosocial support who provide specialized GBV services for survivors following an incident of violence. They have received training and capacity building in their respective GBV service specialization.

Survivor: A person who has experienced gender-based violence. "Survivor" is used rather than "victim" because it implies resiliency, however victim is used interchangeably in Bhutan legislation and relevant policies (eg. DVPARR).

Trafficking: 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[6].

Trauma: Traumatic experiences usually accompany a serious threat or harm to an individual's life or physical wellbeing and/or a serious threat or harm to the life or physical well-being of the individual's child, spouse, relative or close friend. When people experience a disturbance to their basic psychological needs (safety, trust, independence, power, intimacy and esteem), they experience psychological trauma.

Unaccompanied Child: A child who has been separated from both parents/caregivers and relatives and who is not being cared for by an adult who, by law or custom, is responsible for doing so. This means that a child may be completely without adult care, or may be cared for by someone not related or known to the child, or not their usual caregiver e.g. a neighbour, another child under 18, or a stranger.

6 Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organised Crime

Violence Against Women and Children (VAWC): 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 deprivation of liberty, whether occurring in public or in private life.

Vulnerability: Physical, social, economic, family, and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering, and death.

2. Guiding Principles

1. Guiding Principles for All Actors

All actors have an ethical responsibility to prevent GBV and support survivors to access quality services following an incident of violence. All actors should adhere to the following principles to ensure this:

- Understand and adhere to the ethical and safety recommendations regarding the assessment, documentation and monitoring of GBV[7];
- Integrate and mainstream GBV interventions into all programs and all sectors;
- Establish and maintain carefully coordinated multi-sectoral and inter-organizational interventions for GBV prevention and response;
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analysis and assessment information to avoid duplication and to maximize a shared understanding of situations;
- Engage the community fully in understanding and promoting gender equality and gender power relations that protect and respect the rights of women and girls;
- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programs through the systematic use of participatory methods;
- Ensure accountability at all levels to survivors and among all service providers working in any sector;
- Ensure all staff, contractors and volunteers involved in prevention of and response to GBV understand and sign a code of conduct or similar document setting out the same standards of conduct especially with regards to sexual exploitation and abuse.

2. Guiding Principles for Working with GBV Survivors

Case management actors and specialized GBV service providers who work directly with survivors and are signatory to the GVB SOPs should adhere to the following principles/approach[8]to ensure quality GBV response services and prevention actions:

Survivor-Centred Approach

A survivor-centered approach places the rights, needs and desires of women, girls and survivors at the centre of service delivery to ensure that they come

7 See WHO (2007) Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies

8 Adapted from USAID (2017) Inter-Agency GBV Case Management Guidelines, and UNFPA (2015) Essential Service Package for Women and Girls Subject to Violence

first and foremost. It ensures that survivors are supported to make decisions regarding their care based on their own needs, wishes and capacities. It creates a supportive environment in which the survivor's rights and wishes are respected, their safety is ensured, and they are treated with dignity and respect. It recognizes that the survivor:

- Has equal rights to care and support;
- Is different and unique;
- Will react differently to their experience of GBV
- Has different strengths, capacities, resources and needs;
- Has the right, appropriate to her/his age and circumstances, to decide who should know about what has happened to her/him and what should happen next;
- Should be believed and be treated with respect, kindness and empathy.

This approach helps promote a survivor's recovery and empower them to make decisions about possible recovery interventions. The survivor-centered approach is considered essential for the following reasons:

- To protect survivors from further harm. The survivor is best placed to assess her safety and risks to it. Failure to respect the survivor's decisions which are based on their sense of safety may put them at risk of further harm and violence;
- To provide survivors with the opportunity to talk about their concerns without pressure;
- To assist survivors in making choices and in seeking help if they want it;
- To cope with the fear that they may have about negative reactions (from the community or their family) or being blamed for the violence;
- To provide basic psychosocial support (PSS) to the survivor;
- To give back to the survivor the control they may have lost during the GBV incident.

Critical to achieving a survivor-centered approach are the following four guiding principles[9]:

Guiding Principle	Actions/Examples
RIGHT TO SAFETY The safety of the survivor and others, such as their children and people who have assisted them, must be the number one priority for all actors. This includes their physical and emotional safety. Individuals who disclose an incident of GBV or a history of abuse are often at high risk of further violence from the perpetrator(s) or from others around them. All actions must safeguard the short and long-term well-being of the survivor.	• Conduct conversations, assessments and interviews in a quiet and private place • Assess the safety of the survivor and promote security measures the survivor believes should be taken • Only take action with the informed consent of the survivor.

9 GBV Sub-Cluster (Iraq, 2016) Standard Operating Procedures for Prevention and Response to GBV

RIGHT TO CONFIDENTIALITY Confidentiality reflects the belief that people have the right to choose to whom they will or will not tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.	• Confidential collection of information during interviews. • Sharing information on a need-to-know basis • Permission is obtained from the survivor before sharing information • When making a referral, only details relevant are shared, and only with the permission of the survivor • Case information is stored securely • Do not include identifying information on records. Files should be identified by a number or code, and not by an individual's name.
RIGHT TO DIGNITY AND SELF-DETERMINATION The survivor is the primary actor. The role of helpers is to facilitate recovery and provide resources for problem solving. All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor.	• Show respect for survivors' strength and capacities to cope with what has happened to them. • Show that you believe the survivor. Do not question or blame the survivor. • Provide emotional support to the survivor. • Carefully and attentively listen to the survivor and provide them space to share their story in their own time. • Do not make judgments. • Provide the survivor with information about available services and the quality of these services. • Allow the survivor to make choices about the care and support they want. Value and respect their decisions • Avoid advising the survivor. • Be clear about your role and about the type of support and assistance you can offer. • Never make promises that you cannot keep. • Make sure you are well informed about the options for referral (e.g., medical, psychosocial, economic, judicial), including what services are available, the quality of these services and the safety for survivors when accessing these services. • Consider the possibility of accompanying the survivor throughout the process, if necessary. • Ensure attention to survivors' various needs, including medical and psychosocial needs, material needs and the need for safety and security.
RIGHT TO NON-DISCRIMINATION Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic	• Treat all survivors equally and in a dignified way. • Do not make assumptions about the history or background of a survivor. • Be aware of your own prejudices and opinions about GBV, and do not let these influence the way you treat a survivor. • Ensure you have been trained on human rights, humanitarian principles, and relevant agency non-discrimination policies.

Refer to the following additional principles and approaches for further guidance given in annexures 11.4.

Working with child and adolescent survivors[10]
All GBV actors should adhere to the following principles when working with or for child and adolescent survivors. Service providers should recognize the distinct age and gender-based risks, strengths and consequences of violence for persons under 18.

Attention should also be paid to the different experiences, capacities and consequences for infants, young children, youth and adolescents; while young children are at risk of sexual violence, adolescents may be at risk of multiple forms of GBV including but not limited to sexual violence such as early marriage or IPV.

Promote the child's best interest: A child's best interest is central to good care. A primary consideration for children is securing their physical and emotional safety—in other words, the child's wellbeing— throughout their care and treatment.

Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that children's rights to safety and ongoing development are never compromised.

When working with adolescent survivors, service providers priorities her best interest, safety and wellbeing while respecting her right to self-determination. Adolescents have the capacity to understand information given to them and evaluate available service options. Accordingly, they should be involved in decisions regarding their care commensurate to their maturity and capacity including the exercising of full control over decisions based on their informed consent where appropriate.

Ensure the safety of the child and adolescent: Ensuring the physical and emotional safety of children and adolescents is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short and long terms.

Subject to the age and capacity of the child, services providers should seek to create safety by providing clear information, being patient, and giving them as much time as they need to think, ask questions, express their feelings and needs, arrive at their own solutions, and explain their ideas and decisions.

10 USAID (2017) Inter-Agency GBV Case Management Guidelines

Comfort the child and adolescent: Children and adolescents who disclose sexual abuse require comfort, encouragement and support from service providers. This means that service providers are trained in how to handle the disclosure of sexual abuse appropriately. Service providers should believe children and adolescents who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced. A fundamental responsibility of service providers is to make children and adolescents feel safe and cared for as they receive services.

Similarly, for adolescent and/or child survivors of other types of GBV service providers should show empathy and offer comfort, encouragement, and support. Central to this is believing the survivor, taking their disclosure seriously, never blaming or judging them, and choosing kind words that help them feel safe and cared for.

Ensure appropriate confidentiality: Information about a child or adolescent's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring 1) the confidential collection of information during interviews; 2) that sharing information happens in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child, adolescent and/or caregiver; 3) and that case information is stored securely.

Where mandatory reporting of CIDC cases apply, mandatory reporting procedures should be communicated to the children, adolescent and/or their caregivers at the beginning of service delivery. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

Recognising the decision-making capacity of adolescents, the involvement and consent from a caregiver or trusted adult is encouraged but not required. Service providers should never refuse care or services if the adolescent survivor does not want to get caregiver consent. Asking the girl survivor for her consent throughout her care is empowering, and keeping confidentiality builds trust.

Involve the child in decision-making**:** Children have the right to participate in decisions that have implications in their lives. The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age.

Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent/ caregiver manner with maximum respect.

As above, subject to an adolescent's maturity and capacity they may be able to give informed consent and lead decision-making regarding their care.

Treat every child fairly and equally (principle of non-discrimination and inclusiveness)**:** All children and adolescents should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.

Strengthen children and adolescent's resiliencies: Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the child and family's natural strengths as part of the recovery and healing process.

Factors which promote children and adolescent's resilience should be identified and built upon during service provision. Children and adolescents who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from abuse.

Adolescent girls face age-specific factors which contribute to their disempowerment which is further exacerbated by GBV. Supporting an adolescent girl to feel power and control over her life is critical to fostering her empowerment and resilience and thus, her long-term recovery. Care that affirms girls' strengths and agency, supports girls to create and maintain meaningful relationship and access opportunities for meaningful social engagement gives girl survivors' a better chance to recover and heal.

Working with persons with a disability[11]

As with all survivors, services for survivors with a disability should respect their dignity, individual autonomy and the principles of non-discrimination, diversity and empowerment. Full and effective participation of Persons with Disabilities (PWDs) in the society should be supported and actors working with a survivor with disability should:

- Recognize that PWDs are not a homogenous group. It encompasses people with distinct impairments and a wide spectrum of capacities;
- Understand that women and girls with disabilities often face greater risk of GBV while experiencing specific and additional barriers to accessing services including often being excluded from service design and delivery;
- Support their full and effective participation in society;

11 Adapted from Women's Refugee Commission (2015) GBV and Disability Toolkit

- Ensure inclusive accessibility and regularly consult PWDs in service design, delivery and monitoring.

Working with male survivors of sexual violence[12]

Actors working with a male survivor of sexual violence should:

- Recognize that male survivors face distinct barriers to accessing care including feelings of shame and fear of stigma, concerns and fears about sexuality, and fear of not being believed and other masculinity norms that deter help-seeking;
- Provide tailored service provision that addresses these barriers and male survivors' distinct needs including through non-discriminatory care.

Working with LGBTQI survivors[13]

Actors working with a LGBTQI survivor of violence should:

- Prioritise their safety and access to non-judgmental care;
- Ensure a clear understanding of the different terms and identities that encompass the LGBTQI community;
- Reflect and address their own perceptions and potential bias in order to provide quality, non-discriminatory care;
- Not assume a survivor's gender or sexual orientation;
- Use language carefully;
- Not reveal their sexual orientation or gender identity to other staff, support group members, etc..

12 Adapted from Inter-Agency (2017) GBV Case Management Guidelines

13 Ibid

3. Disclosure

3.1. Disclosure and Adult Survivors

Survivors have the right to disclose[14] an incident of violence to anyone, the right to choose not to disclose to someone or anyone at all, the right to disclose as little or as much of what happened to them, and to choose when to disclose information[15].

3.2. Disclosure and Child and Adolescent Survivors

Due to their age and capacity, identification of child survivors may be practiced in line with the mandatory reporting requirements for children and adolescents. As per guidance elsewhere, responses to the needs of adolescent survivors should be informed by the concept of evolving capacities[16], the principle of the best interest of the child and an empowerment approach. In some circumstances, older adolescent survivors may be recognized as having the maturity and capacity of an adult. In these circumstances, identification and disclosure practices should by informed by this.

Given the differing capacities of children and adolescents, distinct terminology is used. It is included here for clarity:

Direct Disclosure: Child survivors or child survivors' family members or friends directly share information about the abuse with a service provider [because the child has told them directly].

Indirect Disclosure: A witness to sexual abuse shares information with a third party or a child contracts a sexually transmitted disease or becomes pregnant, and this event propels the abuse to be disclosed.

Voluntary Disclosure: A child readily shares information or requests that another person share information about sexual abuse.

Involuntary Disclosure: Person shares information about sexual abuse against the child's wishes, or the child is forced into disclosing sexual abuse.

3.3. Responding to Disclosure

All actors should know how to respond to disclosures in order to provide survivors immediate support and minimise risk of further harm. This includes front-line

14 Disclosure refers to an adult survivor's choice to share with someone that they have experienced GBV.

15 GBV Sub-Cluster, Turkey Hub (2018). SOPs for GBV Prevention and Response

16 The Convention of the Rights of the Child recognizes the concept of "the evolving capacities of the child" to participate in decision-making regarding their lives.

responders, non-specialized service providers, specialized service providers and case management actors.

When any actor receives a disclosure of GBV from a survivor they should:

- Provide Psychosocial First Aid (PFA);
- Provide accurate and up to date information on services available to assist the survivor regardless of their view of the violence, survivor and personal beliefs. This includes honest information about service limitations to manage expectations;
- Provide details on how to access these services;
- Provide appropriate support to help the survivor access these services;
- Ensure survivor's confidentiality and privacy when supporting them to access services, including only sharing information relevant to another service provider for the purpose of the survivor's care and safety.

3.4. Psychological First Aid

What is PFA? Psychological First Aid (PFA) refers to an empathetic, supportive response to someone who is suffering and may need support. It can include:

- Listening to someone, but not pressuring them to talk;
- Comforting and helping someone to feel calm and safe;
- Helping someone to connect to information, services and social support;
- Providing practical care and support;
- Helping someone to address their basic needs such as information, water, etc.

What PFA is not: It is only the very basic level of emotional support. It is not professional counselling or mental health care. As such, it does not necessarily involve a detailed discussion or analysis of cause of distress or the person's situation. It should not involve pressuring someone to tell you their story. It is not a replacement for more tailored forms of emotional or psychosocial support.

Who is PFA for? PFA is for people who are upset, distress and/or have experienced a crisis or traumatic event such as GBV. It can be for adults and children. Not everyone who is distressed or experienced a crisis will need PFA.

Who can do PFA? Anyone! PFA can be practiced by anyone who is familiar with its function. It is not just for mental health care or other service professionals. It is good practice for all service providers and front-line workers to know how to provide PFA if and when someone may need it.

Prepare, Look, Listen, Link[17]: Responding to Disclosure Steps

The following guidance is of relevance to front-line responders and/or non-specialized service providers. While it may also be relevant to specialized service providers, note that specific guidance for provision of specialized GBV services including case management is included in following chapters.

Prepare	All service providers should prepare to receive disclosures of GBV whether or not they provide GBV services. Service providers should: • Ensure frontline staff can provide PFA, provide accurate and up-to-date information on GBV services and link survivors with said services; • Train all staff on GBV Guiding Principles and SOPs relevant to their organization and specialization; • Establish and ensure familiarity with available specialized GBV services, referral pathways and procedures; • Conduct information sharing and awareness raising in communities on GBV, existing services, referral pathways and basic emotional support;
Look	• Allow the survivor to approach you; • Listen to their needs; • Ask if you can provide help; • Check for safety- Assess the safety and security situation together with the survivor. Remove the person from danger if it safe to do so. If they are in danger, identify actions to help them (safer location, people to contact); • Check for urgent basic needs- Ask how you can support with any urgent basic needs first. Some survivors may need immediate medical care or clothing; • Provide practical support like offering water, a private place to sit, a tissue etc.; • Ask the survivor if s/he feels comfortable talking to you in your current location. Find a safe and quite space to talk if necessary; • If a survivor is accompanied by someone, do not assume it is safe to talk to the survivor about their experience in front of that person.
Listen	• Act in a respectful manner; • Do not interview or attempt to conduct an assessment; • Allow the survivor to disclose their distress and seek help; • Do not pressure the survivor to talk; • Recognise that every survivor is different. Do not expect them to display particular emotional reactions; • Practice active listening; • Assure the survivor it is not their fault; • Tell them it is common to feel strong negative emotions in these situations;

17 Adapted from Inter-Agency Standing Committee GBV Guidelines Pocket Guide

Link	• Ask if there is someone, a friend, family member, caregiver or anyone else who the survivor trusts to go to for support; • Share information on all services that may be available even if not GBV specialized services, including any limitations (eg. Delay); • For adult survivors, inform them that they have the right to decide what services they wish to receive and with whom they wish to share the information; • Tell the survivor that they do not have to make any decisions immediately, they can change their mind and access these services in the future; • Give the survivors time to take breaks and ask for clarifications; • Respect the rights of the survivor to make their own decisions; • Use language they will understand; • Ask for permission from the survivor before taking any action; • With their consent, help survivors access services • End the conversation supportively; • Inform them that they are entitled to protection from violence, abuse and exploitation, and to receive care and support.

3.5. Identification of GVB survivors

The identification of GBV survivors is not recommended[18] because identification:

- **Places the survivor at risk of harm or violence**. Identification of GBV survivors places them at great risk of additional harm or violence by the perpetrator/s who may not want them to get care or report the violence, and family, friends and/or the community based on perceptions of the violence committed (eg. Honor killings following cases of rape).
- **Places staff at risk of harm or violence.** Staff or volunteers identifying survivors can face risk of harm or violence by the perpetrator/s, family, friends and/or the community for the reasons stated above.
- **Places third parties at risk of harm or violence**. The identification of survivors may increase risk of harm or violence towards third parties by the perpetrator/s, family or community, for example revenge violence against children in cases of IPV.
- **Impacts the survivor/s long-term recovery** by eroding their control agency, their care and decision-making agency. In line with a survivor-centred approach, all interactions with survivors should support their empowerment, which is critical to their long-term recovery and reintegration.

Service providers should not promote or practice identification of GBV survivors and should actively discourage the identification of GBV survivors

18 Identification here refers to the situation where other people (e.g., friends, other service providers) inform a service provider that the survivor has experienced GBV without their consent.

by community members or any other individual/agency. The service provider recognising the best interest of the survivor should foster awareness on the risk associated with identification of GBV survivors among the community members to deter identification. This includes addressing common misunderstandings of mandatory reporting requirements especially in regards to the Penal Code provision on reporting a crime one directly witnesses[19].

3.6. Responding to Identification

Where a service provider receives a report of GBV from a person other than the survivor (ie. Identification), they should:

- Not document and reach out directly to the survivor.
- Instead provide the person who reported the case with information on available services which they can pass on to the survivor, in a safe, confidential and non-identifying way for the survivor.
- Provide PFA to the person who reported the case, if required.
- Consult the case management agency/actor in their location for guidance, if unsure on how to respond to a disclosure of GBV. Contact information should be made available through referral pathways.

Women and Child Helpline

The Women and Child Helpline of the NCWC aims to support women and children in difficult circumstances, including GBV survivors to access multi-sector support. The Helpline is managed by staff trained in PFA and referrals. The function of the Helpline is to link survivors with specialized services in their geographic location. When a survivor with non-immediate safety needs contacts the Helpline for support, Helpline staff may provide information and support referral to specialized service providers including case manager in line with the survivor's wishes. Where a third party reports a GBV case with non-immediate safety needs and that is not in progress, Helpline staff may provide this person with information on available services which they may provide to the survivor in a safe and confidential way to support the survivor to access services themselves.

Where a survivor or a reported GBV incident in progress poses urgent and immediate safety risks to the survivor and potentially other persons, the Helpline may trigger a Helpline Response Team (HRT) immediate response at a Dzongkhag-Thromde level. Further information on this may be found in **Multi-Sector Response: Immediate Response - Helpline Response Teams** section.

Refer to the Standard Operating Procedures for Helpline Response Teams for further guidance.

19 The Penal code compels all individuals to report crimes they directly witness. This is commonly understood to apply to all incidents of possible criminality, whether or not directly witnessed (eg. through third hand reports). This is not correct. Even when GBV as a crime is directly witnessed, it is recommended that individuals not be held legally liable for the non-reporting, and thus non-identification of GBV incidents for said safety reasons.

Skills to promote a survivor-centred response to GBV disclosures[20]

Do's	Don'ts
Do believe them.	Do not trivialise or minimise the violence. Not taking a survivor's story seriously can serve as a barrier for a survivor to seek help.
Do reassure them that the incident of GBV is not their fault. They are not the person who is in the wrong.	Do not judge them and what they tell you.
Do say that it is positive that they have talked to someone about the incident.	Do not carry out proactive identification activities (e.g., looking for GBV survivors, asking about past abuse, pushing for disclosure).
Do be honest and trustworthy.	Do not exploit your relationship as a helper by asking for money or favors.
Do listen to what they have to say and take anything they say seriously.	Do not expect them to make decisions quickly.
Do listen to what they have to say and take anything they say seriously.	Do not expect them to make decisions quickly.
Do affirm the person's strength in disclosing the incident.	Do not blame the GBV survivor.
Do allow the person to take back some sense of control in their life by allowing them to make decisions on what to say and do.	Do not make unrealistic promises or give false information.
Do be aware of and set aside your own biases and prejudices.	Do not exaggerate your skills. For example, do not ask survivors to look in depth at how they are feeling, as this is work that should only be undertaken by a professional trained in psychosocial care.
Do make it clear to the survivor that even if they refuse help now, they can still access help in the future.	Do not be intrusive or pushy, and do not ask the survivor to tell details of what happened to them
Do respect privacy and keep the person's story confidential. Try to have the conversation in a private place.	Do not pressure the survivor to tell you their story.
Do behave appropriately by considering the person's culture, age and gender.	Do not ask for proof or evidence to collaborate the incident of GBV.
Do help the survivor to plan for safety. This may prove difficult but efforts should be made to improve the survivor's safety	Do not do nothing.
Do inform them about all available options for services, and the benefits and potential consequences of accessing them.	Do not tell them what do to or take decision on their behalf.

20 GBV Sub-Cluster, Turkey Hub (2017) GBV SOPs

4. Referrals

4.1. Multi-Sector Referral

The ethical, safe and confidential referral of survivors for care done on the basis of their informed consent is central to a quality GBV multi-sector response. Referrals pathways at a national, Dzongkhag/Thromde and Gewog-level should be developed and updated regularly to facilitate timely and quality referrals (Refer to annex 11.2 for referral pathway template).

Case management actors at the respective levels should lead this development/ revision with the support of relevant coordination bodies such as the NCWC and Women and Child Welfare Committees (WCWCs). Referral roles and responsibilities should be assigned according to an individual's professional position and level of professional responsibility.

While all specialized GBV service providers should have access to referral pathways, non-specialized service providers and/or front-line responders may request access to referral pathways from lead case management agencies/ actors based on need.

4.2. Referral Documentation

Front-line responders and/or non-specialized service providers do not **need** to document referrals they make to specialized GBV service providers. However, those that operate within an established service providers structure (eg. front-line responders in hospitals or in CSOs) who have an existing system of documentation **may choose** to document it with the informed consent of the survivor. This documentation should adhere to the data management protocol (see **Documentation, Data Management and Monitoring** section). Upon receiving a referral, case management and specialized service providers will document the case including this initial referral to formally commence documentation of treatment/care in line with the data management protocol.

Referrals between case management actors and specialized service providers should use the standardized referral form developed by the NCWC with the informed consent of the survivor prior to every referral.

4.3. Transportation of Survivor

The case management agency primarily responsible for a given case has the responsibility to ensure safe and accessible transportation for the survivor to ensure their access to relevant services. Where a case manager is not involved in a case, a specialized service provider involved in their treatment should provide required transportation. In cases where neither exist or are available,

the Dzongkhag/Thromde Women and Child Committee (D/TWCC) may support arranging transportation.

4.4. Remote referral

Remote referral refers to the situation where a survivor is referred by one service provider to another remotely (eg. via phone, hotline, message, etc.).

In such cases, specialized service providers should ensure accurate knowledge of the availability, accessibility, safety and quality of services in the location of the survivor in order to prove this information to the survivor.

The specialized service providers may support remote referral through coordination with on-the-ground bodies such as D/TWCC based on the survivor's informed consent.

See **Responding to Disclosure: NCWC Helpline**, and **Immediate Response: Helpline Response Teams** sections for further guidance on this.

4.5. Non-availability of services

In locations where specialized GBV services are not available or accessible, all service providers including community volunteers should avoid raising unrealistic expectations about what support is possible. It is therefore important for all actors to maintain up-to-date knowledge about what community and GBV specialized services are operating in their areas.

When GBV specialized services are not available, a survivor should still have access to information to ensure their safety and basic emotional support. Non-case management service providers should support the survivor to access other services in line with their wishes including through arranging safe transportation. Case management actors should update referral pathways ensuring they reflect up-to-date service coverage.

4.6. Refusal of services

GBV survivors must never be forced or coerced into receiving support or services. The survivor has the right to refuse any support or service that is available or offered.

When a survivor refuses a particular service, the case manager should:

- Assure the survivor it is their right to refuse any service;
- Explain to the survivor that their refusal right now does not affect in any way their right to request or access that service at some time in the future;
- Confirm the survivor understands the consequences of not accessing

the service;

- Identify if there are any safety risks that may be the reasons the survivor has refused the service;
- With the agreement and in consultation with the survivor build a safety plan that includes identifying ways to eliminate or mitigate the risks of future GBV.

4.7. Informed Consent

Informed consent of the survivor should drive all decisions and actions regarding their care. Obtaining the survivor's informed consent before any step is taken is important because:

- It helps achieve a survivor-centred approach by ensuring they remain in control of decisions regarding their welfare.
- It demonstrates respect for their personhood and indicates an intention to be accountable to the needs of the survivors as they are defined by the survivor themselves.
- It helps facilitate protective measures and promote their healing through supporting their empowerment and agency.

Informed consent should be taken before the following steps throughout the survivor's care and recovery:

- Before interviewing the survivor or conducting an assessment of needs;
- Before any service is provided (eg. Medical examination);
- Before any action is taken (eg. Intake form is filled with survivor's details, referral);
- Before any information about the survivor, incident or case is shared.

Informed consent is **not a once off** event, but **an ongoing process**. A survivor may retract their informed consent or choose not to provide it in any circumstance, including in regard to an action/service they have previously consented to.

In order to provide informed consent, the individual (adult) must:

- have all the relevant information and facts pertinent to the decision/ circumstance.
- be of sound mind and have the capacity and maturity to understand the information being presented to them, and the potential consequences of their decision (to the extent that is reasonably possible).
- be legally able to give their consent.

In order to obtain a survivor's informed consent, service providers should:

- Explain who they are, their role and their service;
- Provide accurate and up-to-date information on other available services, including any limitations or gaps;
- Ensure the survivor's expectations are managed;
- Explain confidentiality, and any exceptions to confidentiality (see below **Confidentiality** section for further guidance);
- Explain survivor's rights;
- Ask the survivor if they have any questions and would like to continue.

INFORMED CONSENT AND SURVIVOR RIGHTS

- The right to request that their story, or any part of their story, not be documented;
- The right to not share information or partially share information;
- The right to refuse to answer any question that they prefer not to answer;
- The right to request a break or slow down during service provision;
- The right to ask questions or ask for explanations at any time;
- The right to request for a different servicer provider (eg. Female staff, a different organization);
- The right to refuse referrals, without affecting access to other services;
- The right to retract their informed consent.

4.8. Informed Consent and Child and Adolescent Survivors

A child's ability to participate in decision-making regarding their care and to provide informed assent and/or consent will be informed by their age, capacity and maturity. Service providers should recognise the concept of "the evolving capacity of the child[21]" as articulated in the Convention on Child Rights and the CCPA.

For the purposes of GBV service provision, this SOPs recognises that some adolescents may have the capacity and maturity to provide informed consent. In such cases, service providers should seek to balance the principle of best interest of the child with the survivor-centred and empowerment approach as relevant to the adolescent.

All service providers should involve children and adolescents in decisions regarding their care. This may be done either through their informed consent or informed assent. The case worker/GBV specialized service provider should work with the child survivor to ascertain their capacity.

21 The Convention of the Rights of the Child recognises the concept of the "evolving capacities" of the child to participate in decision-making regarding their care

The table below provides guidance on determining a child's capacity regarding consent/assent. It should be taken as suggested guidance for case worker/ specialized services providers who have the prerogative to assess maturity and capacity, rather than a set formula for determining capacity.

Informed Consent/Assent and Child Survivors[22]

Age group	Child	Caregiver	If no caregiver or not in child's best interest	Means
6-11	Informed assent	Informed consent	Other trusted adult's or Case manager's informed consent	Oral assent, written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight	Written assent, written consent
15-17	Informed consent	Informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

Where the child is deemed able to provide informed assent only, service providers should work with the child to identify a supportive, safe caregiver to provide informed consent on their behalf.

Service providers should not assume an adult presenting with the child and/or a parent is best placed to make safe decisions regarding the well-being of the child. Service providers should be attentive to situations where:

- There is suspicion that the parent or guardian is involved in the abuse;
- The child might become a victim of harmful reactions such as physical punishment or being forced to leave the home;
- The child does not want his/her parents to know about the abuse (and the child is old enough/mentally sound to make such a complex decision);
- A child is unaccompanied or separated and there is no responsible adult acting as guardian.

In such situations, service providers should:

- assess safety risks to the child in speaking with them without the accompanying adult and ensure risk mitigation measures (eg. Providing a reason to speak to them separately that is acceptable to the adult).
- seek to speak with the child alone/not in the company of the parent/ care-giver to determine safety risks and to try to identify an alternative trusted caregiver.

22 UNICEF, IRC (2012) Caring for Child Survivors Guidelines

Where no trusted caregiver can be identified, the case worker may exercise authority to provide informed consent on behalf of the child in line with the principles of best interest. The means of taking informed consent/assent should be tailored to the child's literacy capacity (eg. Written or oral).

Recognising adolescents' greater maturity and capacity, the involvement and consent from a caregiver or trusted adult is encouraged, but not required. Service providers should:

- respect the adolescent's agency as part of their commitment to the principle of best interest.
- **never refuse care or services to adolescents if they do not want to get their caregiver's consent.**
- Instead, discuss with the adolescent options for alternative trusted caregiver, accepting their informed consent or providing it on their behalf in line with case workers/specialized service providers' mandate and authority.

4.9. Informed Consent and Persons with a Disability

Service providers should assume all survivors are able to give their informed consent. This includes survivors with a disability. In order to enable survivors with a disability to exercise their agency to provide informed consent, service providers may where relevant:

- Ask if they would like support to help them give informed consent;
- Adapt communication to their preferred method;
- Allow additional time;
- Check they are not being coerced into decisions. Always consult with survivor before involving caregiver or other family members;
- Routinely assess risks and benefits of involving the caregiver and if it is necessary, safe and empowering to do so;
- Use the principle of best interest where survivor is unable to provide informed consent.

Women and girls with a disability often face greater risk of GBV while experiencing specific and additional barriers to accessing services including often being excluded from service design and delivery. This may influence their decision to provide informed consent for services or referral. As with all survivors, service providers should respect the survivor's decision regarding her care and wellbeing.

4.10. Confidentiality

Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. It is an important part of the survivor-centred approach, and should be given consideration at all times.

In certain circumstances confidentiality may need to be broken. This includes:

- If the survivor is an adult who threatens their own life or who is directly threatening the safety of others, in which case referrals to life saving services can be sought;
- If the survivor is a child, when there are concerns for his/her health or safety;
- When there are mandatory reporting laws or procedures (see below for further guidance).

Confidentiality and its limitations should be explained to the survivor **before** any services are provided or action taken on their behalf including the sharing of information or referrals. In this way, the survivor may choose what details to share with the service provider.

4.11. Mandatory reporting

MANDATORY REPORTING REQUIREMENTS UNDER NATIONAL LEGISLATIONS

Mandatory reporting refers to the obligatory reporting of specific types of GBV by service providers to police or other Government authorities.

Mandatory reporting for GBV is not recommended as it violates the survivor-centred approach and in doing so, may place the survivor at risk of further violence and undermine their recovery.

The Penal Code compels all individuals to report crimes that they directly witness themselves. This **does not** apply to service providers who receive reports of GBV against an adult either from the survivor or a third party (ie. not witnessing it themselves). The DVPA outlines mandatory reporting requirements in cases only involving aggravating circumstances[23], but also notes the principle of reporting and referral only **in line with the wishes of the survivor.** Recognising significant risks for the survivor associated with mandatory reporting, a narrow interpretation of these circumstances is recommended.

23 Known to be a recidivist; Poses or is likely to pose a grave risk of death or serious bodily injury to the victim; Impairs or likely to impair the health or development of the victim; Causes or likely to cause bodily injury to the victim with a weapon; Conducted sexual offence that humiliates, degrades or otherwise violates the dignity of the victim (only rape); Committed domestic violence as a result of intoxication.

Health service providers are exempted from mandatory reporting under the DVPA. Service providers are governed by existing laws as well as their sector-specific Codes of Conduct. Where the two are found to be in tension, service providers should be guided by a survivor-centered approach, the principle of do no harm and in regards to children, the principle of the best interest of the child in relation to all forms of GBV.

In cases of mandatory reporting, the service providers should:

- understand how to explain mandatory reporting requirements to survivors.
- make the survivor aware of these mandatory reporting rules, the types of information which may trigger them, and the possible consequences of reporting, before beginning an interview, needs assessment, service provision, referral, and/or the sharing of case and survivor details with others.
- Provide services according to the information shared by the survivor and their desire, even in cases where a survivor choose not to disclose vital information, which is within her/his rights.
- Not share information without the survivor's consent which will result in a loss of trust and have negative consequences.

4.12. Mandatory report of all forms of GBV against children

Mandatory reporting of all forms of GBV against children is required. As noted elsewhere, service providers should recognise the concept of the "evolving capacities of the child" with regards to adolescents, including an individual adolescent's potential capacity to provide informed consent. The service provider should not withhold services from a child or adolescent survivor where they refuse involvement of or where the informed consent of the parent or caregiver is absent.

MANDATORY REPORTING IN TEENAGE PREGNANCY AND ILLEGAL ABORTIONS

Teenage pregnancy should not automatically be considered an indicator of violence and thus grounds for mandatory reporting. Service providers should conduct individual assessment of the adolescent, their capacity and maturity and circumstances to determine if violence took place. Responses should seek to respect mandatory reporting requirements while adhering to the principles of do no harm, best interest of the child and an empowerment and survivor-centred approach.

Where an illegal abortion has been performed and the female requires post-abortion care, service providers including healthcare workers are not compelled to report the case to police[24]. Non-discriminatory and judgment-free post-abortion care should be provided in line with quality standards of care.

24 except the act is caused in good faith for the purpose of saving the life of the mother or when the pregnancy is a result of rape or incest, or when the mother is of unsound mental condition.

Refer to annex 11.X for sample scripts on how to manage confidentiality and mandatory reporting.

5. Case Management

GBV case management involves one organization/agency, usually a psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process[25]. Case management is also often the primary entry point for survivors to receive crisis and longer-term psychosocial support[26].

The goal of case management is to empower the survivor by giving them increased awareness of the choices they have and supporting them to make informed decisions about GBV and their care and wellbeing. GBV case management focuses primarily on meeting the survivor's health, safety and security, psychosocial and justice needs following the incident(s) as well as their long-term recovery.

A case management-based referral system allows survivors to be active participants in defining their needs and deciding what options best meet those needs. It is useful for persons with complex and multiple needs who seek access to services from a range of service providers, organisations and groups[27]

5.1. Roles

The NCWC as the Competent Authority is responsible for the overall management of GBV case management services in the country.

As per the DVPA/RR and CMSOPs, Protection Officers are the primary case management actors for adult and child GBV survivors. Accredited CSO Social Welfare Officers may also provide case management in coordination with and under the guidance of the Protection Officer. However, currently due to shortage of human resources and required services, other actors also provide case management service (see Annex: Memo).

Refer to Annex 11.6 for qualities and competencies of GBV case workers.

25 Ibid

26 Ibid

27 Taken from Syria

5.2. Case Management Overview

Organizations/agencies that provide GBV case management services should:

- ensure clear GBV case management protocols that complement the existing CMSOPs for CIDC and WIDC cases. These protocols should cover maximum caseloads, assignment of cases, handling of high-risk cases, mandatory reporting, handling of different types of GBV cases including child survivors, list of forms and case filing and data storage practices, referral networks and staff safety.
- Ensure that case workers/managers are familiar with these protocols.
- Ensure that one case worker/manager take on no more than 15-20 cases at any one time (1:15-1:20), while case management supervisors supervise no more than 5-8 (1:5-1:8) case workers/managers at any one time.
- Ensure that case management is provided by trained, well-supervised and experienced staff who have the time and resources to carry out their work.
- Ensure that a set supervisions schedule is established including debriefs.
- Support ongoing training, learning, support and other capacity building opportunities for Case managers to further develop core qualities and skills and for supervisors to advance their technical and management abilities.
- Ensure that infrastructure where case management services are provided is safe and comfortable for the survivor to speak with the case manager. Ideally, this would be a private place where a survivor can speak one-on-one without being heard or identified. There are various options, which include:
    - A separate physical location, for example community centre. In this case, do not call it a “GBV centre” or anything that suggests that anyone going there has experienced GBV—that would make it unsafe for both survivors and staff. Offering a variety of services that are not necessarily related to GBV allows survivors to access services more safely and discreetly;
    - If your organization operates centres for women and girls where GBV survivors can receive services, it is important to keep the centre a women only space. This is to protect both the psychological and physical safety of all of the women and girls who go to the centre. Centre-based models that offer a broader range of services to women and girls facilitate disclosure and help-seeking and also allow for the provision of more holistic psychosocial care;
    - A space within an existing service venue such as health clinic. In

this case, ensure to create a private safe space— a separate room or a space separated by a partition. It is important that the person cannot be seen or heard by others as they speak to you;

- Think about and plan for child care options in order to facilitate help-seeking among mothers and caregivers.

5.3. Case Management Process

Case management is a specialized service structured around six key steps[28]:

a. Introduction and Engagement

Case management always begins with disclosure and/or referral to a case management actor, including obtaining informed consent from the survivor. As part of this, case managers should:

- Create a comfortable, safe and private environment to greet and comfort the survivor;
- Begin to develop rapport with a survivor and build a foundation for a healing relationship;
- Explain confidentiality and the exceptions to confidentiality including mandatory reporting (see Mandatory Reporting section for guidance on this);
- Guide survivors through the process of informed consent in a safe and empowering manner: explain case management process, case work role, confidentiality, informed consent, survivor's rights;
- Ask the survivor if they have any questions and if you have their permission to proceed;
- Ensure that the Head of Protection Division, NCWC is notified of the complaint within 24 hours of receiving the survivor in line with confidentiality protocols;
- Where case is received by case manager other than the Protection Officer, they will notify the Protection Officer of the case to proceed under their overall guidance;
- Where necessary (for example, in cases of high caseload), facilitate referral to other case manager in line with the wishes of the survivor to commence case management process.

b. Assessment

The purpose of the case management assessment is to support the survivor to identify and articulate her needs. Information provided by the survivor regarding the incident/s of violence should be considered true and sufficient to do this.

28 Adapted from Inter-Agency (2017) GBV Case Management Guidelines

With the informed consent of the survivor, the case manager may contact previous service providers that have been involved in her care. Beyond this, no other third party should be involved in the assessment.

It is not the role of case managers to verify or find out 'why' the violence occurred. The search for evidence of the incident ignores the fact that many forms of GBV including life-threatening forms such as strangulation often leave no physical evidence. Insistence on evidence as a basis for the provision of care opposes international best practice and should not be practiced.

The search for evidence of the incident/s, including through interviewing third parties apart from relevant prior service providers risks critically undermining the survivor's trust in the case manager, their willingness to continue with the case management process and thus jeopardises their safety, wellbeing and long-term recovery. Survivors must be believed and supported to articulate their own needs; this central to a survivor-centred approach.

While the CMSOPs specify the 'notification of all parties' with 7 days of receiving a report of WIDC, this should not be practiced with regards to GBV. Should the survivor request mediation with the perpetrator, this may be addressed as part of case action planning and implementation, with further guidance on this provided in relevant below sections.

As part of the assessment stage, case managers should:

- Use supportive communication to facilitate disclosure;
- Gather information on survivor's background and situation:
    - Age, sex residence, marital status, occupation, ethnicity
- Gather information on the incident/s of violence from the survivor:
    - Location, timing, frequency of any previous incidents, identify of and relationship to perpetrator/s, perpetrator recidivism, nature of violence including any use of weapons, other relevant circumstances including use of alcohol/drugs
- Ask and address any immediate safety or health needs with their informed consent;
- Determine if she has already seen other service providers in response to the violence;
- If the survivor has seen other services providers, seek her informed consent to contact them in order to collect information on her current or prior care and treatment;
- Understand survivor's health, Mental health and psychosocial support (MHPSS), justice, and safety and security needs;
- Coordinate with law enforcement agencies for the issuance of an interim protection order or protection order in line with their wishes, a copy of

which shall be forwarded to the Protection Officer;

- Evaluate the survivor's capacities and resources;
- Document and maintain record this information using intake and assessment form without raising expectations (see Annex);
- Use incident classification tool to support accurate documentation;
- Conduct mandatory reporting of case to police where required and in line with guidance provided in **Referral: Mandatory Reporting** section;
- Notify Head of Protection Services, NCWC of the case if the survivor has children and where the child also has protection issues.

c. Case Action Planning

The survivor with the help of the case managers develops the case action plan. In order to do this, the case managers must provide the survivor with relevant, accurate and up-to-date information about available services. The case managers should be honest about the available services so as to manage the expectations of survivors. It is the case manager's role to help the survivor identify their needs and how they wish to respond to them **and not to decide for them or provide advice or recommendations.**

The case manager should:

- Work with a survivor to map their needs;
- Continue to provide psychosocial support;
- Give information about what health, mental health and psychosocial, justice, safety and security services and other supports are available and what can be expected from them;
- Provide information on their legal rights;
- Plan with the survivor how to meet needs, set personal goals and make decisions about what will happen next;
- Develop and document a case action plan with and for a survivor within 14 days of receiving a survivor either directly or through referral;
- Develop a safety plan that help survivor's analyse risks to their safety, identify strategies to help mitigate these risks including any safe people or places the survivor can go in an emergency for protection;
- Identify a time and place for a follow-up meeting;
- Where required, seek supervisor's review and approval of case action plan.

Review and Approval of Case Plans

Case management supervisors may conduct case plan review and approval where deemed necessary. The Head of the Protection Division, NCWC has overall responsibility for this while Protection Officers may also conduct review

and approval of case managers under their guidance (eg. Social Welfare Officers). It is not the role of the D/TWCC or its members to review or approve case plans.

The purposes of the review should be for the case manager with their supervisor to reflect on the specific case details, options for survivor care and discuss any potential challenges in order to plan for addressing/mitigating them during case plan implementation. It is critical then that the supervisor have specialist knowledge of GBV and case management.

This process should adhere to the guiding principles, including the principle of self-determination. Should new information or alternative options for care arise from this discussion, the case worker should share this with the survivor and support them to make a decision as to whether or not to incorporate this into the case plan. The case manager and supervisor **should not decide** to add or adapt an action in the case plan during review without the survivor's full involvement and informed consent.

This process should adhere to confidentiality protocols including being limited to the case manager and their supervisor. In complex cases, the case worker may call a case conference with other GBV service providers. Case conferences should be held only when required and subject to the case workers request, with this being differentiated from the process of review and approval.

d. Action Plan Implementation

The action plan is a road map. The case manager is the navigator, helping the survivor maneuver through the steps in the plan. As part of this, the Case managers should:

- Effectively implement the case action plan with the survivor;
- Arrange and ensure safe transportation of survivors to access services;
- Make referrals and assisting survivor to access support including safe accommodation, healthcare, psychosocial support, safety and security services including Protection Order, One stop crisis centre (OSCC), justice and livelihood services;
- Advocate for survivors needs to other service providers;
- Ensure services are well connected;
- Lead case coordination;
- Provide direct services if relevant;
- Ensure survivors can access services safely (eg. Accompanying them);
- Meet with service providers to provide information about the abuse so the survivor doesn't have to repeat their story;
- Undertake periodic visits to the service provider to assess progress of survivors;

- Conduct case conferencing to support the survivor if necessary;
- Conduct any mandatory reporting after first having discussed this with the survivor;
- Continue to provide PSS;
- Conduct visits to survivor's residence (home visits) only where other options for service provision are not available, in close coordination with the survivor and following safety analysis and risk mitigation planning;
- Forward a copy of the medical report to the police station, or the Court of competent jurisdiction if required

In order to do the above, the case manager needs to be knowledgeable on GBV referral pathways. It is important to note that while the referred service (or agency) is responsible for providing a specific service, **the case manager maintains overall responsibility for following up on the case plan**. All referrals should happen based on the informed consent of the survivor.

<u>Case conferencing and WCC</u>
A case conference is a planned and structured meeting called by the case manager to discuss a case with other service providers directly involved in the survivor's care. Case conferences allow you to:

- Review activities, including progress and barriers towards goals;
- Map roles and responsibilities;
- Resolve conflicts and strategise solutions;
- Adjust current action plans.
- Address any problems with services not being provided in a timely way
- Get clarity on who is doing what to avoid duplication

Case managers should always get consent from the survivor before holding a case conference. Not all GBV cases will require a case conference. Case conferencing is done on an ad hoc basis subject to case specificities and is distinct from ongoing service coordination and other coordination forums.

In line with the principle of confidentiality, only service providers directly involved in the survivor's care should participate. Attendance should be as limited as possible and on an as-needs-basis. At a Dzongkhag/thromde level, the D/TWCC is the preferred mechanism for case conferencing subject to members' relevance to the case. At a national level, case conferencing may be done within NCWC/WCWC with inclusion of other service providers as appropriate (eg. OSCC). The case manager has overall authority and responsibility for the case plan and its implementation; actors involved in case conferencing do not have the authority to approve case plans.

e. Case Follow Up

This step involves following-up with the survivor and the different services to make sure the survivor is getting the help and services they need. It also involves monitoring and evaluating that the survivor's medical and psychosocial needs have been met, and/or identifying with the survivor any barriers to achieving the action plan's outcomes, and/or identifying any new needs that require addressing. During this step, the case managers should:

- Meet with or contact the survivor as agreed;
- Discuss which services they accessed, discuss any challenges and identify new needs that have emerged;
- Document outcomes of referrals, new needs and schedule another follow-up visit if necessary;
- Reassess safety;
- Reassess psychosocial state and functioning/mental health needs;
- Review and revise the case action plan;
- Implement the revised case action plan;
- Obtain consent for any new referrals;
- Assist in the follow-up of Court Orders or any other orders by the Competent Authority;
- Where relevant, non-Protection Officer case managers (e.g Social Welfare Officer) will periodically update the Protection Officer and review the progress made by the survivor during visits.

f. Case Closure

The survivor, in consultation with the case manager decides when to close their case. The timing of the closure will depend on when the needs of the survivor have been met and when the survivor is satisfied with the outcome of the healing process. During this step the case manager should:

- Determine if/when the case should be closed;
- Ensure safe integration of survivor and any children back into place of residence where relevant and appropriate;
- Document the case closure;
- If possible, administer client feedback survey;
- Safely store the closed case file;
- Submit a report the Competent Authority outlining the steps taken, progress made at the time that the survivor and case manager are of the opinion that he/she requires no further assistance;
- Maintain a separate record of all cases of IPV settled mutually and submit the same to the Competent Authority quarterly;
- submit a report to the Protection Officer at the time of discharge of the victim from the service provider, in case of Non-Protection Officer case managers.

5.4. Mediation

Mediation is a form of alternative dispute resolution that involves an independent third party supporting two actors to negotiate to find a solution that suits both parties. Mediation is common in customary justice systems and may be preferred by the survivor, perpetrator and/or family and community members. Reasons for this include financial, linguistic and distance barriers to formal courts as well as the perception that mediation promotes the continued unity and cohesion of the family unit and community, even if at the expense of the survivor.

Mediation is not recommended as a response to GBV because of the safety risks that it poses for the survivor which includes the following:

- **The mediation process itself maintains and contributes to the abuser's ongoing power and control over a survivor.** The process of mediation presumes that both parties can speak freely, confidently and safely. However, given the tactics an abuser uses to maintain power and control over a survivor, and social norms that may not enable women to speak freely or consider their views to have equal weight or worth, it is unlikely that a survivor is going to feel that she can speak freely and without fear of consequences. It is also likely that just making a referral to mediation can cause harm to the survivor and the abuser may get angry that the survivor has told others about the violence.
- **Mediation rarely results in an end to the abuser's violence and can actually lead to an increase in violence**. The violence will only end if the perpetrator chooses to stop being violent. A survivor cannot control the abuser's behavior, actions or choice to be violent. There is nothing the survivor can do to make the violence stop—only the perpetrator can do that.
- **It is unlikely that the survivor's rights will be respected** with those who are likely to 'mediate' within traditional justice mechanisms often hold prejudices against survivors and in favor of perpetrators due to social and cultural norms.
- **There is a high risk of survivor-blaming within the mediation process**. The perpetrator, who is used to blaming the survivor, will have a platform to articulate their position, and given the cultural and social norms in place, and the fact the survivor may feel intimidated or scared to answer back, they may sound convincing. The survivor may be asked to change thier behavior as a condition for violence reduction.

The DVPA sanction mediation in cases of non-felonious IPV. The Justice section provides further guidance on mediation and the role of justice actors.

For the purposes of case management, case managers should:

- **Not promote mediation as a preferred justice option to survivors;**
- **Not 'notify both parties' automatically following a disclosure of GBV for the purposes of assessment and/or resolution through mediation.**

Only when a survivor requested mediation should be discussed and supported in line with their informed consent. In this situation, case managers should:

- **Never mediate a case,** even if a survivor requests them to. Their role is always to advocate on behalf of the survivor—trying to play an 'impartial' role and negotiate with the abuser compromises your relationship with the survivor. Case workers may request the support of another case manager to mediate, however one case manager cannot be both the case worker and mediator for the same case.
- **Familiarise themselves with local laws, procedures, mediation practices and potential outcomes.**
- **Provide information to the survivor.** Discuss with the survivor on how mediation works, risks linked to mediation, their rights, and other options available to them.
- **Always assess the safety risks** for both case manager and the survivor.
- **Work with mediators in advance of the session** to ensure the survivor's needs and wishes are taken into account, including pre-mediation meetings between the survivor and the mediator. Ensure they understand the complexities of GBV, and the risks associated with the mediation process. Make them aware of the power imbalance between the abuser and the survivor and encourage them to manage the behavior of the abuser. It will be important for them to understand how experiences of violence might affect the agreement the survivor considers making with the perpetrator. Even if the survivor appears to agree in front of the abuser, this does not necessarily mean that the mediation process was free from fear or intimidation.
- **Work with community leaders,** if appropriate, so they also understand the complexities of GBV and the role they can play in protecting the survivor in a mediation process. Support the survivor before, during and after the mediation process.
- **Make sure the survivor knows how the mediation process works** and what information they will need to share.
- **Discuss the options available in mediation that can make the process fairer**, for example:
    - Limiting community participation, having a private session, and/or

choosing a few support people to join her.
    - Allowing the option of a public setting if the survivor wishes. Having others know about the violence and mediation resolution could help her feel safer. However, this may also make the perpetrator angrier (if he/she feel they are shamed in public), therefore, this needs to be thought through carefully.
    - Allowing the survivor to prepare a written statement to share as their opening statement. This way the survivor can speak more clearly in the mediation session and feel less intimidated.
    - If you can attend the mediation session, check in with the survivor during it to ask how they are feeling, whether they need a break, whether they would like to stop the mediation process, etc. If you cannot attend, help them identify a supportive person who can be there for them during the process.
- **Assist the survivor with safety arrangements**. For example, ask influential community leaders (at the survivor's request) to attend the mediation process if they think it will make it safer. Discuss whether they want to arrive to and leave the mediation without the perpetrator.
- **Plan with the survivor for next steps after the mediation**, especially if they are unhappy with the agreement or is worried that the agreement will only lead to more harm for them.
- **Continue to work with the survivor,** with their informed consent to assess and support their safety and wellbeing, including but not limited to monitoring and responding to any further violence. Any follow up should adhere to guidance in **Case Management** section, including with regards to home visit.

5.5. Home Visits

Case workers and specialist GBV services providers may be compelled to conduct home visits to survivors. However, **home visits are not recommended**. This is because of the potential risk they pose to survivors as well as staff which includes:

- Home visits risk identifying survivors within the community, and thus compromise their confidentiality, privacy and safety.
- Home visits risk the safety of the survivor and the staff if/when other members of the family are home such as the perpetrator, particularly in cases of intimate partner violence or child sexual abuse.
- Home visits can alert the perpetrator that the survivor has sought help from someone. This can be threatening to their power and result in an escalation of violence once the case worker has left the home.

To the extent possible, case managers and service providers should not conduct home visits but rather identify a safe space outside the home that is accessible, safe and private.

As noted in the **Disclosure** section, upon receiving a third-party report of an incident of GBV, service providers should provide the reporter with information on available services, which they may provide to the survivor to support them accessing care. Conducting a home visits following the identification of survivors can place them and staff at great risk of harm.

Similarly, home visits should not be integrated into the case action plan unless required. In circumstances where home visits are necessary, for example where a survivor lives far away from services, faces difficulty leaving the home and/ or accessing services or lacks time and no transportation options are available case managers should minimum associated risks. This includes:

- As above, never using home visits to identify cases; identification should never be practiced for GBV.
- Develop a strategy for visiting multiple households at a time in a small geographic area to provide information or some other type of service not related to GBV. You can visit a survivor's household in that area during this time, which should not draw attention.
- Discuss with the survivor what time of day and which days fewer community members will be around, and when the perpetrator will not be in or near the house. To the extent possible, set aside a specific time with the person so they know when to expect you.
- Make a plan with the survivor to have a code or signal that they can use to let you know that it is no longer safe for you to come to their house. This could be a message sent through a mobile phone, something that the person puts on or near the home (cloth of a certain colour, a stick), or something that is changed within the home so that if you do enter, you will know that it is not safe to speak with the person.
- In the event that the survivor is confronted about your visit, discuss with the person what they can say to others about who you were and why you were visiting so that they do not expose themselves.

5.6. Crisis Response

In circumstances where an incident of violence is in progress, a home intervention led by police is justified. The case manager should not intervene alone. This can place them at extremely high risk of violence from the perpetrator. See **Multi-Sector Response: Immediate Response** section for guidance on role of Helpline Response Teams in crisis response.

5.7. Child and Adolescent Survivors[29]

Child and adolescent survivors require tailored case management that recognizes their specific needs, vulnerabilities and capacities.

As per CMSOPs, child and adolescent survivors are considered to be Children in Difficult circumstance (CIDC). In addition to the case management guidance, the Case managers will:

- Use simple, clear language;
- Do not use professional jargon, terms or phrases;
- Promote and adhere to the principle of best interest;
- Take into consideration the age, maturity, physical and mental capacity of the child and adolescent;
- Involve child and adolescent survivor in decision-making in line with their capacities;
- Respect the rights, wishes, opinions, and dignity of the girl survivor;
- Obtain informed consent from adolescent survivors who have the appropriate capacity and maturity. In cases of child survivors and where appropriate, young adolescents obtain their informed assent and the informed consent of a trusted caregiver. Where a safe and trusted caregiver is not present, the Case manager may exercise authority to provide informed consent on behalf of the survivor in line with the principle of best interest. Full guidance on this is included under Informed Consent;
- Where involvement of parent or caregiver is relevant and/or required, conduct ongoing assessments of safety risks associated with their inclusion in the case management process;
- Understand any national mandatory reporting laws that exist and how they apply to children and adolescents and what the potential safety risks may be if followed;
- Develop case plan within 24 hours of receiving child or adolescent survivor using Form 1 of CCPR&R;
- Provide age-appropriate referrals and support the capacity of service providers to provide age-appropriate care;
- Accompany the child survivor to all examination and interviews;
- Where relevant, receive inputs from the members of the D/TWCC and other relevant personnel including individuals or institutions who were responsible for the care of the survivor prior to coming under the care of the Protection Officer;
- If girls are married, potentially advocate with husbands (if they are not

29 UNICEF, IRC (2012) Caring for Child Survivors of Sexual Abuse.

the perpetrator and it is safe to do so) to allow them to access services;

- Ensure that the case plan be updated after every monthly visit with the child or adolescent reflecting all the changes, progress, issues related to the situation of the survivor;

Child/Early Marriage

The following guidance applies to both formal and customary cases of early marriage, the latter including cases where children and/or adolescents or a child/adolescent and an adult is found to be living in a domestic arrangement recognised as a marriage or similar.

Case management in cases of child/early marriage may differ subject to the marital status of the girl. It is not the immediate role of a case manager to directly intervene to stop an early marriage from happening. Doing so can have harmful unintended consequences for the girl and is potentially dangerous. Case managers should proceed through the case management steps and adhere to the guidance noted above.

In cases where a girl is at imminent risk of child/early marriage, the Case manager should:

- Understand how the girl feels about the marriage;
- Provide information on the potential negative consequences of early marriage on the health and wellbeing of the girl;
- Determine whether there is a supportive family member or other trusted adult in her life. If so, engage with them;
- Understand the family and environment circumstances that are contributing to the early marriage decision;
- Provide information to the parent about health, safety, and psychosocial consequences of early marriage and in cases of intended formal marriage, the legal consequences;
- If the person the girl identifies is not the parent, but a trusted adult, engage that person instead.

The case manager may also reduce risk of child/early marriage through:

- An Assessment;
- Safety planning;
- Providing information and making potential referrals for reproductive health, safety and security, and legal information/support;
- Keeping or getting the girl involved in supportive services;
- Helping the girl identify a supportive person in her life;
- Helping her identify positive coping strategies;
- Advocating for the girl;
- Continuing to engage a supportive adult.

In cases where a girl is already married, the Case manager should:

- Support the survivor to assess her needs. Key information will include whether the relationship with the husband is consensual, her understanding of her own body, access to money, violence from husband or other family members, whether she still attends school and/or has other social support system and how she feels about the marriage.
- Provide information to the girl about the health, safety and psychosocial consequences of early marriage.
- Support her access to health and reproductive health, safety, protection, legal and psychosocial services and any other relevant support available.
- Carry out safety planning.
- Help the girl identify a supportive person in her life.
- Help the girl identify positive coping strategies.
- Inform the girl and her parents of mandatory reporting requirements. Following this, inform police of such cases.

5.8. Survivors with a Disability

Services for survivors with a disability should respect their dignity, individual autonomy and the principles of non-discrimination, diversity and empowerment. PWD's full and effective participation in society should be supported. When providing case management services to survivors with a disability, Case managers should:

- Recognise that PWDs are not a homogenous group. It encompasses people with distinct impairments and a wide spectrum of capacities.
- Understand that women and girls with disabilities often face greater risk of GBV while experiencing specific and additional barriers to accessing services including often being excluded from service design and delivery.
- Adapt care to respond to PWD's distinct needs and capacities.
- Assume all survivors including those with a disability are able to give informed consent and adapt communication to enable this. Where a survivor with a disability does not have the capacity to provide informed consent, use the principles of best interest of the survivor to determine the next steps.
- Always consult with survivor before involving caregiver or other family members. Routinely assess risks and benefits of involving the caregiver and assess if it is necessary, safe and empowering to do so.
- Provide for their safety including ensuring safety plans reflect their specific safety needs.

5.9. Survivors who are Elderly

Case manager should ensure tailored case management support for elderly survivors in line with their needs and capacities. When working with elderly survivors, case manager should:

- Recognise elderly survivor's distinct health needs and experiences;
- Understand age-based distinct and additional barriers they face to accessing care including but not limited to disability;
- Use clear language that they will understand.

5.10. Male Survivors of Sexual Violence

Men also face risk of sexual violence and require tailored care as a distinct affected group. When engaging with male survivors:

- Recognise male survivors face distinct barriers to accessing care including masculine norms that deter help-seeking, feelings of shame and fear of stigma, concerns and fears about sexuality, and fear of not being believed.
- Provide tailored service provision the addresses these barriers and male survivors' distinct needs including through non-judgmental care.
- Advocate for and support other service providers particularly health and psychosocial support service providers to tailor their services to meet the needs of male and female survivors.

5.11. LGBTQI Survivors

Case manager should be able to provide tailored, appropriate and quality case management diverse sexual orientations, gender identities and persons with diverse sex characteristics. case manager should:

- Ensure a clear understanding of the different terms and identities that encompass the LGBTQI community.
- Recognise and address through tailored services the specific barriers to care faced by LGBTQI persons including fear of persecution, lack of a support network, fear of being revealed, fear of not being believed and/or the view that their violence is justified based on community perceptions, previous negative experiences with service providers, lack of awareness amongst service providers and lack of specialized services.
- Not assume a survivor's gender or sexual orientation.
- Use language carefully.
- Ask questions in a way that does not assume the gender of the perpetrator.
- Not ask unnecessary questions.

- Not relevel their gender identity and sexual orientation to other staff, support group members, etc.
- Ask permission before disclosing to another staff person, which you should only need to do if it is clearly relevant for the care and support of the survivor.
- Let them take the lead; do not press for details if they seem reluctant or unwilling to disclose them.
- Explore extensively with a survivor their current and past experiences with the police and other authorities as well as safety risks before it is included in the safety plan.
- Understand the high risk for suicide by people that identify as LGBTI, particularly if they have been ostracised from family and community and are isolated.

All service providers should reflect and address their own perceptions and potential bias in order to provide quality, non-discriminatory care.

5.12. General Duties

The general duties of the case managers include the following:

- Maintain a list of all service providers across relevant sectors in order to provide full case management service.
- Throughout the case management process, adhere to confidentiality principles and protocols and ensure non-disclosure of the survivor and perpetrator's identity except when compelled to do so to lawful authority.
- Monitor the situation of violence against women and girls in their area.
- Declare any conflict of interest that may arise or appear to arise between his or her duty and private interest, pecuniary or otherwise, upon which another case managers will be assigned the case.

5.13. Staff Care

GBV work, in particular case management can often be challenging, stressful and emotionally intense. Without appropriate support and supervision, case managers may begin to feel overwhelmed and tired, and may even begin to feel hopeless and helpless.

Organisations and agencies who provide GBV services have a responsibility to ensure the emotional and physical safety and wellbeing of staff. Along with this obligation to staff themselves, doing so helps avoid burnout and thus staff turnover and ensure uninterrupted quality services.

Staff safety should always be prioritised. Staff should not be asked or expected to place their own safety at risk, for example through home visits. Organisations

and supervisors should also make an explicit comment to staff wellbeing including through the implementation of staff and self-care strategies. This may include[30]:

- Creating a supportive climate – regularly check on the well-being of staff and create an environment where staff feel comfortable sharing information and concerns with you.
- Establishing routines – including for supervision and team meetings.
- Regularly demonstrate appreciation for staff. This can be as simple as communicating gratitude or praise for something they did or arranging to have refreshments at meetings to something more elaborate such as a “staff of the month” award.
- Managing information – Routinely share information and create an environment of transparency.
- Monitoring the health and well-being of staff. For example, be mindful of how staff are taking care of themselves and encourage them to take lunch breaks, etc., and take note of changes in appearance or health.
- Monitoring stress levels – support staff to identify and monitor stressors in their lives and to develop self-care plans.
- Providing opportunities for exercise and access to the outdoors.
- Organising “staff care” days that allow staff to come together to do something fun or relaxing.
- Encouraging staff to identify a “self-care buddy” – another staff person with whom they connect on a regular basis to discuss how they are and what support they need from each other.
- Accommodating staff – be flexible with the response of different individuals to personal or work crises (e.g. allow flexible schedules if possible, give time off where needed, provide additional supervision, etc.)

Providing support for staff in crisis

When staff are in crisis either because of a professional or personal experience that may be impacting their work, the following may be important:

- Create opportunities for staff to share experiences and stressors (e.g. through supervision).
- Watch for case managers who may be suffering in silence and actively reach out to them.
- Connect them to psychological support.

30 GBV Sub-Cluster, Iraq (2017) GBV SOPs

5.14. Case Management and Non-Specialized Service Providers

Case management is a specialized service and requires ongoing case management training and skills development, as well as close supervision. Service providers who are not case managers and are not trained in case management **should not** attempt to provide case management services.

All service providers should have an understanding of case management and be able to provide information and facilitate a referral of a survivor to case management services in line with their wishes. As per the CMSOPs, organizations interested to assume case management responsibilities should consult with the Competent Authority regarding their accredited services.

6. Multi-Sector Response

A multi-sectoral model informs best practice in GBV response and service delivery. This model recognises that survivors commonly have needs that cuts across health, mental health and psychosocial support, justice, and safety and security sectors spanning immediate to long-term term assistance.

While some survivors may have multi-sectoral needs, it is important to recognize not all GBV survivor wants or need assistance. Many survivors will recover without specialist support and should be provided the space to do so. Others may require only some forms of support like PFA and clinical treatment.

As part of a multi-sectoral model, actors will have sector-specific tasks, roles and goals based on the nature of their service. However, all providers have a shared responsibility in supporting GBV survivors and are compelled to be familiar with and adhere to the guiding principle and a survivor centered approach as outlined in previous sections. In general, the following are the main services which make up a holistic GBV response:

- Immediate material assistance;
- Safety options;
- Health care;
- MHPSS;
- Justice assistance;
- Long-term assistance;

6.1. Immediate Response

Survivors may need basic assistance to ensure their immediate wellbeing, safety and security. In response to a disclosure of GBV by a survivor, all service providers should seek to address these immediate needs in line with the guiding principles.

As in **Responding to Disclosure** section, non-specialised service providers and community members may provide PFA, provide information on specialised services and support the linking or referral of survivors to said services.

Case-workers and other GBV service providers can help by providing or arranging more tailored assistance including through referral to other service providers, for example for material assistance.

When providing immediate assistance, GVB service providers should consider the following:

- Assistance should never stigmatise GBV survivors by identifying them as survivors in the specific services they receive or at the locations in which services are provided.
- Assistance should not expose survivors to additional risks (e.g., domestic violence or robbery after receiving cash assistance).
- Assistance should be provided by other sectors based on the case worker's assessment and evaluation of the survivor's needs and context. The case worker will still be the responsible person for ensuring quality of assistance and follow-up in line with a survivor-centered approach.
- Material assistance, such as emergency food, clothes and shelter should be provided through quality and timely referrals.
- Assistance should be considered part of the healing process, aimed at addressing immediate needs related to the GBV incident, within a specific timespan, and in line with the action plan agreed between the case manager and the survivor.
- Assistance should be guided by the principles of confidentiality, safety, respect and non-discrimination.

6.2. Helpline Response Team

The NCWC Helpline aims to support women and children in difficult circumstances, including GBV survivors to access multi-sector support.

Helpline Response Teams (HRTs) have been embedded within D/TWCCs to respond to cases with urgent and immediate safety needs received through the Helpline. HRTs are comprised of a Protection Officer and representatives from police (Women and Children Protection Unit/Desk, Royal Bhutan Police), health (Dzongkhag/Chief Medical Officer/Medical Superintendent), education (Dzongkhag/Thromde Education Officer) and the community representative. The Protection Officer functions as the primary point of contact between the Helpline and HRTs.

Where a GBV incident reported through the Helpline has immediate and urgent safety needs, helpline staff will contact the Protection Officer in the survivor's

location who will trigger a local urgent and immediate response in coordination with the HRT police representative and other HRT member as relevant. It is not necessary and may be unsafe to involve all HRT members in every case and this should not be practiced. Following the urgent and immediate safety response, the Protection Officer will continue to work with the survivor to provide case management and support referral to and coordination with other multi-sector services as relevant and in line with the survivor's wishes.

Whereas survivor with non-immediate safety needs contacts the Helpline for support, Helpline staff may provide information and support referral to specialized service providers including case manager in line with the survivor's wishes.
Where a third party reports a GBV case with non-immediate safety needs and that is not in progress, Helpline staff may provide this person with information on available services which they may provide to the survivor in a safe and confidential way to support the survivor to access services herself.

The functioning of the HRTs should align with the key principles and standards outlined in this document. Where a survivor with urgent and immediate safety needs contacts the Helpline for support, they may seek her verbal consent to trigger a HRT response. Where a third party reports a GBV incident in progress that poses urgent and immediate safety risks to the survivor and potentially other persons, the Helpline may trigger a HRT response.

Following immediate intervention, all actions should be guided by the wishes of the survivor and done with her informed consent as per guidance throughout these SOPs. Documentation, data management and information sharing as part of this immediate safety response should adhere to data management protocols outlined in Documentation**, Data Management and Monitoring** section. Additional guidance may also be found in the NCWC Standard Operating Procedures for Helpline Response Teams.

6.3. Health

Health care providers play a crucial role in providing immediate and lifesaving care for GBV survivors that addresses acute needs and prevents further harm and health consequences of this violence. A coordinated, survivor-centered approach to the health response to GBV follows the principles of safety, confidentiality, respect and non-discrimination. Following a survivor-centered approach is at the core of all health assistance to protect GBV survivors.

The *National Guideline for Management of Victims of Intimate Partner Violence and Sexual Violence in Healthcare Settings in Bhutan* (henceforth the Guidelines) outline standard operating procedures and standards of care for the interviewing, assessing, documenting, treating and reporting of GBV cases in healthcare settings. Health care providers should be familiar with these guidelines and have

an understanding of GBV core concepts, guiding principles and practices of confidentiality, informed consent/assent and mandatory reporting requirements. Refer to the Guidelines for full details on health responses to GBV.

Health workers should:

- record the interview and examination findings in a clear, complete, objective, non-judgemental way.
- not determine whether or not a woman has been raped. Documentation should state medical findings rather than stating conclusions about the incident of violence (eg. Rape). Note that in many cases of rape there are no clinical findings.

At present, medical examiners are not obliged to give an opinion on physical findings however may be called to do so in a court of law.

6.4. Mandatory Reporting

Health care should be provided to survivors in line with their wishes and as a first and overriding priority. As outlined in the mandatory reporting section, non-health service providers are not required to refer a survivor to a health facility but should do so in line with the survivor's wishes. Healthcare professionals are not required to refer survivors to police, even in cases where mandatory reporting requirements apply to other service providers.

6.5. Screening

As per the relevant guidance[31] screening for GBV is not recommended. However, healthcare providers may raise the topic with patients who have injuries or conditions that are consistent with GBV. Healthcare providers must ensure to do this in a highly sensitive manner and **only** when it is safe to do so (survivor alone).

As first-line responders, healthcare settings are often the entry point for survivors. The priority must thus be on providing practical care and responding to a survivor's needs rather than screening with the view of treating the 'most' survivors.

31 Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook, WHO/ *National Guideline for Management of Victims of Intimate Partner Violence and Sexual Violence in Healthcare Settings in Bhutan*

The healthcare providers should practice the following while providing services to the survivors:

LISTEN	Listen to the woman closely, with empathy, and without judging.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)
VALIDATE	Show her that you understand and believe her. Assure her that she is not to blame.
ENHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
SUPPORT	Support her by helping her connect to information, services and social support.

In addition to the above, healthcare providers should:

- Establish appropriate facilities with trained medical and health personnel;
- Ensure confidential, accessible, compassionate medical care for survivors of GBV in line with guiding principles;
- Ensure age-appropriate, culturally, and sexual orientation and gender identity sensitive care;
- Provide the survivor with information about medical procedures in a language and vocabulary that they understand;
- Obtain the informed consent of the survivor (see section on informed consent and mandatory reporting) before any treatment or referral (verbal or written as appropriate);
- Report case to police **in line with the wishes** of the survivor except where mandatory reporting applies[32]. In cases of mandatory reporting, the healthcare provider should explain reporting requirements as part of obtaining informed consent process, so that the survivor can decide what they choose to disclose.
- Ensure the safety of the survivor at all times;
- Ensure a separate, private and segregated space for the survivor during the consultation, examination and treatment. This space should not be labeled or identifiable as a space for GBV survivor (eg. ‘ GBV room’) to avoid identification of her as a survivor by other health workers/patients;
- In line with the survivor’s wishes, ensure same sex health personnel conduct consultation, examination and treatment in line with their right to privacy;
- In line with the survivor’s wishes, ensure female staff/family/trusted person is there during examination in addition to the same-same health

32 Ministry of Health, Government of Bhutan National GBV Health Guidelines

personnel providing care

- Provide medico-legal services;
- Document the nature of the incident, past and current medical history, social history and medical examination and treatment as per medical forms;
- Provide emotional support to the survivor;
- Support survivor to access other care by providing them with accurate, up to date information on other available services in a language and manner they understands;
- Facilitate access to other services such as case management, shelter, psychosocial support and mental health care, counseling, and legal services in line with survivor wishes;
- Ensure follow-up health services and engage survivor in long-term continuity of care to support long-term recovery;
- Ensure a survivor centered approach and adherence with the guiding principles in all interactions;
- Keep victim informed about medical condition;
- Maintain all records and share with Competent Authority;
- Maintain confidentiality except where mandatory reporting compels information sharing with courts, police, or Competent Authority;
- Ensure medical services are accessible for survivors with disabilities and take into account their specific needs.

6.6. One Stop Crisis Centre (OSCC)

The One Stop Crisis Centre (OSCC) is integrated into the Jigme Dorji Wangchuck National Referral Hospital (JDWNR) in Thimphu. It provides the aforementioned services. In addition to this, it will also have the responsibility to:

- Train health workers in dealing with GBV and create awareness;
- Conduct GBV awareness raising;
- Collaborate with Village Health Workers and Out Reach Clinics to create awareness on GBV;
- Ensure signage for survivors to access OSCC;

Survivor-centered care at each stage include:

STEPS	Survivor Centered Approach
STEP 1: Preparing the survivor for an examination	• Introduce yourself. • Limit the number of people in the room to the minimum necessary. • If the survivor wishes, ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend). • Determine the best way to communicate and adapt to the survivor's communication skill level and language. Avoid medical terminology and jargon. • Obtain informed consent (or a parent's informed consent in the case of a child). • Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you will give. Make sure the survivor understands everything. • Reassure the survivor they are in control of the examination. Explain that they can refuse any aspect of the examination they do not wish to undergo, and that this will not affect their access to treatment or care. • Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges. • Apply psychological first aid. *Ask the survivor if they have any questions.*
STEP 2: Taking the history	• If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed. • Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case. • Avoid any distraction or interruption during the history-taking. • Make sure the survivor feels comfortable. Use a calm tone. If culturally appropriate, maintain eye contact. Be aware of the survivor's body language and your own. • Be systematic. Proceed at the survivor‘s own pace. Be thorough, but don‘t force the survivor. • Let the survivor tell their story the way they want to. Document the incident in the survivor's own words. • Avoid questions that suggest blame (e.g., What were you doing there alone?). • Be compassionate and non-judgmental. • Explain what you are going to do at every step.

STEP 3: Collecting forensic evidence	• The main purpose of the examination of a survivor is to determine what medical care should be provided. If applicable, forensic evidence may also be collected to help the survivor pursue legal redress.
	• The survivor may choose not to have evidence collected. Respect their choice.
	• Whenever possible, forensic evidence should be collected during the medical examination so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic
	• Forensic evidence can be collected only if:
	    • Timing is appropriate (e.g., less than 72 hours or more than 72 hours in contexts where the local law accepts evidence from more than 72 hours);
	    • Samples can be analysed in the local context;
	    • Informed consent is obtained; and,
	    • The chain of evidence can be maintained.
	• *At present, DNA testing can only be done cross-border in India. Health worker should not collect evidence that cannot be processed or that will not be used. Health workers should discuss the realistic possibility of proceeding with DNA testing prior to collecting relevant forensic samples to ensure this.

STEP 4: Performing a physical examination	• The primary objective of the physical examination is to determine what medical care should be provided to the survivor. • Work systematically according to the medical examination form. • Use the survivor's history to guide the exam to prioritise the survivor's needs and wishes, to identify and document injuries, and to help guide follow-up care and referrals. • Make sure the equipment and supplies are prepared. • Always look at the survivor first before you touch them and take note of their appearance and mental state. • Always tell the survivor what you are going to do and ask their permission before you do it. • Assure the survivor they are is in control, can ask questions, and can stop the examination at any time.

STEP 5: Prescribing treatment	What you prescribe will depend on when the survivor presents to your health facility following sexual violence, what the survivor experienced, and if the survivor is pregnant. *Treatment* — *Within 72 hours* / *72 - 120 hours* / *After 120 hours* *Prevent sexually transmitted infections (STIs) (gonorrhea, chlamydia, syphilis)*: *Yes* / *Yes* / *Yes* *Prevent HIV transmission (post-exposure prophylaxis)*: *Yes* / *No* / *No* *Prevent pregnancy (emergency contraception pill)*: *Yes* / *Yes* / *No* *Provide wound care*: *Yes* / *Yes* / *Yes* *Prevent tetanus*: *Yes* / *Yes* / *Yes* *Prevent Hepatitis B*: *Yes* / *Yes* / *Yes* • Provide mental health care: Yes / Yes / Yes

STEP 6: Psychological first aid and counseling	• All survivors of GBV should be offered psychological support.
	• Be aware that emotional reactions of survivors in response to GBV are very personal.
	• In caring for survivors of GBV, it's important to be attentive to signs/manifestations of psychological distress/disorder and look, listen, and link.
	• In assessing psychological support needed, identify:
	  • Protection factors
	  • Risk factors
	  • Negative and positive coping mechanisms
	• Basic emotional support must take place from the first contact with the patient, including counseling for specific issues such as pregnancy and STIs.
	• Tell the survivor they can return to the health service at any time if they have questions or other health problems.

STEP 7: Medical certificates	• Medical care of a survivor of rape includes preparing a medical certificate. It is the responsibility of the health care provider who examines the survivor to make sure the certificate is completed. Only the survivor has the right to decide whether and when to use this document.
STEP 8: Follow up care	• All survivors of GBV will benefit from follow-up medical and psychological care.

Special considerations for child and adolescent survivors

Healthcare for child and adolescent GBV survivors should adhere to the guiding principles, the principles with best interest with regards to child survivors and considerations of informed consent and assent with regards to adolescent survivors subject to their age, capacity and maturity. In addition to the guidance provided in section **Informed Consent: Child and Adolescent Survivors**, healthcare providers should:

- Never examine the child or adolescent against his or her will, whatever the age, unless the child is in a life-threatening situation
- Take special care in determining who is present during the interview and examination.
- Remember that it is possible that a family member is the perpetrator of the abuse. Always ask the child or adolescent who he or she would like to be present and respect his or her wishes.
- Recognize that some adolescents may have the capacity to provide informed consent and may not need or want the presence of a caregiver. Allow for this possibility through discussions with the adolescent survivor and by respecting their capacity and wishes where appropriate
- Assure the child or adolescent that he or she is not in any trouble.
- Never restrain or force a frightened, resistant child to complete an examination.
- Remind the child or adolescent often that they are safe, and they are not to blame.
- Not respond in harmful ways to children and adolescents' stress reactions (e.g. beating, abandonment, belittling, mocking).
- Ensure age-appropriate medical care including medical equipment and drug proscriptions

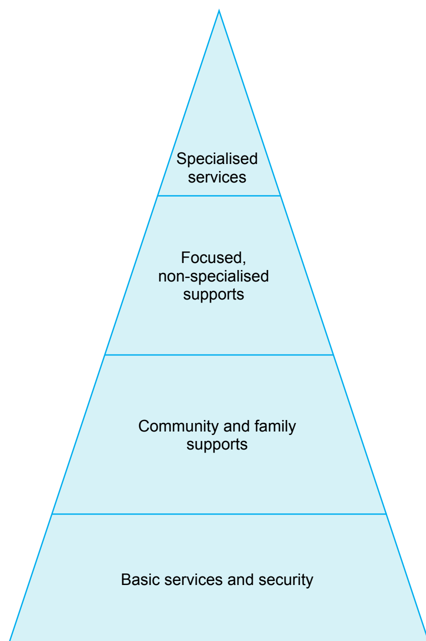
6.7. Special considerations for Male Survivors

Male survivors are often less likely than women to report an incident of sexual violence, because of extreme embarrassment, shame, criminalization of same sex-relationships and slowness of institutions and health workers to recognize the extent of the problem.

The needs of male survivors are often similar to those of females, but oftentimes the subject is even more sensitive, and many providers are uncomfortable. Male survivors may feel guilty if they had an erection and ejaculated during forced anal intercourse. Healthcare providers should ensure they have relevant materials including medical equipment and recommended proscriptions amount required for the treatment of male survivors.

6.8. Mental Health and Psychosocial Support

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental distress. The MHPSS pyramid outlines different levels of care with each meeting distinct needs through a range of MHPSS services:



Level One - Basic Services and Security: Actions to ensure basic physical and practical needs are met in a way that protects and promotes emotional wellbeing. May include provision of basic services, ensuring services are accessible and safe women and children.

Level Two - Community and Family Supports: Non-structured response for people who are able to maintain their mental health and psychosocial well-being if they receive support accessing community and family support systems. May include working with community leaders, female-only safe spaces, community centers, GBV awareness-raising, women and girls groups, self-help and resilience initiatives, livelihoods activities, community-mobilisation activities.

Level Three - Focused, Non-Specialised Supports: Focused response to more specific emotional needs and/or distress. May include basic emotional support, women's groups where they can discuss shared experiences/challenges, build relationships and learn positive coping mechanisms, one-to-one PSS.

Level Four - Specialised Services - Clinical care for severe distress, mental health, behavioral and emotional disorders including depression, anxiety, PTSD, psychoses. May include the prescription of psychiatric drugs, psychological interventions.

All MHPSS interventions should recognise that individuals, including GBV survivors can and do overcome adversity including trauma with the correct support. Not all survivors will require focused or specialized MHPSS. MHPSS care should be provided based on an individual assessment of needs. MHPSS for women and girls should recognize that GBV is widespread and is a result of society-wide inequality, which results in women and girls having shared experiences of discrimination. MHPSS should support women and girls' empowerment so that they may re/establish their power and agency to make decisions in their life and address the source of emotional distress; this critical to fostering their resilience and supporting long-term recovery.

All MHPSS should adhere to the guiding principles and ensure participants' safety. MHPSS should be non-identifying for survivors who seek support. One-to-one care should ensure the confidentiality of the survivor (eg. In private space, not labeled "GBV room"). Group-based PSS should be open to all women, not just survivors.

A survivor-only group risks identification and thus, their safety and removes the opportunity for survivors to build social support networks with diverse women to support their recovery. Given the prevalence of GBV, it is important to recognise that it is likely in any groups of women survivors may be present, and thus benefit from this support.

Service providers should be familiar with the distinct MHPSS levels of care and provide MHPSS in line with their knowledge and skills and with their organisation's mandate. It is important to note that the pyramid services as general guidance on levels of MHPSS care rather than a strict classification tool; the design of individual interventions will determine which level/s its addresses.

All service providers should be able to provide PFA for community members in need, including survivors upon receiving disclosures. Service providers providing more tailored MHPSS should be trained on their specific intervention and have ongoing supervision and capacity building to support quality care.

6.9. Safety

Security and safety are the responsibility of all actors and staff. All service providers should prioritise the safety and security of survivors, their families and workers providing care. A safety and security assessment is part of GBV case management and service delivery.

Case managers must priorities the safety of survivors at every step of the case management process. While considering all the options below, GBV case workers and survivors should always assess the related security risks. Case managers may, upon receiving a case:

- Find strategies that enable the survivor to stay with their family, when appropriate, always prioritising safety;
- Explore and address any concerns about social stigma for the survivor and/or their family that may prevent the survivor from taking action for their own safety
- Provide the hotline number to be used in case of emergency;
- Provide interim alternative accommodation, pending long term solutions (Further guidance included below).
- Involve non-offending caregivers in the healing process, especially when the aggressor is one of the parents of a child GBV survivor.
- Ensure more frequent and regular follow-up on cases where the survivor is particularly at risk if no alternative relocation solutions could be found.
- For cases at risk of repeat or escalating domestic violence, help the survivor establish a safety plan whereby they can identify mechanisms to decrease trigger points that cause or lead to the aggression (e.g. not being at home alone when the husband comes back from home;

inviting other family members when discussing important issues). In such cases, be very cautious never to blame the survivor.

- Identify a safe place to meet the GBV survivor for follow-up visits and agree a trusted person to contact in case the survivor is not reachable.
- Provide GBV survivors with information about the whole healing and referral process highlighting potential consequences and benefits of accessing services.
- Engage other sectors to meet in a timely manner other immediate needs raised by the survivor that may further expose them to harm and violence.
- Train staff involved in GBV case management in how to identify suicidal thoughts in survivors.
- Train and ensure all staff comply with an organisation's security procedures while on duty.
- Ensure staff engage the community in respecting the core humanitarian principles
- Ensure your organisation has a clear code of conduct and that your staff know it.

6.10. Emergency Shelter Homes

The *Guidelines for Accreditation and Management of Shelter Homes for Women and Child in Difficult Circumstances (*henceforth Shelter Guidelines) set the standard operating procedures for WIDC and CIDC temporary and interim shelters in Bhutan. Temporary shelters are for emergency use while interim shelters are intended as transitional accommodation and may be used for up to 6 months or longer based on individual case needs. These shelters and their accompanying guidance include but are not limited to GBV survivors. The following guidance seeks to complement the Shelter Guidelines, recognising the specific risks faced by GBV survivors and women and girls at risk of GBV, and their distinct safe accommodation needs.

To the extent possible shelters for GBV survivors and their accompanying children-only should be established. Where shelters cater for CIDC and WIDC, including but not limited to GBV survivors, adherence to a survivor-centered approach and the GBV guiding principles is required in all aspects of shelter function and management. Given the wide range of needs and capacities of persons who may be considered a CIDC or WIDC, it is critical that these shelters do not compromise GBV survivors' safety, confidentiality and access to quality GBV case management services while seeking to meet the needs of other shelter residents. Examples of this include but are not limited to ensuring an all-female shelter staff, having clear and set safety protocols regarding visitors and

in cases of emergency, and strong confidentiality protocols. Further guidance includes:

- The establishment and management of shelters must be in line with accreditation requirements as per the Shelter Guidelines;
- Management of shelters will be done in line with the guiding principles of right to safety, non-discrimination, dignity and self-determination and confidentiality;
- Survivors will be provided full information on shelter rules, services, conditions and confidentiality and privacy protocols prior to admittance and before they are provided with any services to support their informed consent;
- The informed consent of the survivor will be obtained prior to decision or action regarding her care, referral or the sharing of information. Where a child or adolescent survivor cannot provide informed consent, a trusted caregiver or the case management actor will provide consent based on the principle of best interest;[33]
- Confidentiality protocols respect the rights of women, adolescents and children to privacy and confidentiality regarding any information including but not limited to their names, names of family members and any other information that may reveal their identity at all times, unless the woman provides “informed consent” to wave her right to privacy and confidentiality or the Court authorises as per Section 45 of the DVPA;
- Survivors will be informed of their rights and their entitlements, which shall include but is not to limited to legal and human rights;
- Women, adolescents and children with disabilities who have special needs shall be given due care and assistance appropriate;
- All case files and other confidential materials will be kept under locked cabinets/cupboards;
- The safety and security of survivors shall be ensured through the development of a safety and security policy/guideline, including 24 hour protection and security services, adequate lighting and sex and age segregated facilities;
- Only male children under the age of 13 years may stay at the shelter;
- Sleeping quarters will be separated based on gender and age, with separate sleeping quarters are provided for children of the opposite sex for 6 years and above;
- Regular visiting hours shall be established for approved visitors who survivors must first consent to in order to be granted visitation. A child shall be permitted to only receive visitors approved by the Competent Authority;

33 Child Care and Protection action, Bhutan

- A shelter home shall provide adequate and where necessary, private space and physical structure as per the Shelter Guidelines for sleeping, the storage of personal items, bathing, eating, recreation, visitations and the provision of case management, counseling and medical services;
- During sleeping hours, one caregiver shall be on duty. While the Shelter Guidelines note a preference for a female caregiver for girl children and a male caregiver for male children to be on duty at the sleeping premises of children under 5 years of age, the presence of adult males at the shelter critical undermines the safety and wellbeing of GBV survivors residing there and should not be practiced.
- Shelters will be staff by at least:
  - One shelter Manager
  - One case worker - Social Worker (where shelter CSO managed), or one Protection Officer (where shelter Government managed);
  - One counselor certified by the Bhutan Board of Certified Counselors
  - One health personnel
  - Cleaners
  - Security guards
  - Caregivers as per ratio outlined in the Shelter Guidelines
- Where a female survivor is in need of interim accommodation and/or is in imminent danger the case manager or other service providers such as police will coordinate with the shelter manager to facilitate their entry into the shelter within 24 hours;
- GBV case management will be provided on-site by shelter case manager (Social Worker or Protection Officer) as well as referral to health, justice, safety, mental health and MHPSS as well as other services as required to ensure continuity of care;
- Upon entering the shelter, transfer of the case from the non-shelter case manager to shelter case manager will be done based on the wishes and informed consent of the survivor and both parties' existing caseload and capacity. The shelter case manager and non-shelter case manager will coordinate closely throughout the case to ensure continuity of care.
- An individual case plan shall be prepared and implemented for each survivor in accordance with the SOPWCDC;
- A medical staff certified by the BMHC shall be employed to provide immediate access to basic health services as well as at the shelter home;
- Preventive (including routine) and remedial medical and dental services will be made available where required;
- Accessibility to public and private transportation to and from the facility to other service providers shall be ensured;

- While individual, group and family counseling/psychosocial support as well as psychological and psychiatric services as needed, will be available to WIDC and CIDC residing at the shelter, provision of MHPSS care for GBV survivors should adhere to guidance in MHPSS and Mediation section. MHPSS care for all shelter residents should not compromise the safety of GBV survivors, and thus should not involve presence of adult males on-site;
- Assist in maintaining contact with family/parents;
- Case manager will coordinate with other services providers based on the individual needs of the survivors;
- Case manager will conduct follow-up for survivors of per above guidance (see case management section)
- Shelters will be required to produce annual reports as requested by the Competent Authority. These reports should ensure adherence to data management standards outlined in Data Management Section;
- Shelters will be required to submit time based reports on the needs of the Competent Authority and to submit an annual report for review by the Competent Authority and the Board;

6.11. Alternative Safe Accommodation

Where emergency or interim shelters are not available either due to restrictions on entry as in the case of males above 13 years of age, or do not exist/are not accessible non-shelter alternative safe accommodation options may be explored as part of the safety and case action planning process. This may include family or friend’s homes, short-term rental accommodation or other options are available. Case managers should work closely with the survivor to assess safety risks related to alternative accommodation before proceeding and throughout the survivor’s stay. Key considerations should include:[34]

- Usage and presence of others: Consider the original function of the site and how this will influence the access and presence of non-survivors to the site. In some cases, this may compromise the safety of the survivor. Consider if this may be managed/controlled through regulating access and traffic through the site.
- Location: Consider the location of the site, whether it allows survivors to access basic services (eg. market) while also maintaining their safety and confidentiality. The site should not identify survivors accessing it as such. Consider survivors’ children and their basic service need including access to education.
- GBV specialised services: Survivors will require access to case management and multi-sector specialised support. Who will provide

34 Adapted from UNICEF Help Desk Safe Shelter Summary Call

this? Will this be available on or off-site? If on-site, how will this be provided in a way that ensure the survivors confidentiality and safety? What specialised services might a survivor's children also need access to?

- Basic needs: Can the site meet survivors basic needs? Does it have water, heating, electricity, adequate furniture, etc.
- Safety Protocol: How will the safety of the survivor and all other persons at the site be addressed at all times/ 24 hours a day? Consider use of security guards. Development a safety protocol is required.
- Code of Conduct: Consider expectations of the survivor in terms of behaviour, contribution, responsibilities while staying at the site. How will conflict between the survivor and another person a the site be managed?
- Capacity and Resourcing : How many survivors and their children will the site accommodate? If services or activities are provided for them, where will they be done? Will additional staff be required, and if so for what? How will they be recruited?
- Admission and exit: How will survivors access or be referred to the site? Who will manage their admission. How will survivor's exit be managed and by whom? Police

6.12. Women and Child Police Unit/Desks

All police stations are equipped with a Women and Children Police Unit/Desk (WCPD/Unit) manned by police who have received specialised training on GBV, or have a WIDC/CIDC focal point who has received the similar training. As noted in previous sections, GBV cases should be reported and referred to the police by other service providers only **in line with the wishes of the survivor**, except in cases which fall under mandatory reporting requirements (see mandatory reporting section). A survivor may also report directly to the BPF.

Specific procedures vary according to the type of violence and whether the survivor is an adult or child or adolescent. In all cases and where relevant, the following actions should be taken:

- Priority is given to medical treatment when deemed necessary prior to interviewing the survivor and in line with the survivor's wishes;
- All complaints should be dealt with by desk/unit or focal points by a female officer with expertise on GBV;
- Handled cases with extreme confidentiality with a coding system;
- Police shall share details of complaint with Case manager in line with their wishes. In cases involving a child survivor, this will be done within 24 hours;

- Obtain informed consent is obtained before every action and/or informed assent of the child survivor and informed consent of trusted caregiver as relevant;
- Advise survivor of their rights under applicable laws;
- Protect survivor and relevant family members from further violence including through the issuing of Protection Orders;
- Hold in demand the perpetrator for the legal period;
- Ensure the safe passage of survivors to and from safe houses;
- Visit the scene where the abuse took place if/when necessary and gather evidence to be sent to the laboratory;
- Open a case file and process all relevant documents to be sent to the judiciary if/when necessary for prosecution;
- Record testimony and submit to court where relevant;
- Interviews with the survivor take place in private settings with an officer of the same sex or as preferred by the survivor;
- Ensure interviews with children and adolescents are age-friendly and take into consideration the age and maturity of the child or adolescent;
- Follow-up on the results of the OAG;
- Consult with the forensic doctor at all times;
- The forensic doctor will issue a medical report, collect and seal forensic evidence samples and send them to the laboratory;
- Provide accurate and up-to-date information on other services and assist survivor in accessing these including case management, PSS shelter, medical treatment or other services in line with her wishes;
- Maintain confidentiality;
- In case of breach of any term of condition of an interim protection/ protection order by the defendant, the police shall enforce the order along with an arrest warrant, if necessary
- Follow-up on the wellbeing of the survivor ensuring access to social welfare, medical, forensic and psychological services in close coordination with Case manager. Any follow up actions should ensure the safety of the survivor and avoid identifying them or exposing them to further harm. This may be done through planning follow up with the survivor herself;
- Maintain records and share recorded information with Protection Officer, Social Welfare Officer, and/or Competent Authority in line with the principle of confidentiality and when compelled;
- Create awareness and advocacy on GBV
- Submit details of the case to Competent Authority

In GBV cases that are considered misdemeanor or below police and where the perpetrator is not a recidivist police may:

- Prosecute cases (in these cases, police should adhere to relevant guidance provided in following Justice section to ensure a survivor-centered approach to prosecution);
- Make determination if case applicable to be settled mutually in line with survivor's wishes and nature and circumstance of offence, frequency and severity, age, maturity and state of mind, reparation of injury and compensation, safety of family, best interest of victim. Where this is appropriate and desired by the survivor, refer case to CBSS volunteer for consensus building, case managers for mediation and/or seek assurances from the perpetrator directly;
- Where there is a need to conduct follow up visits police should coordinate closely with the survivor and the Case manager where present. Home visits should not be done unless required. Follow up visits with the survivor and perpetrator should be done separately and in both cases adhere to guidance included in sections **Case Action Planning: Home Visits,** and **Follow Up: Monitoring and Enforcement of Mediated Agreements**
- In consultation with Case manager, order the release of perpetrator on surety of detained after providing counseling;
- Maintain separate record of cases settled mutually and share this info with CA/PO;

In felony cases, police may:

- Conduct investigation as per above guidance and refer case onto OAG for prosecution in line with the wishes of the survivor

6.13. Justice

6.13.1. Formal Justice System

The criminal and civil status of GBV incidents informs justice system responses. Survivors may report directly or have their cases referred to the formal justice system.

In criminal cases, where the crime is a misdemeanor or below (emotional, economic, some types of physical violence and marital rape) the police may prosecute the case directly if the survivor reports to them and in line with the survivor's wishes. At the time of writing, police have the authority to prosecute crimes misdemeanor or below. In these cases, the investigator may advise the survivor of following justice option including pressing charges/taking perpetrator to court, referral to a CBSS volunteer for consensus building and/or referral to Local Government representative and/or police for writing up of assurance for

the perpetrator to sign. As noted elsewhere, mediation in all its forms is not recommended in GBV cases. However subject to the wishes of the survivor and where the mediator is not also the survivor's case manager, referral for mediation may take place with their informed consent.

All crimes above misdemeanor fall under the mandate of the Office of the Attorney General (OAG):

- The police must forward the case to the OAG following their own investigation in line with the wishes of the survivor/mandatory reporting
- The OAG then scrutinises the cases file to determine satisfactory evidence of the alleged crime
- Subject to approval, the OAG will then initiate a case before the court seeking a prosecution
- If the OAG determines necessary elements have not been proved satisfactorily, they may ask the RBP to conduct additional investigations.

Following the above, the Court will:

- Inform survivor and/or their Jambi of relief available under DVPA, effect of interim Protection Order, right to file a separate criminal complaint against the perpetrator for a separate crime, right to claim compensation as a result of IPV
- Maintain a record of petition filed, interim protection order and protection order issued by the Court under DVPA;
- Receive applications, issue and revise for interim/protection orders including before the trail commences. The Court shall give a copy of interim protection order to the survivor, complainant, Protection Officer, Social Welfare Officer, police and defendant or legal representatives as relevant;
- The Court shall not deny protection order on the grounds that other legal remedies are available nor shall a protection order not bar a party from initiating civil or criminal proceeding.
- Enforce protection order and where violations occur, direct the RBP to enforce including through arrest;
- The Court may order RBP to seise any arm or dangerous weapons as per conditions outlined in CMSOPs;
- The Court at any stage of the proceeding under DVPA can direct the defendant and/or victim to undergo mandatory rehabilitation, if deemed necessary;
- The Court at any stage of the proceeding can direct the defendant or victim, either singly or jointly to undergo counselling with any service provider who possesses such qualification and experience

in counselling or institution identified by Competent Authority, which renders counselling to the victims of the domestic violence.

> **Joint Counselling**
> The safety, rights and wellbeing of the survivor should be prioritised at every stage. Forcing a survivor to undergo counselling with the perpetrator against her or his wishes can be extremely traumatising, place her at risk of further violence and deter future help seeking behaviour. Joint counselling should only be undertaken with both parties' informed consent, providing by a specialised counselor and while the survivor has access to GBV specialised support, including case management and strong safety planning services.

- The Court may order a defendant who is sentenced for an offence of domestic violence under the DVPA, or any other law to pay appropriate compensation or damages in addition to the sentence as well as cover the cost of medical treatment associated with their violence in accordance with procedures of the CCPC or other existing procedures and laws;

Judicial Proceedings

- Grant bail to the defendant based on preconditions and by set conditions;
- In the interests of the survivor, allow in-camera proceedings, recorded testimony and exclude any person from attending the Court proceeding;
- The Court may hear the case in camera. In the interests of and in line with the wishes of the survivor, Protection Officer and other service providers as relevant should advocate for this;
- Extra protection and security measures should be put in place during the hearing to ensure the safety of the survivor;
- In addition to compensation or damages above, the Court may order the defendant to pay expenses of the victim's medical treatment or other ancillary and incidental expenses incurred on account of the offence committed by the defendant;
- The identity of the complainant shall be protected and shall not be disclosed except by the order of the Court;
- Unless the Court authorises, the proceeding shall not be published in any newspaper, magazine or transmitted through audio-visual electronic medium in any form, which may reveal details of the case or disclose the identity of the parties to the case;

In the case of child survivor or child witness who is required to participate in Court proceedings, the Court shall make provisions to provide a conducive environment for the child's full participation, which shall include but is not limited to the following:

- In-camera trials;
- Provide the child with privacy and ensure that the child is not unnecessarily exposed to the accused;
- Provide separate rooms to seat the child and the accused;
- Treat and ensure that the child is treated with care and sensitivity;
- Ensure that the prosecutor introduces himself/herself to the child prior to the start of the trial;
- Ensure that the child is not asked by anyone, including the judge, to demonstrate through any physical or intimate touching of body parts including the child's own body parts;
- Make an offer to the child to visit the court before a trial for familiarisation;
- Provide the child information about the court proceedings and the child's involvement in it;
- Monitor to ascertain the child has received full information and assistance from persons in charge in a child friendly manner and in accordance with the child's age, maturity, ability and in a language that the child is able to understand;
- Order that the child be accompanied at all times by the Protection Officer and/or the child's parent/s or legal guardian during the child participation in judicial proceedings;
- Closely monitor the examination and cross examination of the child to protect the child from harassment or intimidation;
- Limit the duration of the child's stay in court or order rest breaks to limit the number of questions asked;
- Schedule the appearance of the child in court in a way that is compatible with the child's requirements to attend school;
- Consider the evidence given by the child admissible in court as similar to the admission of evidence given by adults;
- Order proper recording of the child's initial statements so as to limit as far as possible the number of child interviews;
- Give written and recorded statements the same weight as a testimony given in person;
- Where necessary, ensure that the child spends minimum time in the presence of the defendant for the purpose of identification; and
- Order damages or reparation for the child and the child's family as required; and render orders or decisions in a manner that the child is able to understand.

6.13.2.Customary and Hybrid Justice Systems

As elsewhere, mediation is taken to mean a form of alternative dispute resolution that involves an independent third party supporting two actors to negotiate to find a solution that suits both parties[35]. Bhutanese civil and criminal procedures allow for mediation in non-felonious cases of GBV. As per the DVPA, the police may investigate a case to determine whether it may proceed with mediation based on this categorisation. Any persons above 18 years old and not related with the parties may draw a mutual settlement including for the purposes of mediating a resolution between two married parities (formal marriage certificate required in this case). In such cases, IPV may be involved. As such, in practice there is a wide range of actors who may and do 'mediate' a broad range of GBV cases.

As noted elsewhere, mediation is **not recommended as a response to GBV** because of the safety risks that it poses for the survivor (see **Case Action Planning: Mediation**).

However survivors may request mediation. As noted elsewhere, it is critical that the case manager assigned to a case does not also provide mediation.

Where a survivor directly approaches a case manager and requests mediation, the case manager should seek the services of a third party mediator in line with the survivor's wishes and preferences. Where a survivor directly approaches a third party for mediation, the third party should provide information on the mediation process, the role of the case manager and support they may provide to the survivor during and outside the mediation process for their safety and wellbeing. Should the survivor wish involve the case manager, the mediator may contact them with the informed consent of the survivor.

Before mediation, mediators should work closely with the case manager subject to the wishes of the survivor, and seek to understand:

- The complexities of GBV;
- Risks associated with the mediation process;
- Power imbalance between the abuser and the survivor;
- How experiences of violence might affect the agreement the survivor considers making with the perpetrator.

Leading up to and during mediation, mediators should:

- Meet with the survivor alone first to provide full and accurate information on the mediation process including its limitations and potential consequences, and obtain their informed consent to proceed;
- Do not advise the survivor whether to proceed with mediation. Do not

35 Common mediation terminology and practices include but is not limited to "mutual settlement", "assurances", "consensu s building"

question them if they do not want to do anything. Respect this decision;

- Seek to understand the circumstances of the disagreement, for the purposes of mediation to the extent possible in line with a survivor-centred approach and the guiding principles. Communication with and the inclusion of any other actor in the mediation process must be done with the informed consent of the survivor and in a manner that is non-identifying. **It is not the role of the mediator to conduct an assessment or investigation of the case or the survivor's need beyond the narrow parameters of mediation as an informal justice service.**
    - Subject to the wishes of the survivor, limit community participation, have a private session, and/or allow a few support people to join her;
    - Allow the option of a public setting if the survivor wishes. Having others know about the violence and mediation resolution could help her feel safer. However, this may also make the perpetrator angrier (if he feels he is shamed in public), so this needs to be thought through carefully;
    - Allow the survivor to prepare a written statement to share as her opening statement. This way the survivor can speak more clearly in the mediation session and feel less intimidated;
    - Allow breaks and the option of ceasing mediation sessions subject to the needs of the survivor;
    - Involve third parties including other service providers only with the informed consent of the survivor. This may include but is not limited to local government leaders, draftsmen and police for the purposes of finalising the mediated settlement and its monitoring and enforcement.

Following mediation, mediators should:

- Mediators should not seek to enforce the mediated settlement. This includes police who do not have the legal capacity to enforce assurances which function only as informal deterrents;
- Subject to the survivor's informed consent, case managers should continue to work with the survivor following mediation to assess and support their safety and wellbeing, including but not limited to monitoring any further violence;
- Where the perpetrator violates the mediated settlement by committing further violence **and a case manager is supporting the case,** case managers should work with survivor to reassess her needs and revise the case action plan in line with her needs and wishes. This may include but does not necessarily involve formal reporting to police. Further

guidance on this for case managers can be found in Case Management section;

- Where the perpetrator violates the mediated settlement by committing further violence and **the survivor directly approaches the mediator for enforcement and/or further mediation**, the mediator will let them know their limitations in terms of enforcement, alternative justice and security options including reporting to police, and share information on the role of a case manager and support the survivor to contact them in response to their needs and wishes. In this case, mediators may also be bound by mandatory reporting obligations

6.14. Long-term assistance

Each survivor will have distinct needs and capacities, including resilience and need for long-term assistance. Where longer-term assistance is required to support the survivor to recover, establish/resume supportive relationships and participate in their community, referral to the following options may be explored:

- Age-tailored vocational and skill-training opportunities such as provided by RENEW
- Formal and non-formal educational programs
- Safe income-generating activities and livelihood activities and cash assistance.

In locations where these formal long-term supports do not exist, Case managers may work with survivors to identify sources of informal longer-term support that foster their resilience, empowerment and supportive relationships in the home and/or community. This may include religious groups/ceremonies, community groups, women's groups. The case manager maintains a responsibility to follow up on these services to ensure that assistance does not further stigmatise survivors.

7. Risk Mitigation and GBV Prevention

All actors have a responsibility to mitigate the risk of GBV and support the prevention of it. Mitigation refers to actions that seek to reduce the risk of exposure to GBV, for example ensuring services are accessible and safe for women and girls or that codes of conduct relating to sexual abuse and exploitation are implemented. The prevention, or primary prevention of GBV refers to efforts that seek to prevent GBV before it occurs. Through different interventions prevention actions seek to realise gender equality, thus addressing the root cause of GBV.

7.1. Risk Mitigation

All service providers have a responsibility to integrate GBV mitigation measures into their work. This includes both GBV and non-GBV service providers. Key actions include:

- Ensuring staff have the skills and knowledge relevant to their sector and role by providing or participating in training on GBV, relevant legislation, policies and procedures and guidelines to ensure.
- Adopting codes of conduct for all staff that focus on preventing sexual exploitation and abuse. Providing training to all staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow-up on reports.
- Actively seeking the equal participation of women, girls, boys and men in the design, delivery and assessment of services.
- Regularly meeting with women and girls to learn about accessibility, safety, and security concerns related to services and facilities and use this information to adapt services as required.
- Ensuring services are inclusive and accessible for persons with disabilities including through regular meetings with them as above.
- Strengthen the protective environment, by assessing security and safety and addressing protection issues. Always consider intended and unintended consequences of activities and review strategies to ensure survivor's protection and according to the best interests of the survivor(s).
- Foster community mobilisation and outreach information campaigns to prevent further violence and the stigmatisation of survivors.
- Organise economic empowerment activities to reduce vulnerabilities.

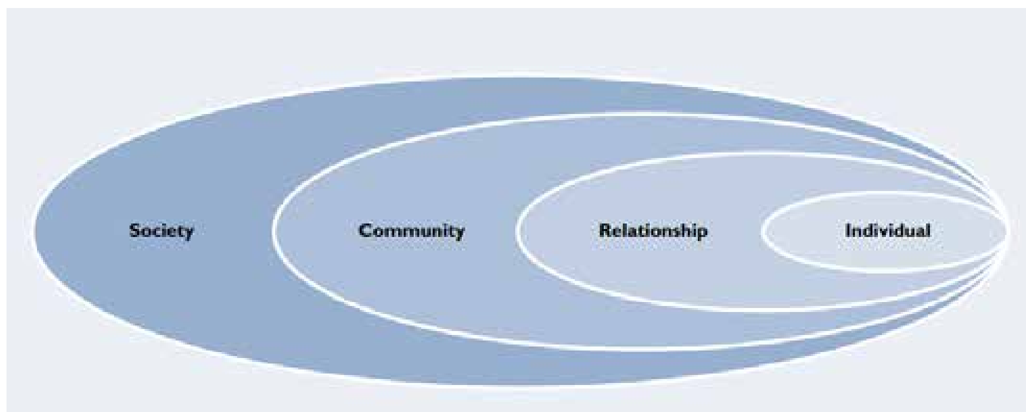
Information sharing and awareness raising on GBV and GBV services helps prevent further incidence of violence and stigmatisation of survivors. Information sharing and awareness raising helps foster demand for and access to services for survivors and women and girls-at risk and contributes to the strengthened protective environment for all.

Standardised messaging helps ensure consistency and avoid gaps and contradictions. Key messages should be developed of key issues including but not limited to: gender inequality is the root cause of GBV, types of GBV, information on available services and how to access them, how to respond to and help prevent GBV including PFA, consequences of GBV for survivors, their family, and the community. Key issues and their messages should be developed through consultation to ensure prioritisation and development appropriate to context.

Efforts to strengthen information sharing and awareness raising should capitalise on existing materials, such as the RENEW Awareness Raising Toolkit and coordination mechanisms for their roll-out, such as the NCWC at a national level and multi-sector taskforce and/or WCWC at a Dzhongkhag level and below. Advocacy and awareness raising campaigns supported by community mobilisation (eg. 16 days of activism(should utilise standardised messaging and be implemented alongside or coupled with prevention interventions as per below guidance.

7.2. GBV Prevention

Prevention interventions should be informed by the social ecological model and its understanding of multi-level, intersecting factors that contribute to incidents of violence in a person's life. The model highlights the complex nature of VAWG and the need for holistic primary prevention interventions tailored to context. The model helps identify key entry points for prevention interventions that respond to these intersecting factors[36]



The **individual level** represents the biological and personal history that shapes individual's behaviour. This may include person a history of abuse, substance use, witness IPV and age. Interventions at this level may include positive parenting, economic or substance abuse interventions.

The **relationship level** represents the immediate context in which violence takes place – frequently the family or other intimate or acquaintance relationship. This may include frequent fighting/conflict within the relationship, marital instability, male dominance and control, economic stress. Interventions at this level may include ones promoting positive, non-violent relationships, life-skills and school-based programs, programs that seek to allay economic stress on families, and male engagement.

36 Heise, Lori (1998) Violence Against Women: An Integrated, Ecological Framework

The **community level** represents the institutions and social structures, both formal and informal, in which relationships are embedded – neighbourhood, workplace, social networks, and peer groups. This may include institutions that tolerate violence or fail to respond to violence, limited social services, level of crime in the community. Interventions at this level may involve community mobilisation, communication and advocacy campaigns, and community education.

The **society level** represents the economic and social environment, including cultural norms. This may include gender-biased policies and laws that discriminate against females, dominant unequal gender social norms and attitudes. Interventions at this level may include legislation reform, school-curriculum based interventions that support wide-spread social norm change amongst youth.

It is important to note that subject to its design, interventions including those mentioned may cut across several levels.

Research indicates that prevention interventions are effective when they:[37]

- **Are based in a gender transformative approach.** Interventions that explicitly address norms, behaviors and relations associated with femininity and womanhood, and masculinity and manhood. In doing so, these encourage critical awareness of relations of inequality and discrimination against women and promote equal gender relations through changed gender norms, roles and behaviors. A gender transformative approach can be integrated into a range of multi-component interventions. For example, women's economic empowerment interventions which couple livelihoods and saving and loans activities for women with structured gender discussions for men and women that challenge the distribution of resources and allocation of duties between men and women and promote women's economic agency and equal control over resources.
- **Engage with multiple stakeholders as part of a multi-component intervention.** Multi-component interventions that seek to address various risk factors as part of the same intervention have shown to be more effective at strengthening GBV prevention than programs that focus on a single risk factor. This can include media campaigns coupled with targeted outreach and training workshops or livelihood programs that integrated gender training.
- **Work with men and women.** Interventions that work with men and women have shown to be conducive to longer-term positive change. It is important to note that modalities for working with men and women vary and may include mixed gender groups, same-gender groups engaged

37 Fulu, Kerr-Wilson (2015) What works to prevent violence against women and girls evidence

simultaneously and/or same-gender groups engaged sequentially (women followed by men). Women's perspectives and safety should be prioritised and inform the modality adopted. For example, working with women to explore their experience of inequality and identify potential risks associated with engaging men before proceeding with men's groups can help ensure it remains safe and is tailored to specific gender relations in a given community. Work with women and men should incorporate a gender transformative approach as described above.

- **Incorporate face-to-face engagement.** While large scale awareness campaigns, for example those done through radio, television or social media are popular research suggests face-to-face engagement is important to affecting substantive change. For example, large-scale awareness campaigns coupled with community outreach components were found to be more effective[38].

Effective Primary Prevention Interventions

Stepping Stones is a non-curriculum based violent prevention approach that engages women and men at a community level to change social norms. Designed by Raising Voices and piloted in Uganda, it has been adapted to many countries and contexts (http://preventgbvafrica.org/wp-content/uploads/2017/01/LP4.StrongerTogether_.FINAL_.dec2015.pdf). It includes 13 participatory training sessions with 50 hours of intervention over a 6-8 week period. It covers topics such as gender inequality and violence, violence against youth, life-cycles of violence, love, stigma, STI/HIV, condom use, self-esteem and substance abuse.

Safe Homes And Respect for Everyone (SHARE) is a community-based intervention conducted by Rakai Health Sciences Programme in Uganda. It includes: training workshops; capacity building of professionals regarding domestic violence, reproductive health, HIV/AIDS and women's rights; community activism through village meetings, music, and dance; HIV/AIDS and reproductive health outreach; counseling services and the distribution of learning materials.

SASA! is a community mobilization intervention that was started by Raising Voices in Uganda. It seeks to change community attitudes, norms and behaviours that result in gender inequality, violence and increased HIV vulnerability for women. It is structured around four stages and engages a wide range of stakeholders to learn about GBV and HIV as interconnected issues, explore male abuse of power over women and possibilities for positive use of power with others to support women, and support community members to taking action to prevent GBV and HIV in the community grounded in power analysis.

The IMAGE project is a 12 month program that combines group-based microfinance with gender and HIV training curriculum deliver to women at fortnightly loan repayment meetings. The purposes of IMAGE is to improve economic wellbeing and independence of communities, reduce HIV and GBV and foster robust community mobilization to address common concerns (http://www.image-sa.co.za/PROGRAMME/The-Intervention). These women-only gender discussion groups and community mobilization approaches showed a statistically significant 55 percent reduction in women's experience of physical and/or sexual IPV (Pronyk et al., 2006).

review

38 Ibid

7.3. Sexual Harassment

As per the CMSOPs, all organisations both Government and non-Government are responsible for establishing an Internal Complaints Procedure (ICP) or similar mechanisms for responding to violations of the Labour and Employment Act, Bhutan (2007), Penal Code of Bhutan (2011) and other relevant legislation. This pertais to sexual harassment. Sexual harassment includes: (a) making an unwelcome sexual advance or an unwelcome request for sexual favours to the other person; or (b) engaging in any other unwelcome conduct of a sexual nature in relation to the other person. "Conduct of a sexual nature" is considered to include (a) subjecting a person to any act of physical intimacy; (b) making any oral or written remark or statement with sexual connotations to a person or about a person in his or her presence; or (c) making any gesture, action or comment of a sexual nature in a person's presence. Each organisation should identify ICP Designated Persons (DPs) who may receive and investigate complaints of sexual harassment in coordination with the Competant Authority. As part of this, DPs should share information with the survivor on the role and availability of case managers (eg. Protection Officers) and support referral for case management in line with the survivor's wishes prior, during and/or after investigation. Survivors may also may direct reports of sexual harassment to the Chief Labour Administrator and Royal Civil Service Commissioner through the Civil Service Help Desk. Survivors may appeal internal investigations through the Chief Labour Administrator and its Labour Relations Officer. All sexual harassment complaint and investigation procedures should ensure the confidentiality of relevant parties. For full guidance see the CMSOPs (2011)and Labour and Employment Act, Bhutan (2007)

7.4. Sexual Abuse and Exploitation

As above, all organisations both Government and non-Government are responsible for establishing an Internal Complaints Procedure (ICP) or similar mechanisms for responding to violations of the Labour and Employment Act, Bhutan (2007), Penal Code of Bhutan (2011) and other relevant legislation. This includes sexual abuse and exploitation, which is considered to be a violation of Penal Code provision regarding sexual and economic violence (see GBV Types legal summary). Where ICP DPs receive a complaint of sexual abuse and exploitation, they are obligated to notify the Competent Authority within 24 hours who will then respond in line with their mandatory reporting obligations. The Ministry of Labour and Human Resources also has the capacity to bring to the notice of the Minister of any defects or abuses at workplaces not specifically covered by existing legal provisions and refer a matter to the Minister for a decision to prosecute for breach of this or other relevant Acts in coordination with relevant Ministries. Survivors of sexual abuse and exploitation should also be informed and offered case management services and supported to access them

in line with their wishes. All sexual abuse and exploitation procedures should ensure adherence to confidentiality protocols for the safety and wellbeing of the survivor.

8. Documentation, Data Management and Monitoring

GBV is happening everywhere however it is under-reported due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care. All service providers should assume GBV is occurring and treat it as a serious and life-threatening problem. While the collection of statistical information on GBV and its prevalence is helpful, it should not be prioritised above care or serve as grounds for the delivery of GBV services.

Focusing only on numbers not only fail to capture the true extent and scale of the GBV that is occurring, it can also expose survivors to further harm, lead to misinterpretations of the data, and result in other, more useful sources of information being dismissed or ignored. Therefore, it is not recommended that the number of cases cared for by a service provider is shared or publicised. Other types of data – both quantitative and qualitative – on GBV patterns, trends and risks can help paint a fuller picture, particularly when multiple sources are reviewed and analysed together. Pressuring service providers for case data compromises their ability to provide life-saving care.

8.4.1. Data Management Protocol

Maintaining case files

- Competent Authority will establish a Central Database to record GBV cases. The database will use a coding system to ensure anonymised data, protocols regulating access and the sharing of information between its users and publicly (see attached Information Sharing Protocol for sample).
- All service providers will maintain their own case files according to the following data management protocols. Where required and with the informed consent of the survivor, service providers may share case information to the extent it is directly relevant to the survivor’s care. Service provider case files will be entered into the Central Database with the Competent Authority having overall management of the database.
- Each service provider is to maintain their own case files with each survivor should have a **separate** case file that includes all relevant completed case management forms.
- A code should be assigned to and marked on the front of each case file. Develop a system of codes to assign unique identifiers to each survivor,

using numbers, letters from their last name or other codes. Only the person who first assigns the identifier and enters the information into the computer should know the identity of the client.

- **Names should never be recorded on the front of case files and photos should never be affixed to case files**.
- To protect confidentiality, a list linking the case file codes to the survivors' names should be stored in a different location, or stored electronically through a password protected file.
- Information collected about survivors belongs to them
- It is recommended that all case files should be kept for a period of 5 years, after which they can be destroyed. Any further reference on the case can be retrieved from electronic archives. Closed case files should not be transferred without survivor consent.

If you are maintaining paper copies of case information:

- Only print information if it is absolutely necessary. Where possible, promote a paper-free working environment to reduce the amount of information that is printed. In most cases, however, Case managers will not have access to computers or hand-held data devices and will thus use paper forms to document cases. If information is printed, register each copy by applying serial numbers (or coding) and track them on a spreadsheet. Ensure that only those authorised to access these documents in your organisation are aware that they are accountable for the security of them.
- In line with your organisation's data protection and archiving policies, destroy all printed material that is no longer needed. You can do this by shredding or burning (if safe to do so).
- Store printed material in a locked file cabinet or other secure container, and limit access to the combination or keys. Rooms containing paper and electronic information must be locked securely when staff leaves the room. All staff should be aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.
- Have a plan in place for destroying all information in the case of an emergency or evacuation.

If you are maintaining electronic case information:

- Do not email information unless absolutely necessary. When you do send an email, include instructions for the recipients so that they are aware that the information in the email and its attached files is sensitive. This could include caveats such as "Limited Distribution: Do not disseminate this email or attachments without permission from…"

- Store electronic data on a single computer or removable storage device, such as a flash drive, and keep limited backup copies.
- Secure backup copies in a locked, safe or room, or keep flash drives with you at all times.
- Access to information should be controlled. This includes establishing protocols for all staff accessing or using survivor information, and limiting access to computers used to store confidential data.
- Information stored electronically should be password protected. Use a series of passwords, establishing a different one for each level of information. Maintain security by ensuring that each user knows only the passwords to the information for which she/he has legitimate need.

Sharing data:

- The notification of and review by the Competent Authority and/or WCWC of cases will use anonymised data. Notification and review will be undertaken by pre-approved persons who have signed the ISP, limited the number of individual involved to as few as possible.
- Reports generating from the central database will use aggregated data to ensure confidentiality
- Completed intake forms should never be transferred or shared between agencies to maintain the safety, security and confidentiality of information. Only in **rare situations** it may be necessary to share all or part of a case file, for example where total care/support of a survivor is being transferred because an organisation is pulling out or the survivor is moving to a new location where another organisation will provide support (with survivor consent);
- Donors or other external entities should not mandate that service providers submit individual case files (i.e. intake or incident report form) as routine reporting.
- DO NOT share case files without the consent of the survivor and only on extraordinary occasions according to the needs of the survivor with explicit consent.
- Bi-annual reports to the Competent Authority will include data on general GBV trends and avoid citing individual cases or using identifying information

9. Coordination

As the Competent Authority, the NCWC has overall responsibility for the coordination of GBV multi-sector prevention and response services across Bhutan. In this capacity, they will:

- Develop, coordinate and monitor such programs and activities for the effective implementation of the DVPA, and other legislation and policies relevant to GBV;
- Conduct periodic study to monitor the situation of GBV;
- Develop advocacy and awareness raising initiatives against GBV including through wide publicity via public media including television, radio and the print media at regular intervals;
- Establish and maintain a central database management system in order to maintain up-to date record of GBV cases;

At a Dzongkhag level, the WCWC and multi-sector taskforce are the primary coordination mechanisms which will perform a similar function to the NCWC at a national level as describe above. The WCWC also functions as a case conferencing mechanisms where required. It is important to make a distinction between its general coordination and case conferencing functions, as the latter involve strict confidentiality protocols (see **Case Conferencing section).**

10. Annex

10.1. Memo

Interim Case Management Arrangements

December, 2019

The 2013 DVPA identifies Protection Officers and Social Welfare Officers as the primary case management actors in Bhutan; Protection Officers as the primary case management actor on behalf of the Competent Authority (NCWC) and Social Welfare Officers as complementary case management actors operating on behalf of CSOs. Since its introduction, efforts to support its full implementation have been ongoing. At the time of writing, the recruitment of permanent Protection Officers covering all Dzongkhags, and the establishment of a system of accreditation for Social Welfare Officers and their subsequent accreditation is ongoing.

As such, actors currently involved in case management also include Interim Protection Officers (Dzongkhag Legal Officers who are the Gender and Child Focal Point) and CSO staff and volunteers who continue to be approached for case management support given their experience, standing and trust with communities. Accordingly, at this time the GBV SOPs guidance for 'case management actors' or 'case managers' also pertains to them. Interim Protection Officers and their CSO counterparts should seek to replicate the relationship between Protection Officers and Social Welfare Officers of coordination and collaboration on case management outlined in the DVPA.

It is envisioned that following the full recruitment of Protection Officers and the commencement of accreditation of Social Welfare Officers, the involvement of Interim Protection Officer and CSO staff and volunteers in case management will be phased out either through their change of status or through the handover of duties, thus aligning with the DVPA stipulations. The GBV SOPs including this Memo will be updated to reflect any relevant changes.

10.2. Bhutan GBV Referral Pathway Template

Summary and Directions: The referral pathways are intended for service providers who receive and/or provide services to support GBV survivors. They seek to provide clear guidance on immediate and ongoing response services, referrals procedures and service provider information to support referrals. They are under the overall management of the NCWC who has responsibility ensuring they contain accurate and updated information.

Gewog:
Dzongkhag:

TELLING SOMEONE AND SEEKING HELP (DISCLOSING)	
Survivor tells family, friend, community member, general service provider; that person accompanies survivor to the health or case manager/psychosocial "entry point":	Survivor self-reports to a medical/ health or case manager/psychosocial "entry point

IMMEDIATE RESPONSE

- Provide a safe, caring environment and respect the confidentiality and wishes of the survivor
- Provide reliable and comprehensive information on the available services and support to survivors of GBV
- If agreed and requested by survivor, obtain informed consent and make referrals
- When family/guardians make a decision on behalf of the child, ensure the best interest of the child is given priority. Preferably, the accompanying adult should be selected by the child
- Accompany the survivor to assist them in accessing services
- For survivors of sexual violence ensure immediate (within 72 hrs) access to medical care

MEDICAL CARE (*please note if serves: adult and/or child survivors (under 18); males and/or females)*	CASE MANAGEMENT INCL. PSS MEDICAL CARE (*please note if serves: adult and/or child survivors (under 18); males and/or females)*	SAFETY AND SECURITY * Police *only if the survivors wants to pursue police action or there is a threat to others*
Name: *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES:
Based on survivor's needs with support of case worker:

MEDICAL CARE	SOCIAL SERVICES (case management, PSS, material/financial support)	SAFETY AND SECURITY (police, safe accommodation)	JUSTICE (court, jambi, CBSS volunteer, local government official)	OTHER (BASIC NEEDS, LIVELIHOOD, ETC)
Name: *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*	*Name:* *Position:* *Phone Number:* *Email:* *Location:*

NOTES:

10.3. Incident Classification Tool

1. Did the reported incident involve penetration?
    - If yes, classify the GBV as "Rape".
    - If no, proceed to the next GBV type on the list.
2. Did the reported incident involve unwanted sexual contact?
    - If yes, classify the GBV as "Sexual Assault".
    - If no, proceed to the next GBV type on the list.
3. Did the reported incident involve physical assault?
    - If yes, classify the GBV as "Physical Assault".
    - If no, proceed to the next GBV type on the list.
4. Was the incident an act of forced marriage?
    - If yes, classify the GBV as "Forced Marriage".
    - If no, proceed to the next GBV type on the list.
5. Did the reported incident involve the denial of resources, opportunities or services?
    - If yes, classify the GBV as "Denial of Resources, Opportunities, or Services".
    - If no, proceed to the next GBV type on the list.
6. Did the reported incident involve psychological/emotional abuse?
    - If yes, classify the GBV as "Psychological / Emotional Abuse".
    - If no, proceed to the next GBV type on the list.
7. Did the reported incident involve GBV?
    - If yes, Start over at number 1 and try again to reclassify the type of GBV (If you have tried to classify the GBV multiple times, ask your supervisor for support)
    - If no, classify the violence as "Non-GBV

10.4. Self-Care Inventory[39]

Rate the following areas infrequency:

5 = frequently 4 = occasionally 3 = rarely 2 = never 1 = it never occurred to me

Physical Self-Care 5 4 3 2 1

Eat regularly (e.g. breakfast, lunch and dinner)	Eat Healthy Foods
Exercise consistently	Get regular medical care for prevention
Get medical care when necessary	Take time off when sick
Dance, swim, walk, run, play sports, sing or do some other physical activity that is enjoyable to self	Take time to be sexual
Get enough sleep	Take vacations
Wear clothes you like	Take day trips or mini-vacations
Make time away from telephones	Other:

39 Adapted from Child Welfare Training Toolkit, March 2008. Original source unknown

Psychological Self-Care 5 4 3 2 1

Make time for self-reflection	Engage in personal psychotherapy
Write in a journal	Read literature that is unrelated to work
Do something in which you are not an expert or in charge	Cope with stress in personal and/or work life
Notice inner experience (e.g. listen to and recognise thoughts, judgments, beliefs, attitudes and feelings)	Provide others with different aspects of self (e.g. communicate needs and wants)
Try new things	Practice receiving from others
Improve ability to say "no" to extra responsibilities	Other:

Emotional Self-Care 5 4 3 2 1

Allow for quality time with others whose company you enjoy	Maintain contact with valued others
Give self-affirmations and praise	Reread favorite book or review favorite movies
Identify and engage in comforting activities, objects, people, relationships and places	Allow for feeling expression (laugh, cry, etc....)
Other	

Spiritual Self-Care 5 4 3 2 1

Allow time for reflection	Spend time with nature
Participate in a spiritual community	Open to inspiration
Cherish own optimism and hope	Be aware of nonmaterial aspects of life
Cultivate ability to identify what is meaningful and its place in personal life	Meditate/pray
Contribute to causes in which you believe	Read inspirational literatures (lectures, music, etc.)
Other	

Workplace or Professional Self-Care 5 4 3 2 1

Allow for breaks during the workday	Engage with co-workers
Provide self-quiet time/space to complete tasks	Participate in projects or tasks that are exciting and rewarding
Set limits/boundaries with clients and colleagues	Balance workload/cases
Arrange work space for comfort	Maintain regular supervision or consultation
Negotiate needs (benefits, bonuses, raise, etc.)	Participate in peer support group
Other	

10.5. Principles and Approaches For Working with GBV Survivors

Rights-based: A rights-based approach seeks to analyse and address the root causes of discrimination and inequality to ensure that everyone, regardless of their gender, age, ethnicity or religion, has the right to live with freedom and dignity, safe from violence, exploitation and abuse, in accordance with principles of human rights law.

Community-based: A community-based approach ensures that affected populations are actively engaged as partners in developing strategies related to their protection and the provision of humanitarian assistance. This approach involves direct consultation with women, girls and other at-risk groups at all stages in the humanitarian response, to identify protection risks and solutions and build on existing community-based protection mechanisms.

Culturally and age appropriate and sensitive: Culturally and age appropriate and sensitive essential services must respond to the individual circumstances and life experiences of women and girls taking into account their age, identity, culture, sexual orientation, gender identity, ethnicity and language preferences. Essential services must also respond appropriately to women and girls who face multiple forms of discrimination - not only because she is a woman, but also because of her race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation or other characteristics – or because she has been subjected to violence.

Gender equality and empowerment: The centrality of gender inequality and discrimination, as both a root cause and a consequence of violence against women and girls, requires that services ensure gender sensitive and responsive policies and practices are in place. Services must ensure that violence against women and girls will not be condoned, tolerated or perpetuated. Services must promote women's agency where women and girls are entitled to make their own decisions, including decisions that refuse essential services.

Promotion of perpetrator accountability: Perpetrator accountability requires essential services, where appropriate, to effectively hold the perpetrators accountable while ensuring fairness in justice responses. Essential services need to support and facilitate the victim/survivor's participation with the justice process, promote her capacity of acting or exerting her agency, while ensuring that the burden or onus of seeking justice is not placed on her but on the state.

10.6. Confidentiality and Mandatory Reporting Sample Scripts[40]

Sample script for 12 year-old child survivor
"My job is to talk to children and help them with problems they face. Although most of what we talk about is between you and me, there may be some problems you might tell me about that we would have to talk about with other people. For example, if I can't help with you a problem you have, we will need to talk to other people who can help you. Or if I find out that you are in very serious danger, I would have to tell the police about it. If you tell me you have made plans to seriously hurt yourself, I would have to inform your parents or another trusted adult. If you tell me you have made a plan to seriously hurt someone else, I would have to report that. I would not be able to keep these problems just between you and me because I want to be sure that you are safe and protected. Do you understand that it's okay to talk about anything with me, but these are other things we must talk about with other people?

Sample script for adult survivor
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 meetings. 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 only a few situations when I may have to speak with someone else without asking your permission. If you tell me you that you may hurt yourself, I would need to tell my supervisor or others who could help keep you safe. If you tell me that you plan to hurt someone else, I would have to tell police so we could prevent that action. If the person that did this to you is likely to pose a very great risk to you or others such as serious injury or death or did this to you while drunk then I may have to inform police. If you have in the past registered a complaint against this person for similar violence, I may also have to inform police. If this person is not your current or former partner, and forced you to have sex with them then I may have to inform police. Sharing information during these times is meant to keep you safe and get you the best help and care you need. Other than these times, I will never share information without your permission.

10.7. Competencies and qualities of GBV Case managers

Qualities of GBV Case Managers

- **Warmth**. Helpers who are kind, accepting and non-judgmental are perceived as warm. Warmth can create a climate of safety and trust that encourages survivors to be open. Warmth can be expressed through appropriate facial expressions, giving one's full attention to the survivor, and using a calm, kind tone of voice.

40 Adapted from Inter-Agency (2017) Guidelines on GBV Case Management

- **Empathy**. 'Being empathic' or 'having empathy' is best described as being able to imagine oneself in another person's situation, including imagining their world views, assumptions and beliefs. You can be empathic by listening attentively to what survivors are telling you, making every effort to comprehend their experiences from their viewpoint and validating their feelings.
- **Respectful**. Respect can be referred to as 'unconditional positive regard'. It is closely linked to acceptance, and as such involves being accepting and non-judgmental of the survivor and highlighting her/his strengths. Blaming, arguing, reacting defensively, and attempting to pressure survivors all indicate a lack of respect.
- **Genuineness**. Genuineness can be expressed by being sincere and authentic. Part of being genuine is accepting and admitting being wrong or making mistakes. Helpers are human and therefore do not know all of the answers and do make mistakes from time to time.
- **Self-awareness**. Helpers are also individuals whose beliefs and values are impacted by culture, ethnicity, religion, gender (or gender identity), sexual orientation, socio-economic status and family and personal history. A Case manager needs to be aware of how her/his beliefs and values may bias her/him negatively towards a survivor. In many contexts, social norms that lead to blaming, shaming and stigmatising of survivors are prevalent. It is important that helpers, as organisations and individuals, reflect on their own potentially harmful beliefs and norms, examine how these influence their response to survivors, and recognise how this could deter survivors from coming forward for help.

Competencies of GBV Case Workers

Good GBV case management also requires that case managers have key competencies to carry out their responsibilities.

Protection Officer	Social Welfare Officer
• Be a Bhutanese citizen • Have not been judged mentally unfit for empowerment by a medical doctor • Not have any criminal record of domestic violence or not been convicted for any other crime • Have a minimum of a bachelors degree in social work, psychology, gender, child development, education, counselling, sociology and where such person is not available, a person with at least a bachelors degree with a diploma in any of the aforementioned fields • Any other requirement that the Competent Authority deems necessary • Adhere to the Authority Code of Ethics	• Be a Bhutanese citizen • Have a minimum of a Bachelor's Degree • Be nominated by the accredited service provider • Have at least one year experience in a relevant field • Produce reference letter from the Organisation which they previously worked • Have successfully completed training provided by the Competent Authority • Be of sound mind • Not have been convicted of moral turpitude • Not have a criminal conviction and have been sentenced to imprisonment

Shared Skills and Knowledge
• A strong understanding of GBV and its causes and consequences • An understanding of social norms and how they affect survivors' help-seeking and decision-making • Knowledge of what services and supports are available and what survivors can expect from them, in particular, the health and justice systems • Knowledge and ability to apply a survivor-centred approach and the guiding principles to case management • A strong familiarity with GBV case management steps, tasks and practices • Active listening skills • Non-judgmental and empathetic approach • The ability to identify key issues and needs related to a survivor's care • The ability to solve problems related to the survivor's care

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