# Case Management Curriculum on Gender Based Violence (GBV)


GOVERNMENT OF KHYBER PAKHTUNKHWA
ZAKAT USHR, SOCIAL WELFARE, SPECIAL EDUCATION
AND WOMEN EMPOWERMENT DEPARTMENT

# Case Management Curriculum on Gender Based Violence (GBV)

## Contents

# PARTNERSHIP BETWEEN SOCIAL WELFARE DEPARTMENT, KHYBER PAKHTUNKHWA, UNFPA AND ROZAN

Zakat, Ushr, Social Welfare, Special Education and Women Empowerment Department, Khyber Pakhtunkhwa, (SWD-KP) is mandated to work for the well-being and uplift of the community at large and especially the vulnerable groups including women. It seeks to improve the quality of life and wellbeing of individuals, groups, and communities by intervening through policy formulation, planning and undertaking projects/initiatives in respect of those afflicted with poverty or any real or perceived social injustices and violation of their human rights including gender-based violence (GBV).

The Zakat, Ushr, Social Welfare, Special Education and Women Empowerment Department undertakes various social protection initiatives through its subordinate offices, institutions, and autonomous bodies. Besides that, the statutory bodies responsible for providing protection, assistance and shelter to GBV survivors also fall under the SWD which includes Khyber Pakhtunkhwa Commission on the Status of Women, Dar-ul-Amaan, Helpline, Zamung Kor, Provincial Council of Social Welfare, Provincial Council for the Rehabilitation of Disabled Persons, Khyber Pakhtunkhwa Child Protection and Welfare Commission and Khyber Pakhtunkhwa Senior Citizen Council. The Department is also responsible for reporting on the international instruments for which Pakistan is a signatory including Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD), and the United Nations Convention on Rights of Child (UNCRC).

Ending gender-based violence and harmful practices against women and girls (which is one of the core functions of SWD -KP) is also a key transformative result for UNFPA, tied to both the Sustainable Development Goals as well as the landmark Programme of Action that stemmed from the 1994 International Conference on Population and Development (ICPD) whose overarching vision, grounded in gender equality, remains more vital than ever.

Therefore, UNFPA together with SWD - KP with technical assistance from Rozan, developed "GBV Case Management Curriculum" to support the strengthening of the capacity of Social Welfare Officers, Helpline, Darulaman, and Crisis Centers staff on quality care standards for GBV survivors. Case management intervention will also support multi-sectoral coordination mechanism among the different institutions and services allowing better utilization of resources and quality care to GBV survivors. UNFPA and Social Welfare Department aim to institutionalize the case management curriculum for the training of Social Welfare Officers.

The curriculum was pre-tested with caseworkers to ensure that the feedback from the field is incorporated to address the needs of the caseworkers who will be using it.

# ACKNOWLEDGEMENTS

Development of this Case Management Curriculum on Gender Based Violence (GBV) is a result of team efforts; so here we would like to thank all those departments, organizations and individuals who made their contributions to this process.

A very special thanks to Honorable Mr. Manzoor Ahmad, Secretary Zakat, Ushr, Social Welfare, Special Education and Women Empowerment Department, Khyber Pakhtunkhwa for continuous support, guidance and commitment.

We acknowledge the contributions of Dr. Asha Bedar for developing this curriculum. Her expertise, experience, and vast knowledge on the subject matter are well reflected in this remarkable work.

A very heartfelt thanks to UNFPA team, especially Ms. Dilshad Pari and Ms. Saliha Ramay for their technical support to enrich the document. We highly appreciate the participants of pilot trainings on this curriculum for their candid feedback and input that helped us to adapt the content according to the ground needs of the case workers.

We would like to acknowledge the contributions of Rozan team members Babar Bashir, Syed Ali Salman, Muhammad Ali, Fouzia Yasmin, Madeeha Waheed, Binish Chaudhary and Meerab Lodhi in the process of developing this curriculum and their commitment to make difference in the lives of survivors of gender-based violence.

# Introduction

Gender-based violence (GBV) refers to any harmful act perpetrated against a person (usually a woman or girl) because of their gender. These acts can be physical, sexual or mental in nature, including manipulation, threats or restrictions on basics freedoms and rights.[1]

According to the Pakistan Demographic and Health Survey 2017 – 2018, 34 % of women have experienced domestic violence.Pakistan is a signatory to the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[2], gendered norms and expectations typically place women in a position where they are vulnerable to violence and abuse. Out of the 153 countries assessed by the World Economic Forum's Global Gender Gap Report 2020, Pakistan is ranked at 151[3].

Over the last few years, various laws have been passed to prevent GBV and support those affected by it[4], but due to challenges in implementation, a lack of awareness and patriarchal norms, reporting and convictions rates continues to be low. Resources and services for women survivors of gender-based violence are scarce, referral systems are limited, and response staff training is insufficient. Services and staff who interact with survivors of GBV lack adequate understanding of the issue, survivor's needs and the impact of violence and at times exhibit negative attitudes, misconceptions and biases towards women and their situations.[5] The effectiveness of the services and mechanism for support that exist, is also compromised because of a lack of coordination between them.

This curriculum is an attempt to bridge these gaps through a collaboration between the Social Welfare Department Khyber Pakhtunkhwa and UNFPA. The purpose, structure and content of the curriculum have been finalised after an extensive process of in-depth consultations among all the stakeholders, pre-and post-testing and reviews, in order to ensure it meets the specific needs of the local communities it aims to serve and fits into the broader global agenda for women's and girls' protection.

## Aims and objectives of the curriculum

GBV affects all those who are affected by it in one way or another. All survivors of GBV have the right to receive quality care and support in order for them be safe and to recover from the impact of the violence. This curriculum is a broad-based resource, aiming to provide basic, but comprehensive information to all those who engage with survivors of GBV in a professional capacity. Specifically, this resource aims to provide guidance on how to effectively and sensitively implement a case management approach with survivors of GBV, keeping in mind the wide range of needs that may be present.

## Target group/s

This curriculum has been developed primarily for Social Welfare Officers (SWOs) working or to be inducted by SWD - KP, however key individuals and staff of other public and private sector organisations like helplines, shelters, and CSO that deal with survivors of GBV, can also benefit from this document. Thereby the curriculum covers all levels of support provision, ranging from the first contact and reporting to the point where the case either reaches court or is otherwise resolved. While the focus is on the case management process, many parts will also be helpful for other professionals engaging with the survivor at various levels of support provision, such as health professionals (who often serve as the first points of contact), lawyers, and researchers.

## How to use the curriculum

This curriculum comprises of four sections, each covering an aspect of GBV case management, including basic information and followed by suggested modules to aid in training:

- Section One introduces the concept of GBV Case management, its rationale, principles and key expectations (knowledge, skills and attitudes), focussing on a survivor-centred approach and self-awareness;
- Section Two unpacks GBV in detail, highlighting its socio-political and psychological aspects, linking it to gender and power;
- Section Three discusses current support mechanisms for survivors in Pakistan, relevant laws, the service gaps in key sectors (police, shelter and medico-legal) and strategies for empowering survivors through basic support and communication skills;
- Section Four outlines the steps and processes of case management for GBV (including adjustments that are needed in pandemics like COVID 19), specifically policies, systems for collecting data, monitoring the system, referrals and self-care for workers.

1 Interagency Standing Committee. (2015). *Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action*. Geneva, IASC. http://gbvguidelines.org
2 http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
3 World Economic Forum (2019). The Global Gender Gap Report 2020. http://www3.weforum.org/docs/WEF_GGGR_2020.pdf
4 UN Women Asia and the Pacific, Legislation on Violence against Women and Girls (Pakistan)
5 SOPs working group - GBV sub cluster Islamabad. (2012). Standard Operating Procedures for Prevention of and Response to Gender Based Violence.

# SECTION ONE

# INTRODUCTION TO CASE MANAGEMENT AND ITS ACTORS

# SECTION ONE: INTRODUCTION TO CASE MANAGEMENT AND ITS ACTORS

Section One covers the following:

- Definition of GBV case management
- Principles of GBV case management
- Actors in case management
- Skills, knowledge and attitudes required in a case worker
- Self-awareness

## 1.1. What is GBV Case Management?

GBV case management is a centralised, structured, team-based mechanism for providing holistic support to a survivor of GBV. It usually involves an organisation, group or team taking responsibility for ensuring that the survivor seeking support and her case are taken care of and effectively managed from beginning to end, and that all the steps and issues that arise along the way are identified and followed up in a coordinated, professional manner. The case management approach is based on the recognition that survivors of GBV have multiple, interdependent and competing needs that must all be addressed, sometimes simultaneously, in order to ensure survivor safety, recovery and overall wellbeing.[1] Case management may, therefore, involve a number of professionals working as a team with a survivor (with one team member/social worker/activist or organisation serving as the coordinator or 'case manager') in order to meet all the varied needs of the survivor and essential services, such as medical, legal, mental health, shelter, etc., outlined in the United Nations Essential Services Package for women and girls subject to violence[2], problem solving and follow up are provided.

An example from Punjab[3]

In 2016 Violence Against Women Centres (VAWCs) were introduced by the Punjab Government's Strategic Reforms Unit (SRU, based on the legal framework of The Punjab Protection of Women Against Violence Act 2016.[4] Each VAWC is mandated to offer comprehensive case management and essential services, and employ an all-female staff. Services within this framework include police reporting, registration of criminal cases, medical examination, and collection of forensic and other evidence. There are Standard Operating Procedures (SOPs) in place for responding to each case. For example, when a survivor enters a VAWC, she first reports the case to the front desk where it is recorded; she is then referred to the medical department for first aid and a basic medical check-up; she then receives a docket for medical confirmation and to register the case; and finally, the case is referred to prosecution to initiate a criminal proceeding. During this process, she is also offered trauma support and counselling services as required. The VAWC model is also in line with the UN Women's Essential Services Package.

## 1.2. What are the principles of case management for GBV?

The principles of GBV case management support have grown out of women movements, both global and local, which have been at the forefront of working with survivors.[5] Key underpinnings of this approach therefore are:

- Gender equality – all support and efforts are aimed at upholding and promoting equality and justice for survivors, even in the face of resistance and gender discrimination which are the norms in Pakistan
- Dignity and respect – the survivor's dignity is upheld at all times and she is treated respectfully
- Survivor Centred approach - the needs and perspectives of the survivor lie at the centre of the kind of service she receives. No one knows or is able to judge the situation or survivor needs as well the survivor herself
- Safety- the survivor's safety (and that of her children's if they are part of the process), both physical and psychological is assessed immediately and prioritised by all involved. This includes assessing potential risks from her own family, especially in cases of 'honour'
- Empowerment – supporting the survivor in establishing/re-establishing control over her own life is seen as the key goal of case management
- Uniqueness – it is understood that every survivor is not the same and may have different needs, choices and priorities and that these are to be assessed and respected
- Intersectionality – there is an understanding that many layers of vulnerability shape women's experienced of GBV, including social class, ability (physical and mental), religion, sect, language, etc.
- Empathy and kindness – survivors are believed, listened to sensitively and affirmed through genuineness, concern and positive regard judgement

1 Gender-based Violence Information Management System (GBVIMS) Steering Committee. (2017). *Inter-Agency Gender-based Violence Case Management Guidelines: Providing care and case management services to gender based violence survivors in humanitarian settings.*
2 United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (UN Women, UNFPA, WHO, UNDP and UNODC). (2015). *Essential services package for women and girls subject to violence*. Available: https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence
3 Khan, F. K (2019). *Improving the State's Response to Gender-Based Violence in Punjab, Pakistan*, Cornell Policy Review. Available: http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
4 Cornell Policy Review. (2019). *Improving the State's Response to Gender-Based Violence in Punjab, Pakistan*. Available: http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
5 GBVIMS. (2017).

- Self-determination and choice – survivor's control over decisions and her consent is paramount, she is free to choose, reject, and affirm any decisions made in relation to her case. This is of particular worth, especially in Pakistan, where immense pressure may be placed on survivors for reconciliation, case withdrawal, etc.
- Focus on resilience and strengths – existing strengths, efforts, resilience and potential for growth are appreciated, encouraged and built upon;
- Non-discrimination – all survivors, no matter what their background, are treated equally. This is especially important in Pakistan where discrimination on the basis of caste, religion, sect, ability, family background, status, affiliations, life style choices, etc., is prevalent and can undermine the degree of support received;
- Privacy and confidentiality - privacy of information and identity is of critical importance in Pakistan where women and girls can lose their lives over information leakages. It is ensured that no information is disclosed to anyone without the informed consent of the survivor, that information is shared only when absolutely necessary to those involved in the survivor's care with the survivor's permission and that written data about a survivor is safeguarded and
- Trauma care – healing and recovering from the mental health effects of the violence, including trauma from an integral part of support efforts. This aspect of case care is typically neglected in Pakistan, often resulting in further distress and re-traumatisation during the support process.

## 1.3. Who are the actors in Case Management?

A number of professionals may be involved in case management, depending on the survivor's situation and needs. These could range from the first people or groups who respond (i.e., first responders) to the GBV case through to the resolution of the case through the court system and sometimes even beyond in order to ensure the safety and rehabilitation of the survivor. Typically, a case management team consists of the following:

- Social/NGO worker/activist – survivors of GBV may come to the notice of social/community workers through communities they work with or through their networks, or they may be contacted for help directly by a survivor or her family through a walk-in facility, a call or a helpline. Social/NGO workers often take on the role of the key case worker or manager, coordinating between the different kinds of supports the survivor may require through the process
- Health professionals (doctors, nurses, health workers, etc) – these are very often the first points of contact for survivors of GBV. Women are more likely to disclose abuse to their doctors or health workers (e.g., Lady Health Workers) or health professionals may discover the abuse themselves because of injury or other signs
- Mental health professionals (counsellors, helpline workers, etc.) who may or may not be part of an organisation, and to whom a survivor may have disclosed her abuse
- Police – if/when the decision is made by the survivor to report her case, the police become involved. This may happen in a crisis situation if the survivor fears for her own or her children's wellbeing and calls the police or it may occur after the act of violence has occurred, sometimes after a significant delay. Once reported, police involvement remains throughout the whole process of evidence collection, investigation, court appearances, etc.
- Medico-legal Officer (MLO) – as evidence collection and documentation are a critical part of the investigation, MLOs may also be part of a case management team, helping to provide valuable information to the police and case managers in regards to medical evidence.
- Lawyer – as the survivor's advocate, the lawyer is an essential case management team member, providing legal information and counsel to the survivor who may have very little, if any, understanding of her legal rights and of the processes. Supporting the survivor in navigating the investigation and court system, ensuring that the survivor understands and is prepared for each step is a key role played by the lawyer.
- Shelter staff and management – if protection is required, as is often the case for survivors of GBV, shelters become prime actors in case management because of their close engagement with the survivor. Shelter staff and management are therefore directly involved in the day-to-day management of the survivor, including their safety, meetings with the police and lawyers, court appearances and mental distress.
- Community influentials – in addition to the above formal supports, survivors may also wish to involve a member of their community (an elder or a leader) whom they trust and whose opinions they value for additional moral support. If suitable, this person could also be involved in the case management process at some point.

## 1.4. Who is an ideal case worker?

Being part of a case management team is more than simply knowing the steps of case management. Engaging with survivors of GBV requires a certain understanding and knowledge, a set of skills and attitudes[1], [2] that support the survivor through the process:

### Knowledge

- Definition of GBV
- Forms of GBV (particularly in Pakistan )
- Prevalence of GBV in Pakistan
- Domains of GBV
- GBV survivors and perpetrators
- Root causes of GBV in Pakistan
- Impact of GBV on survivors (may differ according to type)
- Barriers (personal and structural) to justice for survivors of GBV (for each type)
- Needs of survivors of GBV
- Available support services in Pakistan
- Specialised services and professionals in Pakistan – including strengths and gaps
- Laws on GBV
- GBV courts
- Human rights and dignity
- Basics of emotional support
- Specifics for every case (survivor demographics, unique circumstances, family situation, financial situation, special risks, available support system, client skills/strengths, health/mental health status, legal situation, etc.)
- Socio-cultural understanding of survivor's community – strengths, risks, supports, etc
- Case management approach – importance, principles, steps, roles, etc.
- Services for referral and rehabilitation
- Ethics

### Skills

- Specialised skills related to occupation
- Empathy
- Active, non-judgemental listening
- Communication and expression
- Emotional intelligence
- Interviewing for assessment + evidence + data collection
- Analysis
- Basic emotional support provision (para counselling)
- Team work and networking
- Creativity and flexibility
- Problem solving and conflict resolution
- Initiative taking
- Basic documentation
- Data management
- Monitoring case management

### Attitudes

- Self-awareness
- Positivity
- Motivation and sense of purpose
- Compassion and concern for people
- Sensitivity
- Humility
- Openness to learning
- Confidence
- Dedication
- Patience
- Respect for clients
- Belief in equality, human rights, social justice, diversity, etc.
- Comfort with diversity
- A non-judgemental approach to people
- Professional ethics – hard work, honesty, etc.

When engaging with survivors, all three components – knowledge, skills and attitude - are essential. However, training programs tend to focus primarily on knowledge and skills, ignoring the critical role that attitudes play in supporting survivors. This is particularly important in Pakistan where attitudes towards survivors of GBV can determine what level of help they receive (See Barriers to Justice). Individuals who will make up a case management team are a part of the society and are impacted by their culture, ethnicity, religion, gender (or gender identity), socio-economic status, etc., and will have a range of attitudes that will in turn have an impact on the people with whom they work.[3] It is therefore essential that case workers are self-aware and consciously reflect on how their beliefs and values may affect (perhaps bias her/him negatively?) a survivor.

## 1.5. What is self-awareness?

Self-awareness is the extent to which we know ourselves. It is a skill that refers to the ability to recognise our own thoughts, beliefs, emotions, personality traits, personal values, habits, biases, strengths, weaknesses,

1 Ibid
2 Rozan, Training Module: Strengthening Women's Centres to Support Survivors
3 Ibid.

and the psychological needs that drive our behaviours. It includes the ability to recognise how we react to cues in the environment and how our emotions affect our way of relating to others.[1]

## Why be self-aware?

For case workers who want to work on their attitudes in order to be able to deliver sensitive services to the survivors of violence, the first step is to be self-aware. This awareness comes from thinking and reflecting on oneself. Self-awareness, thus, is the process of identifying, understanding and accepting one's strengths, weaknesses, feelings, potentials, dreams, fears, etc. Once we are more self-aware, we become more comfortable with ourselves and are, as a result, better able to work on and manage our weaknesses, re-evaluate our mistakes and learn from them. Self-awareness of our strengths allows us to make better use of them consciously and to further consolidate them. A self-aware case worker will also be open to the learning process and will seek feedback for continued improvement and self-development. Self-awareness also allows workers to be aware of their attitudes and biases and make an effort to challenge unhelpful attitudes so that they do not block their ability to support survivors.

## How can workers become more self-aware?[2]

- Self-reflect. Take out some time and reflect on yourself. There are many ways of doing this or you could come up with your own: write about yourself in a journal, do a simple Who Am I task by asking yourself this question and complete the sentence "I am…." 15 or 20 times, make columns and identify your strengths and weaknesses as a person and as a professional, note down your self-improvement goals, etc. Remember that you are constantly changing; consequently, these self-perceptions and goals also change rapidly, often in drastic ways. Update them frequently.
- Listen to others' opinions of you. It is your choice to accept or reject what they say, but it is still worth listening to, so you can decide whether or not it is true. In every interpersonal interaction, people comment on you in some way—on what you do, what you say, how you look. Sometimes these comments are explicit; most often they are "hidden" in the way in which others look at you, in what they talk about, in their interest in what you say, etc. Pay close attention to this kind of information (both verbal and nonverbal) and use it to increase your own self-awareness.
- Actively Seek Information About Yourself. Ask for feedback. You can use everyday situations to sometimes gain self-information. E.g., "Do you think I was understanding enough when I talked to that person?" You don't need other people's opinions on everything you do, but every now and then, when you are unsure, this can be a useful way of getting a second opinion.
- See your different selves. Each of your friends and relatives views you differently; to each you are somewhat a different person. Yet you are really all of these, just a bit different in different situations. Practice seeing yourself, as people with whom you interact see you. Perhaps start with visualising how you are seen by your different members of your family, then your friends, the stranger you sat next to on the bus, your employer, your clients, etc. Every now and then seeing yourself through the eyes of others can give you new and valuable perspectives on yourself.
- Express yourself. By talking to people or writing, you can reveal more of yourself by putting yourself out there. This may prove difficult for you, but even that will tell you something about yourself.

1 Rozan. *Ensuring quality and ethical response in cases of violence against women.*
2 Joseph A. . (1995). *The self in interpersonal communication in the interpersonal communication book.*

## TRAINING SUGGESTION MODULE 1: INTRODUCTION TO CASE MANAGEMENT AND SELF-AWARENESS

Module 1 Objectives

By the end of Module 1, participants will be able to:

- Define case management
- Identify the actors in case management
- Identify the characteristics of an ideal case worker – and differentiate between skills, knowledge and especially attitudes
- Understand self-awareness and its importance in case management

Facilitator notes:

The first module is important in that it will set the tone for the entire case management curriculum workshop. It introduces key concepts such as self-awareness, the importance of attitudes, the survivor centred approach and respect. The facilitator needs to be able to demonstrate quality interpersonal skills and attitudes towards the participants, especially respect. The facilitator also needs to be very clear on the concept of case management and self-awareness.

### Session 1: Setting the tone

Topics/methods:

- Introductions – go around and presentation
- Norms - brainstorm
- Expectations – group work
- Objectives - presentation

### Session 2: Introduction to Case Management

Topics/methods:

- Who are the actors? – brainstorming and presentation
- Understanding case management – presentation on definition and principles
- Qualities required of a support worker: Attitudes, Skills and Knowledge – brainstorming on meta cards and discussion
- Importance of attitudes, skills and knowledge – large group discussion

### Session 3: Basics of Self Awareness

Topics/methods:

- What is Self-Awareness - brainstorming
- Importance of self-awareness for support workers – large group discussion
- Strategies to become more self-aware – presentation and discussion
- Self-awareness exercises – small groups (Who am I? Personal histories)

# SECTION TWO

# GBV AND THE PSYCHOSOCIAL CONTEXT IN PAKISTAN

# SECTION TWO: GBV AND THE PSYCHOSOCIAL CONTEXT IN PAKISTAN

Section Two covers the following:

- The definition of GBV
- The prevalence of GBV in Pakistan
- Types of GBV and definitions
- Dynamics and domains
- Survivors and perpetrators of GBV
- Impact of GBV
- Barriers to justice
- Root causes – gender, sex and power
- Gender socialisation and its channels
- Myths and facts around GBV

## 2.1. Basics of Gender Based Violence

### What is Gender-Based Violence?

Gender-based violence (GBV) is the term for any harmful act perpetrated against a person based on socially ascribed (i.e., gender) differences between males and females. It is generally used to refer to the types of violence that affect women.[1] It was first officially defined as any act that "results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" in United Nations General Assembly Resolution 48/ 104, the Declaration on the Elimination of Violence against Women.[2] The term is used to distinguish individuals based on their gender from other types of violence. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty.[3] These acts can occur in public or in private spaces.

### Why the term 'Gender-Based Violence'?

By referring to violence as "gender-based", this definition highlights the need to understand this type of violence within the context of women and girls' subordinate status in society. Many cultures and traditions have beliefs, norms and social institutions that legitimise and therefore perpetuate violence against women and girls. Therefore, such violence cannot be understood, in isolation from the norms and social structure, as well as gender roles within the community, which greatly influence women's vulnerability to GBV.

### How common is GBV in Pakistan?

There are no reliable statistics on GBV in Pakistan, but all reports and surveys indicate that a high percentage of women and girls experience some form of violence or another, with at the very least 34% of all Pakistani women being victimised, according the latest Pakistan Demographic and Health Survey, including women maimed, disabled and even killed by their family members. Pakistan's biggest province Punjab reports some of the highest incidence of GBV, including honour crimes, acid crimes, revenge rape and exchange marriages.

### What types of GBV exist in Pakistan?

GBV includes violent acts or patterns of behaviour towards women and girls in particular. In Pakistan, following are the most common types defined in the law:

- sexual harassment
- domestic violence (including marital rape, violence by in-laws, dowry-related violence, stove burnings,
- sexual abuse of girls
- rape (including gang rape
- honour killings (including karo kari)
- acid attacks
- child marriage/forced marriage (including vanni and swara, and customary harmful practices
- sex trafficking.

### Definitions of forms of GBV

Sexual harassment - conduct sexual advances, or demand sexual favours or uses verbal or non-verbal communication or physical conduct of a sexual nature which intends to annoy, insult, intimidate or threaten the other person or commits such acts at the premises of workplace, or makes submission to such conduct either explicitly or implicitly a term or condition of an individual's employment, or makes submission to or rejection of such conduct by an individual a basis for employment decision affecting such individual, or retaliates because of rejection of such behaviour, or conducts such behaviour with the intention of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.[4]

Domestic violence - all acts of gender based and other physical or psychological abuse committed by a respondent against women, children or other vulnerable persons, with whom the respondent is or has been in a domestic relationship.[2]

Child Sexual Abuse (in this case of minor girls) - Whoever employs, uses, forces, persuades, induces, entices or coerces any person to engage in, or assist any other person to engage in fondling, stroking, caressing, exhibitionism, voyeurism or any obscene or sexually explicit conduct or stimulation of such conduct either independently or in conjunction with other acts, with or without the consent where age of person is less than eighteen years, is said to commit the offence of sexual abuse.[3] When the abuse is perpetrated by someone related (by blood or law) to the survivor, it is known as incest.

Rape - A man is said to commit rape who has sexual intercourse with a woman under circumstances falling under any of the five following descriptions: against her will, without her consent, with her consent when the consent has been obtained by putting her in fear of death or of hurt, with her consent, when the man knows that he is not married to her and that the consent is given because she believes that the man is another person to whom she is or believes herself to be married; or with or without her consent when she is under sixteen years of age.[4]

Honour killing - Offence committed in the name or on the pretext of honour means an offence committed in the name or on the pretext of karo kari, siyah kari or similar other customs or practices.[5]

Acid crimes - Whoever with the intention or knowingly causes or attempts to cause hurt by means of a corrosive substance or any substance which is deleterious to human body when it is swallowed, inhaled, comes into contact or received into human body or otherwise shall be said to cause hurt by corrosive substance.[6]

Child Marriage - a marriage to which either of the contracting parties is a child.[7]

Forced marriage//customary harmful practices Whoever coerces or in any manner compels a woman to enter into a marriage,[8] or Whoever gives a female in marriage or otherwise compels her to enter into marriage, as badal-e-sulh, wanni, or sawara or any other custom or practice under any name, in consideration of settling a civil dispute or a criminal liability.[9]

Child pornography - taking, with or without the consent of the child or with or without the consent of his parents or guardian, any photograph, film, video, picture or representation, portrait, or computer-generated image or picture, whether made or produced by electronic, mechanical, or other means, of obscene or sexually explicit conduct.[10]

Sex trafficking – Any person who recruits, harbours, transports, provides or obtains another person or attempts to do so for compelled labour or for commercial sex acts through the use of force, fraud or coercion, commits an act of trafficking in persons.[11]

## Where does GBV occur?

GBV can occur anywhere – on the streets, in schools, in market places, at workplaces or any other public or private place, but research shows that most of the violence experienced by women and girls occurs at home, for example domestic violence, child/forced marriage, incest, etc. This is a critical piece of knowledge for case workers to use as many strategies as possible, as attempts to resolve cases of GBV in Pakistan are based on the assumption that the safest place for women and girls is home, thus effectively pushing survivors back into the very setting where some of them are at most risk.

## Who are the survivors of GBV?

Any woman or girl may experience GBV, no matter what her age, socio-economic status, education, religion, sect, race, life style or location.[1] However, the nature of the violence and the options available for redress may be shaped by a number of social factors, such as her status, education, ability, citizenship status, religion, location, etc. The lower a survivor's status in society, the fewer protections and support mechanism she has at her disposal, rendering her even more vulnerable.

1 GBVIMS. (2017).
2 PPC, Section 365 A, The Protection of Women (Criminal Laws Amendment) Act 2006,
3 PPC, Section 377 A
4 PPC, Section 375
5 PPC, Section 299, Criminal Amendment Act 2004
6 PPC, Section 336 B
8 PPC, Section 498 B
9 PPC, Section 310 A
10 PPC, Section 292 B
11 Prevention of Trafficking in Persons Ordinance, 2018

Especially vulnerable are minor girls, women with physical or developmental disabilities, women belonging to religious minority groups, women from lower socio-economic backgrounds, women living in unstable conditions (e.g., refugees, women and girls in emergency/ post-disaster, displaced persons' camps, etc.) and transgender women.

Women and girls with disability are generally vulnerable to all forms of violence and abuse, and face further victimisation because of discrimination and exclusion from services and decision-making. Their varied and unique needs, depending on the nature of the disability, are typically overlooked by mainstream service providers and as a result accessing even basic support, such as using the phone, accessing public transport, and communicating their needs becomes challenging.[1]

Many girls begin experiencing violence at a young age, such as sexual abuse, particularly at the hands of people known to them, these may even be their relatives, including blood relatives. Over the years, the nature of the violence may change with new forms being added, such as harassment, rape, forced marriage, domestic violence, etc., and these may continue into old age, and there may be multiple perpetrators.

### Who are the perpetrators of GBV?

Perpetrators of violence are usually men (husband, fathers, uncles, cousins, brothers, male colleagues, but women may also participate in perpetuating the cycle of violence towards other women and girls in relatively weaker positions than themselves in the private domain (e.g., mothers, mothers-in-law, female employers in the case of domestic child labour, etc.)

### What are the dynamics of GBV?

GBV is deeply rooted in social norms and in gender roles and their expectations.[2] In many communities, social and cultural norms as well as religious beliefs encourage the notion that a) men own the women and girls in their families (daughters, sisters and wives) and that b) men are in charge of women's bodies and mobility.

As a result, men are often seen as being justified in controlling, punishing and humiliating women who deviate or attempt to deviate from social norms or from their notions of femininity, whether within the family (i.e., forced marriage, domestic violence, marital rape) or outside (harassment, rape). Violence is about power and control. Abusers find different ways—physical, emotional, psychological, sexual, reproductive, spiritual and economic—to control and dominate women. In cases of GBV within the home, an abuser makes threats, uses intimidation, coercion and often physical violence to over-power and control. GBV is typically a pattern of behaviour and on-going cycle, not a one-time event.

GBV is not about a man being provoked or out of control. Abusers make calculated choices about with whom, when and where they are abusive or whom they assault or overpower. The same men can control their aggression and sexual needs in other contexts when they need to. Their power and force are only displayed when they can display these, in front of someone they perceive to be in a vulnerable situation, such as young girls (and often boys), women/girls in their families, women they see as deserving of the violence or assault because they have challenged a cultural norm, made choices for themselves, etc.

### How is GBV affected by the COVID-19 pandemic?

As in all emergencies and humanitarian crises around the world, cases of GBV have increased significantly in Pakistan in the wake of the COVID-19 pandemic.[3] Increased stress related to illness and economic insecurity and losses combined with survivors and their perpetrators being locked down together in confined spaces over a long period of time created the perfect context for GBV inside the home. Furthermore, access to law enforcement, shelter and justice has also become severely limited for survivors of all forms of GBV because of social distancing requirements. Vulnerable groups, such as women and girls with disabilities, have been even more adversely affected due to social isolation/distancing measures where they or their care-givers may not be able to be together, have encountered disruption to daily routines and faced increased barriers to access support and safety services.[4]

## 2.2. Barriers to justice

The road to support, safety and/or justice for GBV is fraught with barriers – personal, societal and structural - for women at every level. The following are some of the key reasons why women do not report cases of GBV, withdraw cases after reporting or why they do not receive justice from the system:[5]

- Stigma associated with sexual issues – importance ascribed to virginity, modesty, or with reporting any abuse in the private domain (domestic violence, incest, child/forced marriage, etc.)

1 https://www.unfpa.org/news/pandemic-heightens-vulnerabilities-persons-disabilities
2 GBVIMS. (2017).
3 United Nations Office on Drugs and Crime, UNODC. (2020). *Gender and pandemic: Urgent call for action, Advocacy Brief 4.*
4 UNFPA news. (2020).*Pandemic heightens vulnerabilities of persons with disabilities.* https://www.unfpa.org/news/pandemic-heightens-vulnerabilities-persons-disabilities
5 Rozan. (2018). *Against All Odds: Post shelter lives of women survivors of violence.* https://rozan.org/wp-content/uploads/2020/05/Against-All-Odds-Rozan-Research-Report.pdf

- Concept of family or male 'honour' linked to women being confined to the private domain, and to their chastity
- Lack of basic awareness of their rights and of violence (domestic in particular) as a violation of their basic right to safety and dignity
- Lack of awareness of existing laws, safeguards and services
- Pressure from family members to cover up the violence, not report it to the police or to withdraw the case after a report has been lodged and an investigation is underway
- Fear of retribution by the perpetrator, especially if he has more power
- Distance to services
- Lack of protection by the system
- Cost of services/lawyers, etc.
- Lack of privacy and confidentiality in services
- Patriarchal mindset and misogynistic attitudes at all levels in the justice system - police, health services (including medico-legal), courts, etc.
- Invasive, humiliating and sometimes traumatic evidence collection processes
- Limited, if any concept of survivor dignity, rights and mental health
- Socio-political and economic disadvantage – poverty, low education, lack of control over resources, lack of access, etc.

## 2.3 Impact of GBV

All women who experience violence are affected in some way.[1] However, the nature of the effect, its duration and severity of the impact vary vastly between survivors. There are several variables that can shape their immediate reactions and effects (both physical and psychological) both in the short and long-term, such as their age/s, the nature of the violence, its duration, its severity, the number of perpetrators, her relationship with her perpetrator/s, the survivor's life circumstances before, during and after her experience/s of violence, the support she receives, her relationships, societal attitudes and responses, support mechanisms around her system, etc. The following section outlines some of the most commonly seen effects on survivors:

### Health

- Injuries, often serious (bruising, broken bones, etc.)
- Reproductive health problems due to injury
- Loss of pregnancy/still births
- Unwanted pregnancies
- Sexually transmitted diseases
- Stress related health issues and vulnerability to illness (blood pressure, migraines, skin problems, reproductive health issues, excessive weight loss/gain, chronic pain, etc.)
- Death (due to homicide, injury, pregnancy/childbirth related issues or suicide)

### Mental health and trauma

- Shock, numbness, hysteria, confusion and disorientation (possible immediate reactions)
- Memory loss/distorted memories
- Fluctuation in feelings, moods and decisions
- Mixed feelings about the perpetrator (if known to the survivor)
- Worry, anxiety
- Sadness, depression
- Fear, terror
- Hopelessness
- Low self-esteem
- Loss of confidence
- Helplessness, powerlessness
- Self-blame, guilt
- Difficulty in making decisions
- Aggression
- Denial
- Anger, rage
- Passive behaviour
- Lack of trust – may not trust even those trying to help
- Sleep difficulties and disorders
- Eating difficulties and disorders
- Difficulties in relationships
- Sexual problems
- Trauma effects (nightmares, flashbacks, excessive fears and phobias)
- Memory issues
- Problems with focus and concentration
- Agitation and restlessness
- Addictions
- Suicidal thoughts and attempts
- Feeling of disconnection, distorted reality
- Societal (sometimes even familial) shaming and rejection

### Impact on society

- GBV affects families and societies too, both in terms of economic costs and overall development and progress:
- Perpetuation of violence in society

1 Rozan. Strengthening women's centres to support survivors of violence.

- Low human rights indicators
- Low income (due to injury, hospitalisations, lack of women's economic participation, low education in girls), low socio-economic indicator and poverty
- Cycle of disadvantage through generations
- Significant economic costs due to hospitalisations, lawyers, trials, etc.

## 2.4. Root causes of GBV

Gender-based violence occurs across the world, and for many years, women movements around the world have strived to understand why this kind of violence occurs, what are its root causes, why the perpetrators are overwhelmingly men and its victims are women and girls. A vast body of research now supports the view that contrary to biological theories of violence that implicate testosterone as the main culprit for men's violence towards women, men and boys are not biologically predisposed to be violent, but that violence is learnt, perpetuated and reinforced through patriarchal gender socialisation.[1] This is the most basic different between Gender and Sex:

### What are Gender and Sex?

Sex refers to being male or female, the biological differences between men and women, which are universal and do not change.[2] Example of sex differences would be differences in development at puberty (voice breaking, menstruation, etc.), impregnation, giving birth, breastfeeding, etc., which are all biological functions.

Gender refers to social attributes that are learned or acquired during socialisation as a member of a given community. These include roles, activities, responsibilities and needs connected to being men (masculine) and women (feminine) in a given society at a given time. Since gender is learned, and not natural, gendered behaviours can and do change over time, and vary across cultures.

Gender determines how women and men are perceived and how they are expected to think and act (as men and women). These traits and behaviors are not only considered natural for one gender over another, but also desired by society. Expressions such as 'real men'…and 'good girls' serve to reinforce gender stereotypes by putting pressure on men and women to act according to the roles prescribed by society, or otherwise face disapproval, rejection or even violence as a means to control and force conformity.

For example, aggression, toughness, anger, rough play, sports, outdoors, etc., are all associated with men, while submissiveness, sensitivity, shyness, housework, parenting, gentleness, the home, etc., are associated with women etc., even though none of these are natural attributes, but are learnt through a process known as gender role socialization.

Over the last many years, more understandings of gender are emerging which also question the notion of gender binary or the classification of gender into two distinct, opposite forms of masculine and feminine, whether by social system or cultural belief.[3] This questioning allows us to incorporate and accept the third gender into our concept of Gender.

### What is gender socialization?

Gender socialization is a process by which people learn to behave in a particular way dictated by societal values, beliefs, and attitudes that begin early in life.[4] Children learn at a young age that there are distinct family and societal expectations for boys and girls and that adhering to these will result in approval. Cross-cultural studies reveal that children are aware of gender roles by age two or three and by four or five, most children are firmly entrenched in culturally appropriate gender roles.

Gender socialisation occurs through various channels, for example the family, school, peer groups, the media, folklore, books, songs, etc. It also occurs through cultural/religious centres, such as mosques, churches, etc. Each of these channels reinforces gender roles by creating and maintaining normative expectations for gender-specific behaviour in their own contexts. Repeated exposure to these channels and to the approval that follows, leads men and women into a false sense that they are acting naturally rather than following a socially constructed role.

Family is the first agent of socialisation. There is considerable evidence that parents socialise sons and daughters differently, with greater privileges afforded to sons. For instance, boys are allowed more autonomy and independence at an earlier age than daughters. They may be given fewer restrictions on appropriate clothing, dating habits, or curfew. Sons are also often free from performing domestic duties such as cleaning or cooking and other household tasks that are considered feminine. Daughters are limited by their expectation to be passive and nurturing, generally obedient, and to assume domestic responsibilities.

1 WHO. (2002).
2 WHO. Regional Office for Europe. (2002). *Gender: Definitions.* Available: https://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions#:~:text=iStockphoto,grow%20into%20women%20and%20men.

3 Human Rights Watch (HRW) (2020) Transgender, Third Gender, No Gender: parts 1 and 2. Available: https://www.hrw.org/news/2020/09/08/transgender-third-gender-no-gender-part-ii
4 Lumen Learning. Course: Introduction to Sociology, Reading: Gender and socialisation. Available: https://courses.lumenlearning.com/suny-herkimer-intro-to-sociology-1/chapter/reading-gender/

## How is Gender linked to GBV?

Gender is one of the key factors that contribute to power and privilege in society. Other key sources of social power are money, status (in family and society), education, religion, economic stability, social class, etc. In Pakistan's traditionally male- dominated, patriarchal social system, men hold significantly more power in each of these domains because of their gendered position in society. It is therefore in the gender power imbalance, and not biological differences, that we must seek both the main causes of, and the solution to GBV. Across the world, but particularly in more traditional societies, boys and girls from an early age are socialised to behave differently, to want different things, to express emotions differently, to relate to others differently and to have different goals in life, with boys being awarded significantly more power and privileges throughout their lives than girls. Research supports this by showing that the forms of GBV are severer and more pervasive in societies where there is greater inequality in between men and women (WHO 2014).[1] More specifically, this refers to greater inequality in economic rights and less protection available for the rights of women; rigid gender roles and stereotyping; more acceptance or condoning of violence; and decision making being primarily in the hands of men.

Gender is also the reason most crimes of GBV go unreported. Rigid gender norms dictate that women stay within the private domain, that they maintain the privacy and 'honour' of their homes and families and preserve the unit even if they are suffering because of them, and that sexual crimes against women should be hidden because they are seen as a stain on a woman's reputation (who is expected to be sexually pure) and the honour of the family. A woman who has reported her family for a forced marriage or a husband for domestic violence attracts disapproval from the society for failing to keep her husband happy, to maintain privacy and/or preserve the family. A woman who reports rape is seen as being responsible for attracting the assault (through how she behaves and dresses, for example) and for damaging her family's honour by disclosing that she is no longer a virgin or that she has had sexual contact with someone other than her husband. Abusers/rapists know the above norms well and use them to control and intimidate their victims and to keep them silent.

GBV continues to be taboo and survivors are typically silenced in our society. Patriarchy and strict gender stereotyping have a strong hold on our consciousness and, as such, prejudiced thinking/ attitudes provide one of the most formidable barriers to providing sensitive and respectful service to survivors or women in crisis.

### Understanding prejudice and bias

Prejudice is an unjustified or incorrect attitude (usually negative) towards an individual based solely on the individual's membership of a social group, such as race, religion, language group, sect, gender, etc[2]. For example, in the Pakistani society many people hold a prejudice against women (known as sexism) or certain women, namely those who do not conform to societal expectations of femininity.

Bias is an inclination of looking at, behaving towards or feeling towards someone based on a personal and sometimes irrational judgment.[3]

Think about how a worker's interactions with a survivor may be affected if s/he is prejudiced or biased against women generally or women of a certain kind.

### Test your knowledge and attitudes: Myths and facts about GBV

MYTH: Men are naturally violent, it is part of their biology

FACT: No one is born violent, or with violence as part of their biology. Violence is a learnt behaviour.

MYTH: It is always in a woman's best interest to reconcile with her husband.

FACT: Living with violence is in no one's best interest. The effects of violence on a woman can be severe and has implications for the whole family's wellbeing, including the children. In many cases when women reconcile with their violent husbands, they suffer even more severe abuse and can even be killed.

MYTH: After mediation and apology, a violent man will change his behaviour

FACT: While violent men often feel remorseful about resorting to violence in order to achieve their ends, this does mean they have changed or are ready to give up the power they have within the relationship. A violent man may try to "buy back" his partner after a violent incident by being loving and apologetic, but this does not mean that he has changed. A change in violent behaviour is rare and can only happen after serious and genuine self-reflection and attitudinal change such as through therapy.

MYTH: Survivors of violence may be partly to blame for the violence they experience.

FACT: It is widely believed that violence occurs because of some behaviour or failure on the part of the survivor. Women are blamed for provoking men emotionally or sexually and inviting anger, aggression or sexual

1 WHO. (2014). *Violence against women: intimate partner violence and sexual violence against women fact sheet.* Available: https://apps.who.int/iris/bitstream/handle/10665/112325/WHO_RHR_14.11_eng.pdf

2 Simply Psychology. (2008). *Prejudice and discrimination.* Available: https://www.simplypsychology.org/prejudice.html

3 Psychology Today. (2020). *Bias.* Available: https://www.psychologytoday.com/intl/basics/bias

assault. This victim- blaming shifts responsibility of the violence from the perpetrator to the survivor, ignoring the fact that the perpetrator is an adult with the capacity to reflect, decide right from wrong and regulate his behaviour, and is therefore entirely responsible for his violent behaviour. Violence is not an acceptable way of expressing one's emotions, no matter what the circumstances. Nobody asks for, or deserves to be, abused. The responsibility for the violence rests entirely with the perpetrator.

MYTH: GBV is predominantly a lower-class phenomenon.

FACT: Lack of accurate statistics cannot reflect the distribution of this problem. Workers may assess that violence is a problem for working class people because women in families on lower incomes are more likely to come to the notice of helping agencies. Middle class women are less likely to seek assistance because they fear personal embarrassment. While socio-economic factors such as unemployment, poverty can be predisposing or triggering factors in some cases, they are not actual causes. The problem of GBV is about the gender and power imbalance in society. It is about men's socio-political control and its maintenance through force and violence. This violence continues to occur because of women's powerlessness/low status in the family, their inability to retaliate and the society's expectations. These factors cut across all classes in a patriarchal society.

MYTH: Persons who rape are sexually frustrated and do it because they have no other sexual outlet.

FACT: Studies indicate that rape is not actually about sex or sexual frustration. It is about power. Rapists are often married persons or in relationships with other men or women and have active sex lives. They rape not to satisfy their sexual urges, but as a way to disempower, insult, humiliate, put down and assert their power and superiority. Some show their power physically, some emotionally and some sexually. Rape combines all three forms.

MYTH: If there are no visible signs of violence on the victim's body it means that she has not been raped.

FACT: A lack of physical signs of battering or struggle does not at all mean that the victim was willing to participate in the sexual act. It is typically emotional and not physical force that is used in rape. At times, the immediate threat and terror of being raped emotionally and physically weakens the victim to such an extent that she is unable to resist and thus there are often no physical signs of battering or a struggle.

MYTH: Women often make up stories about being abused/raped.

FACT: Reporting something as sensitive as abuse in the family or a sexual crime is very difficult for a woman in the Pakistani society because of societal taboos, notions of family privacy and the response of the system. No woman enjoys going to police stations, having to talk about being harmed by family members or about sexual violence, repeating the story again and again in front on the police, lawyers, courts, undergoing invasive evidence collection procedures, listening to remarks people make about them, seeing how people look at them and the longer-term, social impact of it all. It is a highly distressing, sometimes even traumatising and humiliating experience to go through. It is hard enough for a woman to decide to go through this process when she has been through some form of GBV and when she knows that she may not even get justice – so it is extremely unlikely for a woman to make up a story about this and put herself through this.

## TRAINING SUGGESTION MODULE 2: GBV AND ITS CONTEXT

Module 2 Objectives

By the end of Module 2, participants will be able to:

- Define GBV and identify the types most prevalent in Pakistan
- Define the common types of GBV
- Identify the features of survivors of GBV
- Identify the potential reactions and impact of GBV on survivors
- Understand the role of gender and power in GBV and its dynamics
- Define gender, and differentiate between gender and Sex
- Understand the dynamics of gender socialisation, its roots, channels of transmission and link with GBV
- Clarify myths around GBV.

Facilitator notes: Module 2 is an essential section of the training in that it focuses entirely on helping participants understand GBV in depth – its types, dynamics, root cause, impact – and to clarify for themselves the many myths, misconceptions and biases that surround GBV, its survivors and perpetrators. This understanding is critical for case-workers and managers and anyone interacting with survivors, and forms the basis for quality support in case management. Facilitators will need to try and ensure that there is plenty of time for discussion, that participants are comfortable asking questions and expressing disagreement in order to ensure that all questions regarding GBV, gender, survivors are answered and clarified.

### Session 1: Understanding GBV

Topics/methods:

- Forms of GBV – brainstorming, group work on violence across the life span, presentation
- Dynamics and domains of GBV – presentation, discussion, group work

### Session 2: Impact of GBV

Topics/methods:

- Immediate reactions – discussion and brainstorming
- Short/long-term impact (health, psychosocial, societal) – case study and discussion

### Session 3: Understanding Gender

Topics/methods:

- Gender versus sex – group work and presentation
- Role of socialisation and gender expectations – small group self-awareness exercise, presentation
- Being an ideal/good woman/real man – group work and discussion

### Session 4: Roots of GBV

Topics/methods:

- Social messaging, transmission and link to GBV – large group exercise (tree chart)

### Session 5: Power

Topics/methods

- Types and sources of power – case study, brainstorming and discussion
- Link of power with GBV – role play and discussion

### Session 6: The role of Attitudes

Topics/methods:

- Myths and Facts – large group agree/disagree exercise and discussion
- Biases and prejudice – brain storming, small group exercise and discussion

# SECTION THREE

# RESPONDING TO SURVIVORS

# SECTION THREE: RESPONDING TO SURVIVORS

Section Three covers the following:

- Essential services package
- Key services – roles and gaps
- Communication skills for support

## 3.1. Essential Services Package

In 2015, the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence, a partnership by UN Women, UNFPA, WHO, UNDP and UNODC, launched the Essential Services Package, aiming to improve access to a coordinated set of essential and quality multi-sectoral services for all women and girls who are survivors of GBV, particularly for low and middle- income countries. The package outlines the essential services to be provided by the health, social services, police and the justice system and provides guidelines both for core delivery and for the coordination between services and processes. The package comprises of seven modules:

Module 1: Overview and introduction
Module 2: Health essential services
Module 3: Justice and policing essential services
Module 4: Essential social services
Module 5: Essential actions for coordination and governance of coordination
Module 6: Implementation guide
Module 7: Guidance on estimating resource requirements for a minimum package of services

## 3.2. Key Services in Pakistan: roles and barriers

### The police

The role of the police in cases of GBV is critical. They are often the first responders in serious cases of violence when the survivor, her family or an unrelated person reports a crime. It is the responsibility of the police to take an accurate statement from the survivor, to register an FIR immediately and to begin investigations, evidence collection and documentation as soon as possible. There are police help lines and emergency numbers in all provinces, also specifically for cases of violence against women.

In addition to technical knowledge of and skill in obtaining information and starting investigation processes in a professional and effective manner, it is also the role of the police to ensure all interactions with the survivor are carried out sensitively and respectfully, upholding basic ethical standards.

In reality, however, extensive research and anecdotal evidence indicates that not only are police process often carried out unprofessionally, inefficiently and ineffectively (sometimes as a deliberate effort to sabotage and at other times because of inadequate training and supervision), but that police communication skills and attitudes with survivors are seriously lacking.[1] The following are some of the key findings from research pertaining to barriers that women face in both reporting and getting justice for GBV cases:

#### Personal/societal barriers to reporting GBV

- Stigma, shame
- Lack of awareness of rights, laws and procedures
- Pressure and fear
- Trauma
- Irregularities in remembering and/or changing important information such as dates, time and specific details of the incident which could hurt the victim's case

#### Structural barriers and gaps in the police system

- Police reluctance to intervene in cases of domestic violence, incestual rape or child marriage, or where the victims and accused are known to each other; suggestions at reconciling or entering into outside court agreements
- Registration of FIR contingent on police attitudes towards the survivor or the nature of the violence - reluctance or even outright refusal to register in some cases, for example if the character of survivor is seen as immodest, denial of marital rape, no obvious physical signs of violence or resistance to rape, a marriage, (even if a minor or forced) has taken a place, survivor has a criminal history or a history of sex work or has had a relationship with the perpetrator, a woman from a religious minority has accused a Muslim man
- General bias towards women, but especially if seen as deviating from the norm (e.g., divorced, in an unmarried relationship, perceived as being too independent/modern, too confident or friendly, from a minority group, etc; manifested as victim blaming, shaming and sexist questions and remarks
- Investigations are dropped because the accused are declared 'absconders'
- Lack of knowledge on laws (especially new legislation or amendments) pertaining to domestic violence, rape, child marriage, etc.

1 Legal Aid Society. (2012). *The criminal justice systems and rape: An attitudinal study of the public sector's response to rape in Karachi.*

- Widespread belief that women fabricate stories of violence as revenge, for financial gain or to save own reputation, especially if survivor does not fit societal perceptions of a real victim (e.g., powerless, physical signs, visibly distressed, perpetrator is a stranger, etc.); therefore, survivor credibility is questioned
- Continuous, aggressive and irrelevant interrogation
- Attempts to mediate a financial settlement between the survivor and the accused, rather than following through with investigation and arrest
- Destroying important pieces of evidence, adding fake details in order to unfound case
- General demeanour and behaviour with women humiliating and traumatising
- Cases withdrawn because of hostile or humiliating police attitudes; sometimes withdrawal is encouraged by the police by deliberately creating hurdles and stress
- Pressure to clear cases resulting in unfounding charges that are complex or ambiguous
- Significant delays in processes and procedures, resulting in weak cases
- Important information (dates of evidence collection, tests, age of the survivor, etc.,) is inconsistent or missing from files
- Survivors rushed through the FIR writing process, resulting in important details being omitted
- No support offered to distressed survivors during the reporting process
- No concept of a psychological assessment or report of the survivor
- Female police officers are absent during the registration of the FIR (which is stipulated)

## The Medico-legal system

The weight of justice for a survivor often rests on the quality of the medical evidence that is collected, documented and presented in court. Research clearly shows that a large majority of verdicts rely heavily on the medical examination and the evidence that is extracted from the body of the survivor and the accused, if needed, especially in cases of sex crimes.

It is the role of all those involved in medical examinations, especially the Medico-Legal Officer (MLO), to ensure that a medical examination is done as soon as a survivor is brought in, that the survivor's respect and dignity are maintained, that the most effective and up-to-date techniques are used for the examination, to collect evidence and to document the findings as accurately and as in much detail as possible. The MLO's job is to look for and document all the evidence and to base his/her report on that alone and not on personal opinions and speculations about the survivor's life style or character.

Again, in reality, the medico-legal part of the investigation falls short on each of these accounts. Old age procedures are relied upon, facilities are limited and biased attitudes towards women run high. Following are some of the key issues in the medico-legal area: [1]

- Significant delay in medical examination
- Insufficient medical evidence collection
- Reliance on virginity testing (two-finger test, presence/absence of hymen) in rape cases – the two-finger test is a scientifically inconclusive test and one which inherently violates the dignity of the victim
- Over-reliance on physical evidence (bruising, injury, signs of resistance, presence of semen, etc)
- Limited use of DNA testing
- Prosecutors not involved in investigation
- Lack of official SOPs to guide relationship between police and prosecutor, to allow them to aid each other in a timely and efficient investigation
- Severe lack of female Medico Legal Officers (MLOs) throughout the country, and even fewer in night shifts
- Lack of basic facilities and requirements, such as adequate lighting, examination tables, separate bathrooms/changing rooms, gloves, slides to collect samples, speculums, sterile swabs, bandages, saline solutions, blood tubes, containers, etc.
- Lack of training for MLOs
- Valuable, sometimes critical evidence not collected or documented properly at all, such as evidence from the place of the crime, from the survivor's evidence, bed sheets, witnesses, call records, geo-tracking, etc.
- No emotional support offered to survivors during the difficult and uncomfortable medico-legal evidence collection process
- Biased or unprofessional language being used in writing medico-legal reports
- Evidence not stored in appropriate containers or at the required temperature

## The shelter

There are significant differences between government-run and private shelters. Essentially both services are meant to provide safe and decent accommodation for women (and their children) escaping GBV situations, for varying degrees of time which may range from the duration of case proceedings to a time when alternative shelter is found, and offer support for ongoing legal cases where needed.

1 Ibid.

Now a days, some shelters in Pakistan (especially private ones) offer additional support services such as legal aid, education, skill development, etc. In many government-run shelters; however, the situation is far from satisfactory, not just because of lack of funding and political will, but also because of lack of training and sensitivity on the part of shelter management and staff. The following are some of the key findings from research on shelters (primarily government-run), outlining barriers to women's wellbeing while at the shelter: [1], [2]

- Lack of funding
- Cramped facilities
- Strict rules, especially around mobility
- Poor facilities
- Lack of staff training and awareness
- Lack of gender sensitivity, biased attitudes in shelter staff, humiliating, aggressive treatment on the part of staff and management
- No post-shelter plans for rehabilitation, work or safety, no follow up
- Limited if any support for mental health and trauma
- Pressure to reconcile
- Having to leave behind older sons
- Some functioning like a detention centre – women feeling punished
- Quality of support services (legal etc) provided is questionable

## 3.3. Supporting survivors

As important as technical skills, procedures and structures are, the quality of care a survivor of GBV receives also depends significantly on the behaviour and communication of the professionals with whom she interacts. When the survivor approaches a worker, she will have a range of different emotional reactions and may behave in a variety of ways. She may appear frightened or nervous, she may be angry, she may be in shock. It is important to remember that the survivor is a woman who has been hurt (possibly more than once) by a man or men who could be strangers or part of her family or social system around her, and who are in a more powerful position than her, and she will find it hard to trust the workers because of the similarities, i.e., there are always more men at police stations or hospitals, everyone around her is part of a system or an institution, and more powerful than her. Whatever her fears and behaviour, the survivor is there because she needs assistance and has made the decision to put her trust in the professionals she has approached, and it is the professional's responsibility to interact with and treat their client in the best way possible. Ideally, a woman staff member needs to be available to deal with the survivor, but if this is not possible, all efforts should be made to, at the very least, have a female present at the time. All care must be taken to prevent sexual exploitation and abuse (SEA) [3] of the client in anyway and at any stage. Interpersonal skills and attitudes are an essential aspect of case management to achieve three key goals: to protect a survivor's basic human rights to respect, dignity and safety (both physical and psychological), to provide basic emotional support to the survivor in distress and finally to facilitate the effective implementation of processes and procedures which is influenced both by staff attitudes and communication as well as the emotional and mental health of the survivor. These goals are critical aspects of survivor care, the investigation and case management.

### Basics of communication

There are three main components of interpersonal communication:[4]

- Speaker (speech, tone, language, pitch, words, content, attitudes, body language, etc.)
- Listener (attention, understanding, attitudes, body language)
- Environment (location, noise, comfort, privacy, etc.)

Case workers will, at different times, play the role of the speaker (asking questions, providing information and support, etc.) and the listener (receiving a response, taking a statement, registering the FIR, obtaining information, etc.), and all actors will be functioning in a certain environment, whether a police station, a hospital, a shelter, the place of the incident, etc. Aspects of each component are critical to how effective the communication is.

When in the role of the speaker, workers need to be aware of what and how they are communicating with a survivor, the language they use, their tone, the meanings behind their words, their facial expressions and their body language. These are all ways in which we communicate our thoughts and feelings, including our opinions and attitudes (including our biases and prejudices) about the survivor and her story. Professional ethics demand that workers make a concerted effort to be aware of and to avoid their personal opinions or biases, show or influence their interactions with the survivor.[5]

1 Rozan. (2018).
2 Raazia Hassan Naqvi, Muhammad Ibrar, Christine Walsh. (2018). *History of Social Welfare and Domestic Violence Shelters called Dar ul Amans: A Case Study of Punjab Province Pakistan, Pakistan Journal of Criminology* Vol. 10, Issue 2 (94-106).

3 United Nations (UN). (2017). *Preventing sexual abuse and exploitation: policies and protocols.* https://www.un.org/preventing-sexual-exploitation-and-abuse/content/policies-and-protocols
4 Rozan, Strengthening women's centres.
5 Rozan. (2009). *Guidelines for the protection of dignity and rights of the survivors of violence.* Available: https://rozan.org/wp-content/uploads/2019/12/Guidelines-for-the-Protection-of-

How the survivor (as the listener) hears, perceives or understands what a worker is saying or the non-verbal messages being relayed to her (through the worker's language, tone, body language, etc.,) will shape the extent to which she feels comfortable and respected; physically and psychologically safe; and is able to recall and provide the information that is required. A survivor who hears words or implying, or picks up from the worker's tone or body language that she is being disbelieved, judged or humiliated may react in different ways, such as becoming more confused and anxious (in addition to already being distressed or in a state of trauma because of the violence), uncooperative or hostile, or she may back out from engaging with the worker out of fear or frustration. Not only would this increased distress damage the investigation, but such treatment is also a violation of her human rights and of the basic professional ethics to which all professionals are meant to adhere. On the other hand, a survivor who feels believed, encouraged and respected by the worker's words, language used, tone and body language, is much more likely to participate in an effective manner, to trust the service providers and to feel psychological safe and supported. This is also a basic human right and professional ethical requirement.

The same principle applies when professionals/workers (police, hospital or shelter staff) are in the role of a listener (while receiving a response or information). Even without words, workers can communicate their feelings, thoughts, understanding, attention and interest in several ways through their facial expressions and body language. Active listening is a skill that shows the speaker they have our full attention and that we are correctly interpreting or attempting to correctly interpret what they are saying. The following are common blocks to active listening[1]:

Interruption - constantly breaking the speakers flow by interrupting, questioning or giving opinions

Identifying – interrupting by telling another similar story that the speaker's story has reminded you

Mind reading – making the assumption that you already know that the person is about to say or is saying, and therefore not really making an effort to listen

Rehearsing – mentally rehearsing what you're going to say in response to the speaker, instead of actually listening

Glassy-eyed listening - looking at the speaker, but looking right through, blankly with one's mind somewhere else

Closed-minded listening - Not really listening to the speaker because of own prior biases, opinion on topic of conversation, etc. without wanting to keep an open mind

Listening without eye-contact, or with inappropriate body language - body language clearly showing that listening is not effective. Boredom, anger, disbelief, ridicule, disrespect, judgement, hostility, indifference, etc., can all be expressed nonverbally as a listener.

With self-awareness and practice, workers can learn to listen in ways which are more effective and show attentiveness, concern and sensitivity.

Finally, the environment within which the interaction takes place also shapes the quality of communication. The environment cannot always be entirely controlled, but efforts to make it as suitable as possible are still the responsibility of all the actors involved in case management. Environmental/contextual factors include:

- Physical aspects such as lighting, space, temperature, comfortable places for sitting/lying down, noise, etc., and
- Socio-emotional factors such as privacy, other people in the room (e.g., is it only men?) and their behaviour, the culture of the work space, power differences between the people communicating, the survivor's comfort, etc.

Body language and tone are particularly important when interacting with someone who has been through a traumatic situation. The survivor will already be in a vulnerable position and feeling powerless. These fears, combined with the intimidating behaviour by a worker, e.g., standing too close to her, towering over her or speaking too loudly or harshly, or having a man talk to her can have the effect of making her feel threatened or angry or confused. This can make the process more difficult and less effective as fear can affect the following:

- memory (she may become confused about details)
- trust (she may not want to disclose all the details out of fear, her story might change, etc.)
- willingness to engage (she may become aggressive or quiet or withdrawn)
- trauma (she may become more distressed and even develop physical symptoms such as trembling, breathing difficulties or fainting, etc).

It is important for workers to reflect on each of these components and to ask them themselves if the best possible communication is taking place – is their tone, body language and questions helpful or unhelpful? Are they

1 DS Psychology Group. (2013). *DS Psychology Group Resources: Blocks to listening.* Available: https://dspsychology.com.au/blocks-to-listening/

making the survivor comfortable or intimidating her? Are they listening with full attention and with a genuine interest to understand and solve the case? Are they aware of their biases and able to put them aside for the conversation? Have they ensured to the maximum extent they can that the environment is suitable and comfortable for the survivor (a woman, a young girl) to walk into and be able to talk about her experiences or would it scare or humiliate her or want to make her withdraw? Are there female professionals who can lead or support the interaction?

## Do's and Don'ts

The initial responses of the worker (police, lawyer, shelter staff, hospital staff, etc.) to the survivor set the tone for the relationship and for the quality of the communication that takes place afterwards. The main job of the case worker at this point is to facilitate communication and encourage and empower (give power to) the survivor to feel as much as at ease as she can under the circumstances, to feel that she has done the right thing by reporting the violence and to speak about it, both for the purposes of the report and investigation and for her own mental wellbeing. The following are some things to say (and communicate non-verbally if possible) during your interaction that help communication:[1], [2]

### DOs

- DO appreciate her for reporting the violence, for example, "It was brave of you to come here/report this/continue this process"
- DO explain your role and the process to the survivor, e.g., "My role is to help you with….", "What we will be doing now is…."
- DO show that you understand. "I understand that this is difficult for you to do/talk about"
- DO ask questions gently (both open-ended and closed-ended). "How did you feel when he said that to you?", "Can you tell me what made it hard for you to get out of the situation?" "Can you remember what happened just after this?" Did this happen before or after…?" "Were you children there when this happened?"
- DO ask for elaboration, clarification. "Could you tell me whatever you remember about what happened?" "And what happened next?
- DO show genuine concern and empathy. "I am concerned that you are too scared to give me all the information."
- DO assess risks (health, security, children, shelter, etc.).
- DO give important information that is needed (crisis services, immediate health check needs, etc.).
- DO allow silence, pauses
- DO empower the survivor by encouraging her to take decisions, etc. "What would you like to do about this?"
- DO show support. "I am here to help you."
- DO give the survivor space and time. e.g., "Are you ready?" "Do you need a few minutes to relax?" Do you need more time think about this? You can take some time and remember what happened."
- DO give the survivor full attention and listen closely to survivor concerns.
- DO validate the survivor's feelings and normalise. "Many women who go through experiences like yours feel this way. It's natural to feel angry/scared right now."

### DON'Ts

- DON'T push too hard too soon: "Hurry up and tell me what exactly he did." "Do you want to tell me what happened or not?"
- DON'T doubt what the survivor is saying, e.g., "Are you sure this happened?"
- DON'T asking blaming questions. "Why didn't you tell anyone sooner?" "What did you do to make him so angry?" "What were you doing out at that time?" "Why did you keep screaming?" "What did you expect after that?"
- DON'T judge survivors. "How can you not remember how it started?"
- DON'T try and solve the problem without following due process
- DON'T express shock or horror at the survivor's story. "Oh my God! How could someone do THAT?"
- DON'T criticise the survivor's abuser, offender, etc. "What a terrible father you have!"
- DON'T give the survivor false hopes and reassurances. "Don't worry…. everything will be fine."
- DON'T pity the survivor or make her feel helpless. "Oh you poor thing! That's completely shattering!"
- DON'T negate the survivor's feelings. "There's no need to feel so angry about that."
- DON'T give advice (unless it is specifically your job to do so – e.g., lawyer) or tell the survivor what to do or pressurise her to make a decision.
- Don't get too emotionally involved with the survivor – you are not her sibling, friend, parent, spouse or teacher. You are a professional/an advocate, who must maintain a professional relationship to support her through a difficult process and

## Ongoing emotional support

Once the workers' immediate or initial conversations are done, they will need to decide how much more support they need to or are in a position to offer. Their job may simply be to support enough to get the information or evidence they need and to ensure they do not cause further distress or they (shelter staff for example) may need to continue to offer some level of emotional support.

Workers are not professional therapists or counsellors, but they can use some of these skills to provide support and relief to the survivors in their care. The following are some basic principles and techniques for emotional support:

## What is emotional support/counselling?

Counselling is a client-centred, interactive communication process in which a person supports the other by:[1]

- reducing emotional suffering and distress
- expressing their feelings and talking about their difficulties
- making informed decisions about their personal behaviour
- working towards their own wellbeing and decisions.

Specific objectives of emotional support provision are to create and sustain an atmosphere of:

- Safety
- Calmness
- Connectedness
- Recovery and resilience
- Self-efficacy and self-confidence
- Hope and motivation
- Empowerment
- Empowerment, in fact, is a central goal of case management and emotional support. Whatever plan, decisions or actions are taken must be done in collaboration with the client and must reflect her wishes and choices. This is why counselling and support provision are about information and facilitation, NOT about giving advice. Advice does not work because:
- No one knows her circumstances as well as the survivor herself – so the worker's advice may not be right in the given situation and may result in worse outcomes for her
- Your advice will be based on the worker's values, beliefs feelings and choices, not the survivor's; and
- The survivor has the right and the responsibility for making the choices about her life
- The survivor is the one who will have to live with the consequences of her decision, not the GBV worker
- Giving advice does not teach the survivor how to deal with situations and is likely to keep her dependent on the workers and others
- Thinking through a problem, identifying solutions and making decisions empowers a client to have control over her choices

## Stages of emotional support provision

Stage 1: Welcoming and building a relationship

The goal of this step is to establish a relationship with the survivor by putting her at ease and building her trust. These include greeting, being genuine, empathising and accepting.

Stage 2: Gathering information about the survivor's situation

The goal of this stage is to learn about the survivor's "story". The survivor helps the client to talk about her problem, explore her feelings and reflect on her situation through active listening, sensitively questioning and probing, focusing, affirming, reflecting, correcting misconceptions and summarising, etc.

Stage 3: Helping the client to make a plan and closing through engaging in problem-solving, evaluating options, developing an action plan, closing and supporting through follow-ups where possible.

## Techniques for emotional support during Case Management

Fundamental helping techniques used in counselling are:

### Making the survivor comfortable

The setting in which you talk to a person with emotional difficulties is important. It is not always possible to arrange an ideal setting, such as a private room, but some points are important to consider. For example, is the space friendly? Is it private? Is it safe? Will it make an already distressed person feel comfortable? Is it free of constant disturbances? If a private room cannot be arranged, case worker may consider such place where some calm and privacy can be attained.

### Building trust

One of the first tasks of helping people emotionally is to develop a rapport and a trusting relationship with them. People going through emotional difficulties and crises are often confused and unsure of who to trust and turn to for support, of what to talk about and what to hide. Even once they have taken the difficult decision to seek support, they may be unsure of how to proceed. Case workers are not automatically trusted.

1 Rozan. *Ensuring quality and ethical response in cases of violence against women.*

Therefore, at the beginning, the case worker will need to play a reassuring role.

Ensuring the survivor of confidentiality is crucial to trust building and to the case worker-survivor relationship. The case worker will also need to show that s/he is taking care of the survivor's privacy. It is, therefore, important to try and arrange a setting that is safe and private.

### Active and reflective listening

Good listening is one of the key techniques used in counselling. Often case workers will find that people will come to them simply to be listened to attentively, to be able to have the space to talk about their feelings and concerns without being judged, advised or interrupted. This alone can sometimes make people feel better. The process of good, active listening can be highly empowering for survivors and can help them identify, reflect on, analyse, think through and find ways of dealing with problems on their own. Even when the problems identified by the survivor require active input from the case worker, simple, genuine and attentive listening is an invaluable first step. Active listening includes listening with your ears, your mind and your body.

A technique used in active listening is often called "reflective listening", which involves two tasks:

- listening to, and identifying, the sometimes-hidden feelings behind the speaker's words and
- combining the feeling the listener has picked up with some of the words (key message) the speaker is conveying and saying it back to the speaker, as his/her impression of what s/he has just said.

For example, a young girl says to the worker, "I don't know what to do, everything is gone, and I don't know how to get my life back together". The worker's first task is to identify the feeling behind the speaker's words. Helplessness seems to be the strongest feeling here (because she says, "I don't know what to do…"). Now the listener turns into the speaker and combines the identified feeling with part of what the speaker has said and says it back to her as a reflection in the following way:

"It seems to me that you are feeling helpless because you feel everything is gone and you don't know how to get it back together."

Reflective listening helps the case worker understand how the speaker is really feeling and the speaker to feel understood. Since the listener is not judging, interrupting, questioning or giving advise – simply reflecting what the speaker has just said, it gives the speaker a chance to think about and mentally clarify her own feelings and to then talk some more.

Reflective listening in itself is a very useful technique and sometimes is almost all that is needed. However, even when more active participation is needed by the worker (such as helping the survivor make decisions or deal with difficult issues), reflective listening is still a very important tool to use as a first step. Once feelings have been clarified and the survivor has had a chance to talk and openly express her/himself through reflective listening on the part of the case worker, the worker can then gently guide the survivor towards managing the problem.

### Validation and normalisation

Validation is the communication of respect for the speaker, which involves the acknowledgement that the other's opinions and feelings are legitimate. For a survivor it is extremely important to hear that s/he is not saying something that is bizarre or abnormal, that her/his feelings are acceptable and normal under the circumstances. An expression of understanding and acceptance from the case worker can go a long way in reassuring a survivor and giving her/him the confidence to talk and work through issues. Some examples of validation and normalisation follow below:

- Yes, I understand.
- I understand it is difficult for you to talk about this.
- I feel it was very brave of you to come to our centre.
- Many people feel helpless when confronted with a situation such as yours.
- It is not unusual to feel angry in this situation.
- It was a frightening thing that happened to you.

## Showing genuine concern and support

For healing to take place, it is important that the survivor be given the message that the case worker genuinely cares about her well-being. Genuine concern is different from emotional involvement. Whereas emotional involvement on the part of the case worker can be harmful, genuine concern and positive regard can inspire confidence and motivation to improve one's own situation. Even under normal circumstances, we feel we can open up more to people who genuinely care about us, but when people are distressed and traumatised, this genuine concern becomes even more important. Concern can be communicated through the case worker's body language, behaviour and tone as well as the words s/he uses. Some ways of showing concern are:

- Active listening
- Good eye contact, appropriate facial expression and gestures (e.g., nodding from time to time)

- An active interest in trying to help the survivor and in giving ideas (e.g., "Let me see if I can find a place for you to learn a skill.")
- Direct statements showing concern (e.g., "I am concerned about you")
- Checking back to see if the support the worker is providing is helping, (e.g., "How helpful did you find the discussion we had last time?")
- Showing support (e.g., "I would like to understand your situation better and to help you make decisions about what you would like to do", "Whatever you decide, I am there to listen", etc.)
- Giving space

People talk, express, grieve, analyse, make decisions at their own pace. Pushing the person to talk and move on is not helpful. Case workers need to be patient and calm, allowing the survivor to talk when s/he is ready. Gentle questioning at appropriate times can be helpful, but aggressive and excessive questioning can sound like an interrogation or a judgment. Silences, pauses, time for crying are all okay. Workers can reassure the survivor that this is her/his time and that s/he can take it at her/his own pace by saying things such as, "This is your time and space and we can talk whenever you're comfortable. It's all right if you don't want to talk right now".

### Helping emotional expression

One of the most effective healing techniques in providing emotional support is to facilitate the process of healthy emotional expression. How and to what extent survivors express emotions will vary from person to person. Some people are more cautious or emotionally blocked than others. Case workers can use various techniques to help people express themselves:

- Giving them time and space
- Assuring them of confidentiality
- Reassuring them that emotions and crying are okay
- Validating and normalising
- Empathy
- Specific techniques such as writing, role plays or art followed by a discussion

However, the more critical aspect of emotional expression emerges when survivors do begin to openly express their emotions. This then requires that the case worker is able to deal with the emotions that come out. This means being comfortable with the emotional expression, even if it is intense. Case workers who are uncomfortable with intense feelings or with crying are not in a position to support distressed people. It is therefore essential that case workers themselves have been through a process of both emotionally expressing and listening to others' emotional expressions before they can work with survivors.

### Giving the survivor space to express emotions openly

When feelings do come tumbling out, workers need to be able to allow them to come out in their own way. Some survivors may cry, some may scream and shout, some may simply want to talk. As long as the survivor is expressing her/himself in a safe manner, the case worker will need to reassure the survivor that her/his feelings and her/his expression of them is okay. Often simply being able to express feelings safely and being listened to is healing in itself. Many survivors want and need only this and feel an immediate sense of relief after they have talked. Letting out intensive feelings allows many distressed people to move on and deal with their day-to-day life.

### Identifying ways of managing emotions

Many survivors that seek support will need more than simply talking to a case worker. Once emotions are being expressed and the case worker has reassured the survivor that her/his emotions are normal and okay, s/he may need to help the survivor find ways of managing them in a healthy manner in the future. This is important as survivors who are overwhelmed by their experiences and emotions can sometimes get stuck in the emotional expression phase and may find it difficult to move on from there to more constructive action and coping. Here the case worker needs to be able to gently and gradually guide the survivor from emotional expression to learning simple coping techniques to deal with those emotions. Case worker need to be able to facilitate this process through questions such as "What can you do to feel better when you think about these painful experiences?" and then brainstorm with the client on some helpful ways (e.g. going for a walk, limit the thoughts to 10 minutes every day, exercising, etc).

### Providing emotional closure

At the end of a session, the case worker needs to ensure that the session ends on a positive and significant note. Leaving the survivor in an intensive emotional state or feeling lost or worse than before can be damaging. The case worker may need to end by saying something like, "You have done a lot of work today and have been brave and strong enough to let a lot of feelings out. I know that was difficult at times, but you did really well. Let's go over some of the main points we talked about today and about the ways in which you can deal with some of the issues you talked about".

### Empowering-helping people make their own choices

One of the most critical tasks of providing emotional support is to empower the survivor – in other words, to give the survivor the power to make her own decisions, move at her/his own pace and be able to cope with difficult situations in the future. Even with the best of intentions, actions such as imposing one's own decisions or opinions on the survivor, making decisions for her/him, telling her/him what to do, judging her/his actions or feelings, pushing her/him towards a certain direction, giving her/him constant advice or solutions, etc., are all disempowering rather than empowering. A case worker might mean well and want to genuinely help when s/he gives solutions to every problem the survivor identifies, but this does not give the survivor the tools to deal with problems in the future. Furthermore, it gives the survivor the impression that s/he is helpless and will always needs to go to the case worker for solutions to problems. Encouraging the survivor to think through, analyse and identify her/his own solutions on the other hand, gives the survivor all the power and control over her/his own life. It also allows her/him to practice and gain confidence in her/his own coping and analytical abilities. This confidence can help her/him deal with issues in the future. This does not mean that the case worker plays a completely passive role, in fact, the worker actively participates to help the survivor make her/his own decisions, especially in cases where s/he is feeling particularly helpless. Guiding questions such as the following can help survivors work through problems:

How do you feel about this?

What would you like to do now?

Can you think of ways which might help you feel better?

Which one of these options works best for you?

How did you cope with loss before? What was helpful?

You have identified three things you could do to deal with this. Let's look at each one separately.

What would happen if you did not take this option?

Are there other ways you can identify of keeping yourself safe?

### Stroking

Stroking refers to praising the survivor for taking constructive action. Distressed people are often unsure of their own abilities. Stroking them is a form of encouragement, reassurance and reinforcement, thus enhancing their self-confidence and sense of self-control. Every little step that the survivor takes in a positive direction is worth acknowledging through statements such as, "Well done! I can see that you're working very hard on this".

### Empathising

Empathy, or an understanding of the situation from the survivor's point of view, is a very important skill for the case worker. Empathy is different from sympathy, which involves an element of pity. Sympathy can be disempowering as it places an immediate distance between the listener and the speaker and gives the message that the survivor has been through something unique, something that the listener cannot comprehend. Empathy, on the other hand, has an empowering message within it: that the worker is with the survivor, that s/he is trying to look at things from the survivor's point of view and that s/he understands. This does not mean that the listener's feeling is trivialised as something that everyone goes through, but that the emotion is understandable and natural and not something extraordinary and strange.

### Asking helpful questions

All of the above examples show how effectively gently questioning can help survivors think through their issues and work towards improving their situations on their own. Both open- and closed-ended questions can be helpful, but open-ended questions allow more space to the survivor to reflect and come up with her/his own responses. Therefore, open-ended questions such as "How did you feel when that happened?" are better than "Were you angry?"

Ask questions that allow for elaboration and clarification, such as, "Could you tell me a little bit more about why you felt angry at that time?"

Questions can also help survivors think through and come up with their own solutions, such as, "Who are the people you can go to for help?"

Questions about coping techniques the survivor has used successfully in the past can help her reflect on and re-use those techniques, such as "What usually helps when you feel this way?"

### Helping establish safety

Once basic trust has been established, the worker needs to ensure that the survivor feels safe when with the worker and that safety precautions are also put in place for when s/he leaves. In a crisis situation (e.g., severe domestic violence) this is critical. A worker needs to establish the survivor's safety situation fairly early on in the relationship and then help her identify both short - and long-term ways of keeping herself safe. The case worker can help the survivor develop a crisis plan, which can include

crisis phone numbers, contacts, immediate safety measures, contacts for shelters, etc. The following are examples of statements and questions that can facilitate this process:

Do you know about/can I tell you about some services that can help?

Who are the people you can go to when there is a crisis?

Let's try and list down all the things you can do when this happens.

**Working through**

Providing support requires, in addition to being an active listener, active participation in terms of helping survivors work through problems, analysing them and identifying possible solutions. This process involves several components:

**Clarifying**

So, let me see if I understand you correctly….

So how did you feel about that…?

My role here is to help you make your own decisions.

It's okay to cry.

Anger is a normal emotion.

**Summarising**

So, what you're saying is….

So, what we have talked about today is….

So, what bothers you about your relationship with your husband is….

So, the main issues you are concerned about are….

Let's go over this again – what you can do to raise your self-esteem is….

**Analysing and interpreting**

Why do you think that happens?

What does this mean to you?

Why does this affect you in this way?

**Identifying**

How does that make you feel?

What do you do when you feel stressed?

What makes you angry?

What kind of things can you do to stay safe?

Who are the people you can turn to for support?

Would you like me to give you a list of services in your area?

**Prioritising**

There are a number of issues you have identified. Which one do you think is the most important?

From what you have told me, it seems like the main issues are….

It seems to me that the first thing we need to establish is how you can be safe.

**Providing information**

Providing information on a number of issues - disasters, services, effects, emotional difficulties, coping, resilience and recovery – is an important role to be played by case worker. For this reason, case workers need to have a good understanding of all the different ways in which disasters can affect people and entire communities. They need to understand the fundamentals of recovery and resilience as well as of psychological difficulties and disorders, and to communicate these to people in clear and simple terms.

## Emotional support in a crisis case

A crisis is a perception of an event or situation as an intolerable difficulty that exceeds the person's resources and coping mechanisms.[1]

People are in a state of crisis when they face what they see as a serious obstacle to important life goals –an obstacle that for a certain time cannot be dealt by methods we generally employ to solve our day-to-day problems.

Characteristics of a crisis are:

- Presence of both danger and opportunity: danger because it can overwhelm the individual to the extent that he/she can become homicidal or suicidal; opportunity because the nature of pain the crisis induces is such that it forces the person to seek help;
- Complicated symptomatology: a crisis is not a normal situation or state of being, and people's behaviour and reactions can be unpredictable in a crisis situation, which

1 Smith, H. B. (2006). *Providing mental health services to clients in crisis or disaster situations.* In G. R. Walz, J. Bleuer, & R. K. Yep (Eds.). *VISTAS: Compelling perspectives on counseling*,.(2006) (pp. 13-15). Alexandria, VA: American Counseling Association.

can be complex tangled in difficult relationships and risks
- Causes extreme anxiety: This anxiety can be debilitating initially but crises also force people to act and can thereby facilitate growth and change.

### General guidelines for crisis intervention

- Remain calm and stable and encourage the client to express his/her feelings
- Allow the client full opportunity to speak
- Try to determine the type of crisis; what caused it and how severe it is
- Deal with the immediate situation rather than its underlying, unconscious causes that may be left for later
- Help the client break down the problem into smaller parts and identify which parts of the problem that he/she can do something about. Help him/her to set realistic goals
- Stay focused on the basic practical issues and immediate needs.

### Basic steps of crisis intervention

- Listening: attending, observing, understanding, and responding with empathy, genuineness, respect, acceptance, non-judgment, and care
- Defining the problem: exploring and defining the survivor's problem and immediate needs and risks from her point of view, using active listening including open-ended questions, and attending to both verbal and non-verbal messages
- Ensuring survivor safety: assessing gravity, criticality, immobility or seriousness of threat to client's physical and psychological safety; assessing the survivor's internal feelings as well as the situation around her; ensuring the client has support available so she does not engage in impulsive, self-destructive actions such as self-harm, suicide etc.
- Providing emotional support: directly communicate support and reassurance, through words, body language, tone should be caring, positive, non-judgmental, acceptance, etc., taking action to intervene and ensure survivor has support and safety mechanism in place.
- Examining options: assisting the survivor in exploring choices, prioritising and making her own decisions; facilitating the search for immediate situational supports, coping mechanisms and positive thinking
- Making plans: supporting the survivor in developing a realistic short-term plan that identifies additional resources and provides coping mechanisms (the plan has to be concrete and one that the survivor understands and owns).
- Obtaining a commitment: help the survivor commit herself to definite, positive action steps that she can own, accomplish and sustain.

## 3.3. Human rights, the Law and GBV

### Human rights

Gender-based violence was first recognised in human rights law in 1992 when a report by the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) clarified that GBV against women is a form of discrimination and is therefore included in the scope of CEDAW.[1]

Gender-based violence violates several women rights such as the right to life, the right to equal protection under the law, freedom from torture, degrading and cruel treatment, the right to equality in the family and also the right to the highest standard attainable of physical and mental health.

### GBV and the Government of Pakistan

According to the Constitution of Punjab, there can be no discrimination on the basis of sex alone and the State may take any steps to protect women and children.[2]

### The Pakistan Penal Code, 1860

The Pakistan Penal Code (PPC) is a penal code for offences charged in Pakistan. Whereas the PPC covers the majority of criminal offences; recent pro-women laws have focused on making amendments in the PPC.[3]

Offences covered in the PPC include (but are not limited to):

- Physical harm of any sort (illegal touching, violence and abuse)
- Wrongful restraint
- Assault and criminal force against a woman with intent to strip her of her clothes or outrage her modesty
- Forced abortions and miscarriages
- Mental harm
- Trespass of all types and criminal offences committed during trespass
- Unnatural offences

1 CEDAW. (1992). CEDAW General Recommendation No. 19: Violence against women. Available: https://www.refworld.org/docid/52d920c54.html
2 Punjab Commission on the Status of Women, Government of Punjab (2015). *Women's rights/laws*https://pcsw.punjab.gov.pk/womens_rights
3 UN Women Asia and the Pacific. *Legislation on Violence against Women and Girls.*https://asiapacific.unwomen.org/en/countries/pakistan/evaw-pakistan/legislation-on-vaw

- Exchange of women for purposes of settling a dispute
- Assault
- Kidnapping and abducting children and women
- Human trafficking
- Depriving a woman of her inheritance
- Murder
- Deceiving a woman in affairs relating to marriage
- Forced prostitution
- Attempted offences (including aiding and abetting)
- Honour killings
- Wrongful confinement
- Forced marriages
- Marriage to the Holy Quran

### The key laws aimed at safeguarding women's fundamental rights to dignity and safety include:[1]

- Child Marriage Restraint Act, 1929; Foreigners Act, 1946 and Foreigners Order, 1951;
- Muslim Family Law Ordinance, 1961; Dowry and Bridal Gifts (Restriction) Act, 1976;
- Anti-Terrorism Act 1997; Prevention and Control of Human Trafficking Ordinance, 2002; Criminal Law (Amendment) Act, 2004; Protection for Women (Criminal Law Amendment) Act, 2006; The Protection Against Harassment of Women at the Workplace Act, 2010; Criminal Law Amendment Act, 2010; Criminal Law (Second Amendment) Act, 2011; The Prevention of Anti Women Practices - Criminal Law (Third Amendment) Act, 2011; and Domestic Violence (Prevention and Protection) Act, 2012;

### National and International Commitments

- Universal Declaration of Human Rights - Pakistan is a member of the United Nations and is a party to the Universal Declaration of Human Rights 1948.
- Nairobi Forward-looking Strategies for the Advancement of Women - In 1985, Pakistan became a party to the Nairobi Forward-looking Strategies for the Advancement of Women.
- ICPD, ICESCR and ICCPR - Pakistan is a signatory of the ICPD (International Conference on Population and Development), ICESCR (International Covenant on Economics, Social and Cultural Rights) and ICCPR (International Covenant on Civil and Political Rights), all of which contain clauses with respect to gender equality.
- Vienna Declaration - In 1993, Pakistan recognised that "women's rights are human rights" in the Vienna Declaration and Program of Action.
- Beijing Declaration - Pakistan became a signatory of the Beijing Declaration and Platform for Action in 1995.
- CEDAW - In 1996, Pakistan ratified the Convention on the Elimination of All Forms of Discrimination against Women.
- GSP Plus Status - Pakistan was given the GSP+ status in the Generalised Scheme of Preferences by the EU. This is a scheme of tariff preferences which makes Pakistan's trade with EU conditional to an unqualified commitment for ratification and implementation of 27 international conventions.
- National Plan of Action and National Policy on Development and Empowerment of Women - At the national level, Pakistan undertook two commitments - National Plan of Action for Women in 1998 and National Policy on the Development and Empowerment of Women 2002.

### Specific Laws for the Protection of Women in KP

- The Khyber Pakhtunkhwa Prevention of Hindus Bigamous Marriages Act, 1946.
- Provincial Commission on the Status of Women established under NWFP Act XIX, 2009.
- Establishment of Commission on the Status of Women Act, 2009.
- Enforcement of Women Ownership Rights Act, 2012.
- Elimination of Custom of Ghag Act, 2013.
- The Khyber Pakhtunkhwa Senior Citizens Act, 2014.
- The Khyber Pakhtunkhwa Maternity Benefits Act 2013, amended by the Khyber Pakhtunkhwa Maternity Benefits (Amendment) Act 2015.
- The Khyber Pakhtunkhwa Lissail-e-Wal Mahroom Foundation Act 2015.
- The Protection against Harassment of Women at the Work Place Act 2010 (PAHWA).

1 Pro women laws.

## TRAINING SUGGESTION MODULE 3: RESPONDING TO SURVIVORS

Module 3 Objectives

By the end of Module 3, participants are expected to:

- Understand the role of the key first responders/ caseworkers, services for survivors of GBV
- Identify the gaps in these services that contribute to significant issues, re-traumatisation and lack of justice for survivors
- Identify the basic psychosocial conditions and support needs of survivors of GBV
- Identify the impact of bias in communicating with survivors
- Understand the importance of good communication when interacting with survivors of GBV
- Reflect on and improve their body language when communicating with survivors
- Identify key Dos and Don'ts of communicating with survivors
- Reflect on and improve their tone and language when communicating with survivors
- Reflect on and improve their listening skills when communicating with survivors
- Understand and apply skills to establish a rapport, show respect and encourage sharing by survivors to support them better emotionally

Facilitator notes: This module comprises of the main skill set needed for effective, sensitive and ethical support for survivors. The facilitator needs to be able to both explain (with relevant local examples) and role model supportive and respectful behaviour. The importance of body language, choice of words, tone and the environment in communication need to be emphasised to make the point that case management is not simply a set of processes, steps and procedures but is embedded within an ethical, empowering and humanistic framework.

### Session 1: Services – roles and gaps

Topics and methods:

- The police – brainstorm, group work, expert presentation
- The Medico-Legal processes – brainstorm, group work, expert presentation
- The shelter – brainstorm, group work, expert presentation

### Session 2: Empowerment and support

Topics and methods:

- Basic needs – large group discussion
- Defining principles of support and ethics - presentation
- Dos and Don'ts of supporting a survivor
- Communication skills for support provision – case studies, discussion and presentation
- On-going support – role-play, discussion and presentation

### Session 3: Human rights and Laws

Topics and methods:

- Human rights and GBV – brief presentation
- The Pakistan Penal Code and pro-women laws (Punjab and KP focused) – brief presentation

# SECTION FOUR

# CASE MANAGEMENT AND ITS PROCESSES

# SECTION FOUR: CASE MANAGEMENT AND ITS PROCESSES

Section Four covers the following:

- Setting up GBV case management
- Steps of GBV case management
- GBV case management flow chart
- Important policies and systems
- Information collections and data management
- Self-care for workers

## 4.1. Setting up GBV Case Management

Setting up formal case management service for GBV may not always be possible for services, but it is important to make a concerted effort to incorporate its features as far as possible into any setting in which some form of case management is being implemented. Key features of setting up include:

- Mapping of existing services (health, legal, police, shelters, help lines, NGOs, counselling, legal aid, financial support, etc.)
- Developing a relationship with the above-mentioned services
- Appropriate staffing – hiring staff equipped to deal with survivors of GBV and/or ensuring their capacity building (knowledge, skills and attitudes) in working with survivors; hiring female staff as much as possible
- Ensuring a security system both for survivors and staff
- Procuring basic resources for safe interactions with survivors (safe space, phones, security, etc.)
- Establishing safe and efficient methods for data collection and management
- Structures, policies and procedures

## 4.2. Steps of GBV Case Management[1,2]

### Engagement

Every work place and institution will have its own roles and requirements, but the following are some of the basic steps of case management for GBV:

### Introduction

Whatever their role, workers need to be open and approachable, to greet anyone entering their work space politely and respectfully, to introduce themselves and to create privacy if possible.

### Engagement

The kind of engagement needed will depend on the nature of their role. This may require asking the person what she wishes to do or responding to a crisis (e.g., police), providing information about the worker's or the centre/hospital's services (e.g., shelters, NGO, legal aid, etc.) or about upcoming procedures, forms etc., (e.g., for a medical examination). The following are the features of these engagements:

Listening to a survivor and assessing her needs: the worker needs to be able to answer key questions: Why has the person come for help? What has happened? What are her immediate needs? How does the client see the situation? What supports does the client have?

Providing information: - the worker will need to give the survivor all the information she needs in order to be able to make informed decisions (what to expect, the process, confidentiality and its limitations, how her file will be stored, etc.)

Rights information - the survivor also needs to know what her rights are through the process, what she can accept, reject, ask for, etc. She can, for example, ask for another person (a female if she wants) to talk to, etc. These rights can be given to her in writing or can be read out to her.

Assessment– it is important to understand the situation fully before planning. Assessment could include:

Obtaining more information about the client situation – age, family situation, current living situation, occupation, etc.

Assessing the risks involved (are there any immediate dangers related to her security, her family, her children, health, etc.) and what safeguards can be provided.

Evaluating available support in the family

Assessing the survivor's level of awareness of services, safety options, etc.

Assessing immediate health needs – medical examination for forensic evidence collection or treatment required.

Evaluating the survivor mental health (especially her memory, sense of reality, mental orientation, potential for self-harm or suicide, etc.) and readiness for the next steps. The worker can make a basic assessment of him/herself based on the survivor's behaviour, but it would useful to have a mental health professional make an assessment of her mental health.

Planning– together with the survivor, based on the services being

1 GBVIMS. (2017).
2 Rozan. *Ensuring quality and ethical response in cases of violence against women.*

offered, client needs and the assessment made, a worker will need to make a joint plan in collaboration with the survivor. This would mean patiently and sensitively explaining the steps and process to her including the implications of not complying. While the choice of whether or not to proceed is the survivor's, all efforts need to be made to ensure she understands the importance of each step. The plan could include:

- The next steps within the service, such as forms, fingerprinting, consent taking, etc.
- Referral to another service (medical, psychological, legal, shelter, etc.)
- Safety (or rescue) plans for the immediate protection of the survivor herself or for someone in the family (e.g., children)
- Implementation and follow up

Once the action plan has been made, the assigned worker will need to set up support mechanisms and ensure the survivor moves on to the next step of the process (and others on the team will need to liaise with the coordinator/manager). This may require contacting other services and sharing relevant information with them, ensuring the survivor is able to access them – on her own, by arranging transportation or having the service providers come to where the survivor is for their part of the work. They will also need to ensure the survivor follows up on the next steps and that the steps were implemented as required. The role of the case manager is critical here as s/he will need to coordinate with all the different services involved to understand their requirements, be able to communicate this to the survivor, to ensure these are met and that the steps are followed until the case reaches court or is resolved outside of court. A number of follow ups, both with the survivor and the relevant services, may be needed to ensure all services are functioning as they should and are working for the survivor.

During this process the survivor will need varying levels of emotional support to heal from the trauma of the violence and to deal with the ongoing case. Case workers can use the skills discussed earlier to provide basic support. Bringing in professional counsellors/therapists may also be considered, especially for survivors who are more distressed.

This is also the time to focus on empowering survivors by identifying the strengths and assets she has in order to cope with the consequences of her experience and support her in using these throughout the case process.

### Case closure

The case is officially closed when all steps have been completed, the survivor's needs have been met or her own (normal or new) support systems are functioning.

### Case Flow

The survivor is referred to the service (self-referred or through a service/worker

A case worker is assigned – meets with survivor, follows initial steps

(i) Client wishes to lodge an FIR

Arranges legal information to ensure client makes an informed decision

Case worker accompanies to the police (with other support if the client wants)

Accompanies through the investigation and medico-legal process

Arranges legal help

Assesses need for and arranges accommodation if needed (shelter)

Assesses need for and arranges counselling/mental health support

Prepares for and accompanies through court processes

Attends to additional needs such as medical help, ongoing counselling, child care, financial needs, income generation, etc.

Supports with social and legal needs – e.g., finding safe accommodation, divorce/custody, social support and income generation post court process

Ensures client rights are respected through the whole process

Follows up on all needs

(ii) Client does not wish to lodge an FIR

Arranges legal information to ensure client makes an informed decision

Assesses need for and arranges accommodation if needed (shelter)

Assesses need for and arranges counselling/mental health support

Attends to additional needs such as medical help, ongoing counselling, child care, financial needs, income generation, etc

Supports with social and legal needs – e.g., finding safe accommodation, divorce/custody, social support and income generation post- court process

a. Ensures client rights are respected through the whole process
b. Follows up on all needs

## 4.3. Policies and systems[1,2]

Given the sensitivity of GBV in Pakistan and the many barriers and risks associated with protecting and facilitating justice for its survivors, it is critical to have clear policies and protocols for case management, and to continually develop these with new learning from both global and local contexts. Available polices should ideally be available in writing for all to see and access when required and should also be part of staff induction and ongoing development. The first of these involves setting up a case management manager and team so everyone knows what reporting procedures are. Usually an NGO or advocacy group will take the charge of managing cases. Polices for their team should include systems for the following:

- Staff roles/job descriptions
- Maximum case load
- How cases are assigned
- Case management steps
- How 'high-risk' or crisis cases will be handled
- How to maintain professional ethics/how to deal with breaches
- Hiring of staff – key selection criteria for those involved in GBV cases
- Safety protocols for staff
- Special protocol for crisis cases
- Policy on defining and dealing with the sexual exploitation and abuse (SEA) or any other form of exploitation of clients
- Policy for referral procedure
- Information on important procedures, e.g., medico legal, examinations and registering F.I.Rs
- Policy for follow-up of cases that are ongoing and have been closed
- Procedure for assessing risks or harm to client/survivor and to the staff member
- Staff professional development

## 4.4. Data collection and Management[3]

Collecting and documenting data are an important part of any case management practice. It helps workers understand survivor situations better and to keep track of what was discussed. What kind of data collection and maintenance system is developed depends on a number of factors such as privacy and security mechanism at the work place, the kind of technology and technological capacity the work place has, time availability/staffing, etc. Confidentiality and privacy of information is critical in GBV cases in a country like Pakistan, not just because of basic ethics but also because of the risks involved in data leakages. The women reporting violence as well as the service providers can face violence repercussions from perpetrators and their supporters if sufficient care is not taken.

Data management strategies can include the following:

- If possible, paper copies of client files should be avoided or minimised as far as possible so that confidential information is not easy to access
- Putting client names on printed material and files should be avoided. Instead, codes or serial numbers can be assigned to clients (which can be tracked electronically)
- If it is necessary to have print out of names or other confidential and sensitive material, it should be stored in a safe place with only limited (preferably password protected) access
- All services should have a plan in place for destroying all information in the case of an emergency or evacuation.

Data collection tools can include forms for:

- Registration
- Consent
- Information intake
- Risk assessment
- Action plan
- Safety plan
- Meeting notes
- Referral
- Follow up
- Case closure

### Referral and information sharing[4]

Case management may involve a number of services, such as the police, shelters, health services, legal aid, mental health support, NGOs for case management and advocacy, etc. All services should have a comprehensive and updated directory of contact names and numbers for each of these for cross referrals and advice when needed. Relevant client information may also be shared between agencies. How this information will be shared—verbally, electronically or through a paper system—also needs to be agreed upon and appropriate procedures put in place to ensure that the confidentiality of the survivor is protected at all times. It is important to ensure that all the names on the directory are of individuals/services that are reliable, professional, tried and tested.

1 GBVIMS. (2017).
2 Rozan. *Ensuring quality and ethnical response.*
3 Ibid.
4 Ibid.

## 4.5. Managing cases during COVID 19 (and similar pandemics)

Humanitarian emergencies, such natural disasters, war/armed conflict and pandemics, present another unique set of challenges in responding to survivors of GBV. Not only do cases of GBV typically rise in such situations, but also reaching out to survivors and maintaining their access to essential services become fraught with logistical difficulties.

The current situation (COVID-19 pandemic) and its high rate of infection, requiring across-the-board social distancing (sometimes in the form of official lockdowns) created unprecedented challenges for survivors of GBV as services closed down or significantly scaled down their support. Services/workers have been forced to respond in one of the following ways at some point during their service provision:[1]

- Continuing face to face work observing all Standard Operating Procedures (SOPs), as part of an essential service or when rates of transmission are low
- Scaling down work (service not functioning at full capacity)
- Remote case management (online or over the phone)

Decisions about which modality to adhere to at any given times depend on a range of factors, such as:

- The severity and rate of transmission
- The type of national response to the corona virus, and government policies and restrictions
- Available resources (including technology, donor flexibility, staff decisions)
- Risks and perceived risks for clients and staff
- Location of services
- pandemic
- Organizational policies

Where face to face case management has continued, it must be ensured that all SOPs are being observed and facilitated while still ensuring the safety and integrity of the client. Space/distance constraints should not mean compromising on security in any way. Essential security protocols and staff should continue to function at all times.

Remote case management, on the other hand, poses a new set of challenges and considerations that must be kept in mind:[2]

When interacting remotely with a survivor

- Seeking clear consent for calls (audio or video), texts, time for calls, time available, etc.
- Ensuring the survivor has access to privacy or helping her gain privacy from wherever she is seeking help
- Providing crisis numbers
- Deciding on a follow up mechanism the survivor is comfortable with
- Caution when sending text messages and ensuring no information about the service is revealed
- Being alert to signs of safety or privacy being compromised (e.g., background noise, etc.)
- Assessing the full situation, safety and comfort level through questions such as: Are you comfortable talking right now? Do you agree to continue this talk now over the phone? Or do you prefer we schedule at a different time? Do you prefer a missed-call or text me when you are ready? Is this the right number to call on? Do you prefer for me to call any other alternative number/s? Are you taking the call from a room that can ensure privacy and confidentiality of the conversation? • Do you think someone might walk in during our conversation? What do you advise as the best action to do if this happens? • Ask again: Do you feel safe and have enough privacy for our conversation? • Are you fine talking now? (Ask for consent repeatedly)
- Giving clear information on safety precautions being taken and deciding how to handle difficult or dangerous situations (e.g., a code word) that may arise during the interaction
- Reminding the survivor to delete any text messages between her and the worker if necessary
- Following the basic steps of case management remotely yet, as efficiently as possible – forms may be adapted for more efficient information collection

Services/worker system changes

- Updating referral pathways with a focus on health service providers as these are most likely to stay functional at all times
- Ensuring there are established relationships with existing or COVID 19 related helplines and crisis services
- Preparations for shifting to phone-based case management when needed
- Identification of GBV staff or focal points working with facilities who can provide survivors with crisis specialised response
- Developing an online system for data access and management for case workers
- Safe but easily accessible storage of client and service phone numbers

1 Case Management, GBVIMS/GBVIMS+ and the COVID-19 pandemic.(2020).
2 Ibid.

## 4.6. Monitoring and evaluation

Even with the best policies and protocols in place, services and staff need to be monitored and evaluated regularly in order to ensure that standards and quality are being maintained and that new learnings from other models are being incorporated. Monitoring strategies can include[1]:

- Supervision by an assigned case manager
- Ongoing service evaluations
- Staff appraisals
- Scheduled and on the spot checking and reviews (of forms, documentation, protocols, interaction with clients, etc.)
- System for documentation of case progress and client feedback
- Regular staff training and assessment on:
    - Knowledge (GBV, policies, procedures, laws, etc)
    - Attitudes (gender, GBV, ethics, professionalism)
    - Skills (technical, communication, basic support, crisis management)

## 4.7. Self-care

Supporting survivors of violence is a rewarding experience for most people involved in such work. At the same time however, high levels of stress may also accompany such work from time to time. It is important that workers be aware of their personal reactions and symptoms of stress and burnout. As a professional, it is their responsibility to recognise, face and manage their stress effectively. This is not only important for their well-being as individuals, but can also affect their ability as case workers to help the people for whom they are working.

Stress is a very natural reaction to any big change in one's life, which requires an adjustment. Some pressure in one's life is a good thing because it increases performance and gives us the energy and strength we need to deal with the demands and challenges of daily life. However, when the pressure on an individual seems to be excessive, overwhelming or out of his or her control, it is called stress.

Case worker's stress is the emotional strain of care giving. Studies show that care giving takes a toll on physical and emotional health. Case workers are more likely to suffer from depression than their peers. Limited research suggests that case workers may also be more likely to have health problems, like diabetes and heart disease, than non-case workers.

Case workers working with clients of anxiety, trauma or other kinds of stresses related to trauma after a particular time are vulnerable to burnout. Research shows that most case workers who work for trauma survivors suffer from depression and stress. Also, studies show that the more hours spent on care giving, the greater the risk of anxiety and depression.

It is important to note that caring for another person can also create positive emotional change. Aside from feeling stress, many case workers say their role has had many positive effects on their lives. For example, case workers report that care giving has given them a sense of purpose. They say that their role makes them feel useful, capable and that they are making a difference in the life of a loved one.

Stress in case workers may occur for various reasons:

- They may be constantly exposed to demands to help meet the needs of survivors.
- They may be exposed to a lot of suffering and pain.
- They may often put their own physical (e.g., eating, sleeping and hygiene) and emotional (e.g., support needs) at low priority to ensure maximum service.
- They may think that their efforts to help survivor are not enough and therefore experience feelings of helplessness and frustration.
- They may be working overtime.
- They may face a number of moral and ethical dilemmas.
- They may feel guilty that they have better access to food and shelter than the survivors.
- They may be working in a difficult area where personal comforts are limited.
- They may be working away from their family and friends.
- They may be exposed to an apparent lack of gratitude or even anger from some affected people, which could make them feel their work is not worth it.
- They may be organisational/management issues that could frustrate them.

Being aware of these factors and their effect on case workers is helpful as it allows them to identify effective ways of handling stress.

### Stress reactions and effects

It is important to keep a check on prominent stress reactions in the mindand body, and its corresponding effects on your personal life and work. If you experience the following, it is time to reassess and identify ways of managing your stress:

- Mental confusion, inability to make judgments and decisions, or to concentrate and prioritise
- Inability to express yourself verbally or in writing

1. Ibid.

- Anxiety, irritability, depressive mood, excessive rage reactions
- Neglecting one's own safety and physical needs
- Sleep and appetite difficulties
- Excessive fatigue
- Heroic but risky behaviour
- Progressive decline in efficiency
- Loss of spirit and motivation
- Lack of self-worth and self-esteem
- Self-blame
- Increased stress with relationships, including your team members and colleagues
- Feeling unappreciated or betrayed
- Constant appearance of physical stress-related symptoms, such as headaches, stomach problems, ulcers, aches/ pains and stiffness (especially neck, shoulder and back), heart problems, blood pressure, reproductive health issues, frequent headaches, frequent jaw clenching, , grinding teeth, stuttering or stammering, tremors, faintness, dizziness, frequent sweating, cold or sweaty hands and feet, dry mouth, problems swallowing, frequent colds, infections, herpes sores, unexplained allergies, breathing problems, skin breakouts, palpitations, diminished sexual desire or performance, etc.

## Managing stress

### Harmful ways:

- Excessive smoking
- Drugs
- Drinking
- Acting out
- Self-destructive behaviour
- Over-eating
- Over-working

### Short Term helpful ways:

- Talking to someone
- Avoidance
- Distraction
- Relaxing activities such as music, being in nature, watching etc.
- Hobbies
- Fantasising
- Keeping busy
- Sleeping etc.

### Constructive, long-term ways

- Regular relaxation exercises (yoga, meditation, breathing, visualisation, prayer, quiet time alone, etc.)
- Self-awareness and self-management (therapy, support groups, self-growth)
- Positive self-talk
- Healthy and positive attitudes towards and realistic expectations of oneself
- Good organisational and time management skills
- Assertiveness
- Regular physical exercise
- Good health, nutrition and sleep
- Healthy outlets (having fun, entertainment, hobbies)
- Developing life purpose, philosophy, religion, working for a cause
- Flexibility, ability to accept and adapt to life changes
- Healthy relationships and social support system in friends, family and colleagues
- Healthy routines

## Managing work-related stress

Finding and using constructive coping methods for stress helps prevent, delay, avoid and manage stress. It is very important to maintain those coping mechanisms that have been useful for us in the past, and at the same time, keep adding new ones when needed. The following tips may help:

- Be aware of your stressors and reactions.
- Remember that your stress reactions are normal and to a large extent, unavoidable.
- Care about your work and the community, but try not to be too emotionally involved, i.e., taking on people's grief. Some detachment is important.
- Realise the fact that your work is very important and that it has an impact, even if you cannot do everything, people do not appreciate your work or if the results are not immediately evident. Be proud of yourself for being a part of the effort in such a significant way.
- Plan your activities in advance and manage your time efficiently. Make a conscious effort to relax. Deep breathing exercises can help in this regard.
- Find and use ways to enjoy yourself and relax (e.g., music, reading, exercise, prayer, etc.)
- Think about your stressors and find ways of changing the things you can (e.g., better time management, etc.)
- Find support in people around you (family, friends and colleagues) with whom you can talk and discuss things.
- When necessary, discuss with your team if a certain kind of work is getting too much for you and see if it can be rescheduled or assigned to someone else.
- Avoid perfectionist expectations from yourself or others.

- Avoid getting too attached to the image of you as the "helper", "saviour". This sense of power can be addictive and stressful.
- Communicate with your family and close friends as much as possible.
- Seek the support of your manager, supervisor or a mental health professional if necessary
- Establish systems at work where worker stress can be managed (e.g., team debriefing meetings, case supervision meetings, etc.)
- Do not use drugs or other substances to relax.

- When necessary, discuss with your team if a certain kind of work is getting too much for you and see if it can be rescheduled or assigned to someone else.
- Avoid perfectionist expectations from yourself or others.
- Avoid getting too attached to the image of you as the "helper", "saviour". This sense of power can be addictive and stressful.
- Communicate with your family and close friends as much as possible.
- Seek the support of your manager, supervisor or a mental health professional if necessary.

## TRAINING SUGGESTION: MODULE 4: PROCESSES OF CASE MANAGEMEN

### Module 4 Objectives

By the end of Module 4, participants are expected to be able to:

- Identify the steps of case management
- Understand the adjustments needed for case management during the COVID-19 pandemic
- Define the role of a case manager
- Understand the importance of certain policies and procedures for case management, in particular related to information collection, data management and referrals
- Understand the importance of self-care for case workers
- Identify strategies for self-care and stress management

Facilitator notes: This module is important in that it provides detailed information about the process of case management for GBV, which will be new for many participants. The facilitator needs to emphasise the importance of effective and efficient policies and systems which are meant to support case work and without which, even the most well-intentioned workers and services can fail to fulfil their obligations to the survivor as well as to the worker. This is also an opportunity for workers to share with each other the systems already in place and to discuss learnings, especially in the current COVID-19 pandemic, and the many adjustments that are needed.

### Session 1: The process of case management

Topics/methods:

- Setting up case management – small group work and discussion
- Steps of case management – case study and presentation
- Case management in a pandemic – brainstorming and large group discussion

### Session 2: Policies and systems

Topics/methods

- Importance of policies – discussion
- What policies are important – presentation
- Data collection – scenario, group work and discussion
- Data management – large group discussion
- Referral – large group discussion

### Session 4: Monitoring and evaluation

Topics/Methods:

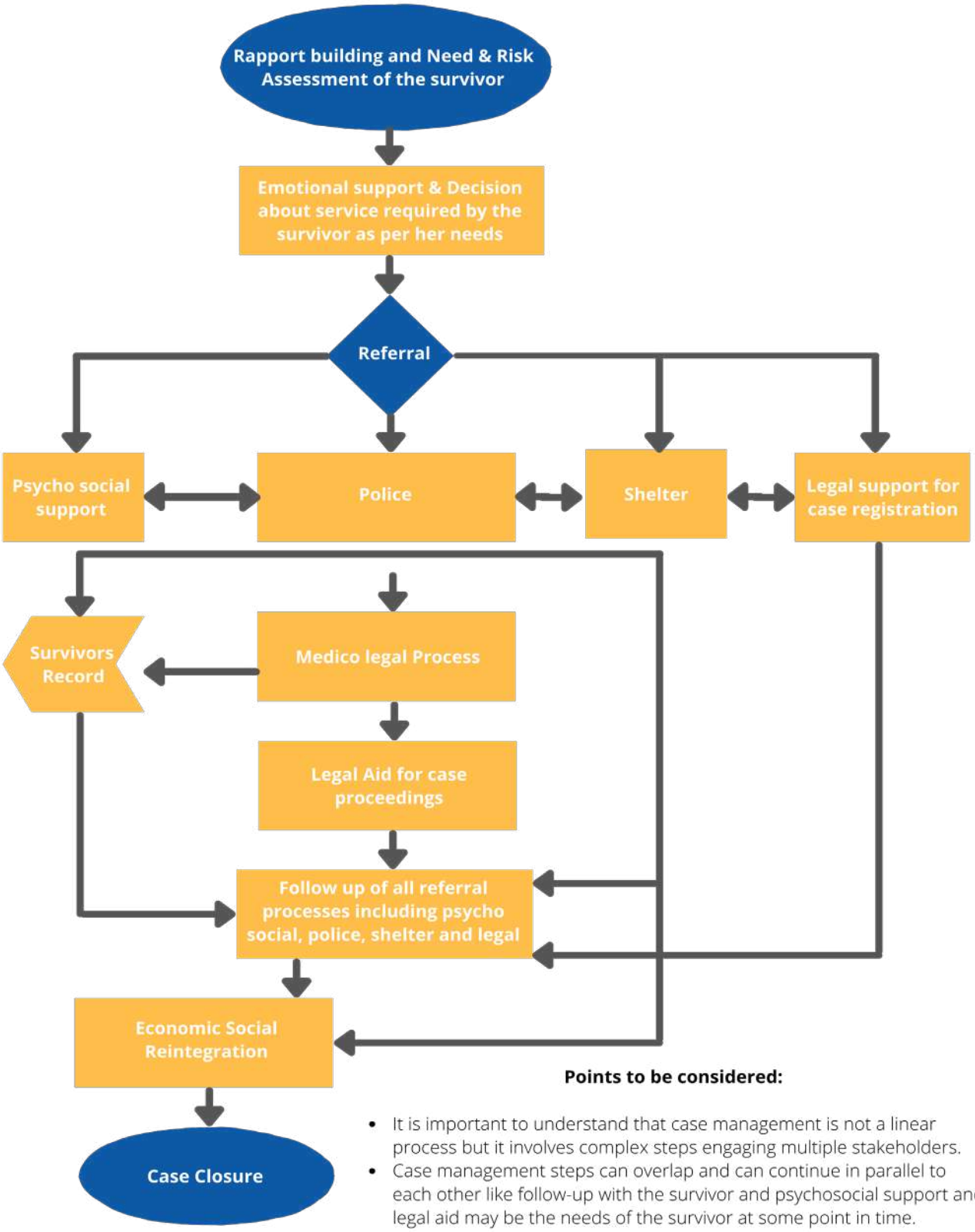
- Importance of monitoring – large group discussion
- Strategies for monitoring – group work and presentation

### Session 5: Self-care

Topics/methods

- Reasons for worker stress – brainstorming and presentation
- Symptoms/impact of stress – presentation and discussion
- Stress management – group work and presentation

## ANNEXURE - A: Flow Chart of Survivor centered Case Management Process




**Points to be considered:**

- It is important to understand that case management is not a linear process but it involves complex steps engaging multiple stakeholders.
- Case management steps can overlap and can continue in parallel to each other like follow-up with the survivor and psychosocial support and legal aid may be the needs of the survivor at some point in time.

## REFERENCES


1. Committee on the Elimination of Discrimination against Women. CEDAW (1992). CEDAW General Recommendation No. 19: Violence against women. Available: https://www.refworld.org/docid/52d920c54.html
2. Committee on the Elimination of Discrimination against Women. CEDAW (2017). General Recommendation No. 35, updating General Recommendation No. 19.
3. Cornell Policy Review. (2019). Improving the State's Response to Gender-Based Violence in Punjab, Pakistan. Available: http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
4. DS Psychology Group. (2013). DS Psychology Group Resources: Blocks to listening. Available: https://dspsychology.com.au/blocks-to-listening/
5. Gender-based Violence Information Management System (GBVIMS) Steering Committee. (2017). Inter-Agency Gender-based Violence Case Management Guidelines: Providing care and case management services to gender based violence survivors in humanitarian settings.
6. Interagency Standing Committee. (2015). Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action. Geneva, IASC. http://gbvguidelines.org
7. http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
8. Human Rights Watch (HRW) (2020) Transgender, Third Gender, No Gender: parts 1 and 2. Available: https://www.hrw.org/news/2020/09/08/transgender-third-gender-no-gender-part-ii
9. Joseph A. . (1995). The self in interpersonal communication in 'The Interpersonal Communication Book'
10. Khan, F. K (2019). Improving the State's Response to Gender-Based Violence in Punjab, Pakistan, Cornell Policy Review. Available: http://www.cornellpolicyreview.com/gbv-punjab-pakistan/
11. Legal Aid Society. (2012). The criminal justice systems and rape: An attitudinal study of the public sector's response to rape in Karachi.
12. Lumen Learning. Course: Introduction to Sociology, Reading: Gender and socialisation. Available: https://courses.lumenlearning.com/suny-herkimer-intro-to-sociology-1/chapter/reading-gender/
13. Psychology Today. (2020). Bias. Available: https://www.psychologytoday.com/intl/basics/bias
14. Punjab Commission on the Status of Women, Government of Punjab (2015). Women's rights/laws https://pcsw.punjab.gov.pk/womens_rights
15. Punjab Commission on the Status of Women (2018). Punjab Gender Parity Report 2018. Available: https://pcsw.punjab.gov.pk/system/files/PGPR-2018_0.pdf
16. Raazia Hassan Naqvi, Muhammad Ibrar, Christine Walsh. (2018). History of Social Welfare and Domestic Violence Shelters called Dar ul Amans: A Case Study of Punjab Province Pakistan, Pakistan Journal of Criminology, Vol. 10, Issue 2 (94-106).
17. Rise. (2020). What is Acid Violence? Available: https://www.risecoalition.org/what-is-acid-violence/#:~:text=Acid%20violence%20refers%20to%20the,torture%2C%20or%20kill%20the%20victim.&text=Although%20acid%20throwing%20is%20a,cases%20documented%20in%20recent%20years
18. Rozan. (2009). Guidelines for the protection of dignity and rights of the survivors of violence. Available: https://rozan.org/wp-content/uploads/2019/12/Guidelines-for-the-Protection-of-Dignity-and-Rights-of-Survivors-of-Violence-2009.pdf
19. Rozan (unpublished). Training Module: Strengthening Women's Centres to Support Survivors
20. Rozan (unpublished). Ensuring quality and ethical response in cases of violence against women
21. Rozan. (2018). Against All Odds: Post shelter lives of women survivors of violence. https://rozan.org/wp-content/uploads/2020/05/Against-All-Odds-Rozan-Research-Report.pdf
22. Simply Psychology. (2008). Prejudice and discrimination. Available: https://www.simplypsychology.org/prejudice.html
23. Smith, H. B. (2006). Providing mental health services to clients in crisis or disaster situations. In G. R. Walz, J. Bleuer, & R. K. Yep (Eds.). VISTAS: Compelling perspectives on counseling,.(2006) (pp. 13-15). Alexandria, VA: American Counseling Association.
24. Social Policy and Development Centre (SPDC), NUI Galway, Ipsos Mori, and
25. International Centre for Research on Women (ICRW). (2019). Economic and Social Costs of Violence
26. Against Women in Pakistan: Summary Report. Galway: NUI Galway. Available: https://www.ipsos.com/sites/default/files/ct/publication/documents/2019-07/economic-social-costs-violence-women-girls-pakistan-2019.pdf
27. SOPs working group - GBV sub cluster Islamabad. (2012). Standard Operating Procedures for Prevention of and Response to Gender Based Violence. Standard Operating Procedures for Prevention of and Response to Gender Based Violence.
28. UNFPA news. (2020). Pandemic heightens vulnerabilities of persons with disabilities. https://www.unfpa.org/news/pandemic-heightens-vulnerabilities-persons-disabilities
29. UNICEF South Asia. Child Marriage. Available: https://www.unicef.org/rosa/what-we-do/child-protection/child-marriage
30. United Nations Division for the Advancement of Women & United Nations Economic Commission for Africa. (2009). Forced and early marriage: a focus on Central and Eastern Europe and former Soviet Union countries with selected laws from other countries. Available: https://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Expert%20Paper%20EGMGPLHP%20_Cheryl%20Thomas%20revised_.pdf
31. United Nations Human Rights Office of the High Commissioner. (2000). Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography. Available: https://www.ohchr.org/en/professionalinterest/pages/opsccrc.aspx#:~:text=(c)%20Child%20pornography%20means%20any,child%20for%20primarily%20sexual%20purposes.
32. United Nations Office on Drugs and Crime, UNODC. (2020). Gender and pandemic: Urgent call for action, Advocacy Brief 4.
33. UNODC. The crime of trafficking in persons. Available: https://www.unodc.org/unodc/en/human-trafficking-fund/human-trafficking-fund_projects.html
34. United Nations Economic and Social Commission for Asia and the Pacific (UN ESCAP). (2009). Pacific perspectives on the commercial exploitation and sexual abuse of children and youth.
35. UN General Assembly. (1993). Declaration on the Elimination of

Violence against Women, 20 December 1993, A/RES/48/104, available at: https://www.refworld.org/docid/3b00f25d2c.html
36. United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (UN Women, UNFPA, WHO, UNDP and UNODC). (2015). Essential services package for women and girls subject to violence. Available: https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence
37. United Nations (UN). (2017). Preventing sexual abuse and exploitation: policies and protocols.https://www.un.org/preventing-sexual-exploitation-and-abuse/content/policies-and-protocols
38. UN Women. (2011). Defining 'honour' crimes and 'honour' killing. Available: https://www.endvawnow.org/en/articles/731-defining-honourcrimes-and-honour-killings.html
39. UN Women Asia and the Pacific, Legislation on Violence against Women and Girls (Pakistan)
40. Pakistan Demographic and Health Survey. (2012 – 2013).
41. The Thomas Reuters Foundation. (2018). The World's most dangerous countries for women 2018. Available: https://poll2018.trust.org/
42. UN Women. (2013). Prohibition of discrimination, harassment, including sexual harassment, and abuse of authority.
43. UN Women Asia and the Pacific. Legislation on Violence against Women and Girls. https://asiapacific.unwomen.org/en/countries/pakistan/evaw-pakistan/legislation-on-vaw
44. World Economic Forum (2019). The Global Gender Gap Report 2020. http://www3.weforum.org/docs/WEF_GGGR_2020.pdf
45. World Health Organization (WHO). (2017). Violence against women. Key facts. Available: https://www.who.int/news-room/fact-sheets/detail/violence-against-women
46. WHO. (2002). World report on violence and health. Available: https://www.who.int/violence_injury_prevention/violence/world_report/en/
47. WHO. Regional Office for Europe. (2002). Gender: Definitions. Available: https://www.euro.who.int/en/health-topics/health-determinants/gender/gender-definitions#:~:text=iStockphoto,grow%20into%20women%20and%20men
48. WHO. (2014). Violence against women: intimate partner violence and sexual violence against women fact sheet. Available: https://apps.who.int/iris/bitstream/handle/10665/112325/WHO_RHR_14.11_eng.pdf

# ABOUT ROZAN

Rozan, an Islamabad based, non-government organization founded in 1998, works on the issues of gender, emotional health, and violence against women, children, and youth. Rozan uses capacity building, awareness- raising, research, counseling, and advocacy as its core intervention strategies.

Rozan works through the program approach to sustain its initiatives and has established dedicated programs to address its focus areas of work.

**Aangan** (Children's Program) deals particularly with the issues of child protection with a special focus on child sexual abuse. **Zeest** (Women's Program) works on the emotional and mental health of women with a special focus on Violence against Women. **Rabta** (Police Trainings and Reforms Program) executes police trainings on gender sensitivity, conducts action-oriented researches, voices for police reforms, and implements community policing initiatives. **Humqadam** (Men and Masculinities Program) aims at creating spaces for men and boys to engage in the issue of violence against women. Community Program capacitates communities on GBV and emotional health. Rozan Counseling **Helpline** provides counseling services through telephone, email, and in-person to GBV survivors, adolescents, youth, women, and men. A dedicated nation- wide helpline number **0304-111 1741** and email yhl@rozan.org provides psychosocial counseling.