



Provincial Gender Based Violence
Action Committee Secretariat
Standard Operating Procedures





Provincial Gender Based Violence Action Committee Secretariat **Standard Operating Procedures**



DEPARTMENT FOR COMMUNITY DEVELOPMENT



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1. Rationale

Papua New Guinea (PNG) continues to feature in international headlines as a country with a high rate of Gender Based Violence (GBV). While updated and reliable data is scarce, the extrapolation of existing figures suggests that levels of GBV have reached epidemic proportions, with one of the worst incidence rates of GBV in the world.

It is reported that 41 per cent of men in PNG admit to having raped someone and over two-thirds of women are estimated to have suffered some form of physical or sexual violence in their lifetime.¹ 7.7 per cent of men admit to having perpetrated male rape. Only 73 per cent of survivors of GBV in PNG seek assistance and the vast majority of these individuals (88 per cent) seek this assistance² through informal support structures, such as familial, kinship or collegiate networks, or village courts and community leaders, rather than through official channels. This indicates that GBV is underreported.

The Government of PNG (GoPNG) has highlighted the importance of addressing GBV and Family and Sexual Violence (FSV) by making it a priority area for intervention in its PNG Vision 2050, the 2010-2030 Development Strategic Plan (DSP) and the 2011-2015 Medium Term Development Plan (MTDP). Its new National Security Policy is also giving prominence to GBV/FSV, identifying it as a threat to national security. In order to address the issue in a more strategic and coordinated manner, the GoPNG established the Family Sexual Violence Action Committee (GBVAC) in 2002 as part of the **Consultative Implementation and Monitoring Council (CIMC),³ an entity answerable to the Department for National Planning and Monitoring (DNPM).**

There is an overwhelming acknowledgment of the GBV/FSV epidemic, whilst at the same time an outcry

for increased capacity building and coordination to facilitate evidence-based and coordinated interventions. In 2014 sub-national consultations highlighted that existing approaches and services are not necessarily informed by the best interest of the survivors. Interventions are at best ad-hoc and last for as long as funding can be secured from donors. Provincial and national commitment to health and police services are not guided by strategic planning, budgeting, and strong core values condemning any form of violence. Sometimes police working in the Family and Sexual Violence Unit (FSVU) are themselves victims and even perpetrators of GBV/FSV.

Until recently much of the leadership on this issue came from activists outside of government and from international organizations and donors. While these actors have critical roles to play, **GBV/FSV can only be systemically tackled with full engagement and leadership from the Government.** Recently there has been increasing pressure for provincial authorities to plan, budget and implement for prevention and services for survivors of GBV/FSV. **The National Executive Council (NEC) decision No. 151/2013 urges provincial authorities to plan, budget and implement towards zero tolerance for GBV/FSV.** In the 2014 subnational consultations, the establishment of the Provincial Gender Based Violence (PGBVAC) Secretariats came as one of the key recommendations for the provincial government to implement.

The document outlines standard operating procedures for the PGBVAC Secretariats operating as coordinating, monitoring, referral pathway support and data collection office, established within the provincial government to respond to gender based violence in the province.

¹ Jewkes, R., Fulu, E., Roselli, T. and Garcia-Moreno, C. (2013) 'Prevalence of and factors associated with non-partner rape perpetration: Findings from the UN Multi-country Cross-sectional Study on Men and Violence in Asia and the Pacific'. The Lancet Global Health, 1(4), e208-e218.

² World Bank (2014) Crimes and disputes: Missed opportunities and insights from a national data collection effort in Papua New Guinea. Briefing Note 5.

³ <http://www.inapng.com/cimc/>

2. Terms and Definitions

Abduction – Taking an unmarried female out of the care of her parents or guardians with the intention of having sexual intercourse with her is an offence. Taking the female away against the will of her parents or guardians. Taking her away against her will for marriage, or making her a servant, or enslaving her, with the intention of benefiting from any property or inheritance or any assets that she may have. If the victim is under 16, it is immaterial if the offender has the consent of the girl or if he believes she is older than 16 years of age (Criminal Code 2013).

Aggravated Rape – Additional factors present in rape case, such as: the offender was in the company of another person; the offender knowingly had a sexually transmitted disease or HIV/AIDS; if the victim was confined or restrained at the time of the offence; if the victim was threatened with a weapon. The maximum penalty can then be increased to life imprisonment (Criminal Code 2013).

Child – A person under the age of 18 years (Lukautim Pikini Act (LPA) 2014) who is 1) a biological, adopted, step or foster child of the person; 2) in the care or custody of the person (Family Protection Act 2013).

Child Marriage – Marriage for boys and girls under the age of 18 (National Lukautim Pikinini Policy 2015 – 2025).

Child in Need of Protection – Includes a child 1) who has been, or is likely to be physically harmed, sexually or emotionally abused or sexually exploited by some person other than the child's parent, and the parent is unwilling or unable to protect the child; 2) who has been, or is likely to be physically harmed because of neglect by the child's parents, or who is sexually or emotionally abused by the child's parents or guardian; 3) who is living in a household where there has been incidents of domestic violence and, as a consequence, the child is at risk of serious physical or psychological harm (LPA 2014).

Child in Care – A child who is in the care and custody of the Family Services Director or any person authorized by the Director (LPA 2014).

Child Protection Officer – A person appointed under Section 35 of the Lukautim Pikinini Act. The powers of the Child Protection Officers are to prevent and respond to violence, abuse, neglect, exploitation and discrimination against all children.

Confidentiality – An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary.

Defilement of Young Girls – A person who knowingly has sexual intercourse with a young girl under the age of 16 who is a virgin. Any person who permits sexual intercourse or any sexual act, by young girl(s) under the age of 16 on premises owned or occupied by said person is guilty of an offence (Criminal Code 2013).

Denial of Resources, Opportunities or Services - Denial of rightful access to economic resources, assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner, spouse or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc.

Disability – An evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others (Preamble of the United Nations Convention on the Rights of Persons with Disabilities 2006).

Domestic Violence – Violence against a family member that includes 1) assaults, 2) psychological abuses, harassment, intimidation, 3) stalking, 4) sexual abuse, 5) indecent or offensive behaviour, 6) damage to property, and 7) threatening to do any of the above.

Forced Marriage – The proposed amended Marriage Act (2015) (currently in bill) defines marriage as 'the union between a consenting man and a woman who are 18 years and above'. A marriage can be entered into either under a customary, or a non-customary marriage ceremony. The penalty of persons forcing minors to marry is imprisonment for a term not exceeding five years.

Gender Based Violence (GBV) – Physical, emotional, psychological and sexual abuse directed against a person because of her or his gender in a society or culture including, but not limited to, acts committed with force, manipulation or coercion and without the informed consent of the survivor, to gain control and power over them.

Grievous Bodily Harm - Any bodily injury of such a nature as to endanger or be likely to endanger life, or to cause or be likely to cause permanent injury to health (Criminal Code 2013).

Incest – The relationship between a victim and offender who are close blood relatives. The Family Protection Act (2014) has expanded the relationship between the offender and victim to include children from adoption, stepchildren or any recognized person who is treated as a family member.

Indecent Practices Between Males - Any act of buggery or homosexuality between two male persons with or without consent. Providing, persuading, appointing or obtaining, or even trying to approach someone to have sex with another man, or approaching someone on another's behalf, also constitutes an offence. The Criminal Code does not clearly define the offense but it has been derived from any act of affection of a sexual nature including but not limited to sexual intercourse between two males.

Informed Consent – The voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents/caregivers are responsible for giving consent for their child to receive services until the child reaches 18 years of age.

Key Populations – Defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV, irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The key populations include men who have sex with men, sex workers, and transgender people.

Mandatory Reporting – The Lukautim Pikinini Act (2014) mandates certain persons in helping professionals (teachers, social workers, health staff, members of the clergy, police officers, etc.) to report actual or suspected child abuse.

Most at Risk Populations (MARPs) – Also known as Key Affected Populations. These are the populations that are at higher risk of being infected with or affected by HIV. It refers to persons who 1) use drugs, 2) engage in sex work, and 3) men who have sex with men.

National Family and Sexual Violence Action Committee (GBVAC) – A sectoral committee of the Consultative Implementation and Monitoring Council. The mandate of the GBVAC is to work towards reducing the occurrence of and suffering caused by physical, sexual and psychological violence.

Perpetrator – The person who commits FSV/GBV against another person/s.

Physical Violence – An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, or any other act that results in pain, discomfort or injury.

Procuring a Woman or Girl – Also known as 'Pimping'. Coercing a female with money, or bribing her with some sort of promise or gift, or forcing her to have sex with another person, is a criminal activity. It does not matter if the sex or sexual act occurs in another country.

Provincial Referral Directory – A compilation of referral organizations and/or service providers in each province detailing contact information, as well as types of service provided, the population served and any eligibility criteria. If any particular documentation is required on intake, this should be detailed here. It is important for the PGBVAC and/or Secretariat to update the Referral Directory on a regular basis to avoid giving survivors misinformation, which might put them at risk.

Psychological Violence – Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual or menacing nature, destruction of cherished items, etc.

Rape – The sexual penetration of a person without their consent.

Referral Pathway – A comprehensive institutional framework that connects various entities with well-defined and delineated (albeit in some cases overlapping) mandates, responsibilities and powers into a network of cooperation. The overall aim is to ensure the prevention of GBV, protection and assistance of survivors, to aid in their full recovery and empowerment, as well as the prosecution of perpetrators.

Refugee – Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his or her nationality, and is unable to or, owing to such fear, is unwilling to avail him- or herself of the protection of that country (UN Refugee Convention 1951).

Relocation – A process whereby a service assists the survivor (and any dependent children) to move to an alternative location; possibly the survivor's place of origin.

Repatriation – A process whereby a service assists the survivor, and any dependents, to return to the survivor's place of origin. Ideally, at that place of origin, the survivor will have family able to provide supportive care once the repatriation has occurred. In order that the survivor is not completely dependent upon family, additional support should be provided by the service provider. (Repatriation should not be confused with Reintegration, described below.)

Reintegration – A process whereby, at the survivor's request, a service assists the survivor to return to the place they moved from when escaping violence. When a survivor is reintegrated, a range of costs is involved, such as assisting access to housing, schooling, employment, etc.

Service Provider – A service provider is any individual or organization, whether government or otherwise, that provides a service, resource or guidance to a survivor.

Sexual Assault/Touching – Involves 'touching' the sexual parts of another person without their permission. 'Sexual parts' include the genital area, groin, buttocks or breasts of a person. It also includes the touching of the sexual parts of a person with any part of the offender's body, or with an object; and if the offender makes another person touch the offender's sexual parts with any part of the other person's body, or with an object. Contact can be made with these sexual parts using any part of the body, e.g. hands, feet, mouth, etc. (Criminal Code 2013).

Sexual Penetration – Introduction, to any extent, of a person's penis, or an object, or any other part of his body (other than his penis) into the anus or mouth or vagina of another person, without that person's consent. Both men and women can be victims of rape. Women can also be perpetrators of rape. Rape can also occur within a marriage, i.e. a spouse raping his or her spouse (Criminal Code 2013).

Sexual Penetration of a Child – A person is considered a 'child' if he or she is under the age of 16 years. Consent is not a defence in offences against children under the age of 16 years. An offence covers the sexual penetration of children of both sexes.

Aggravated Sexual Penetration of a Child – The law provides that where additional aggravating factors are present, the maximum penalty can be increased to life imprisonment. **Aggravated factors include: the child was under the age of 12 years at the time of the alleged act of sexual penetration;** the offender had an existing relationship with the child involving trust, authority or dependency; the abuse is found to be persistent; that is, the offender is found to have had sexual relations with the child on more than two occasions (Criminal Code 2013).

Sorcery – The Repealed Sorcery Act (1971) provides the following definition: 'Sorcery includes what is known, in various languages and parts of the country, as witchcraft, magic, enchantment, puri puri, mura mura dikana, vada, mea mea, sanguma or malira, whether or not connected with or related to the supernatural.'

Survivor – Refers to men and women, girls and boys, who have experienced FSV/GBV, directly or indirectly, or who are at imminent risk of experiencing FSV/GBV.

Torture – Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession; punishing him for an act he or a third person has committed or is suspected of having committed; or intimidating or coercing him or a third person, for any reason based on discrimination of any kind, when such pain or suffering is inflicted by, or at the instigation of, or with the consent or acquiescence of, a public official, or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions (UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984).

Sex Workers – Female, male or transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. As defined in the Convention on the Rights of the Child, children and adolescents under the age of 18 who exchange sex for money, goods or favours are 'sexually exploited' and not defined as sex workers.

Transgender – An umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. The term includes people who are transsexual, transgender or otherwise gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman or transman, or trans-sexual.

Trafficking – The recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force, or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or the abuse of a position of vulnerability; or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, as a minimum, the prostitution of others, or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

3. Guiding Principles

The guidelines are underpinned by a number of values and principles, such as the Constitution of Papua New Guinea, which protects the rights of its people through the Bill of Rights provisions, which includes the Right to Freedom, the Right to Life, Freedom from Inhuman Treatment and Protection of the Law. Papua New Guinea is a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child.

The Family Protection Act (2013), the Lukautim Pikinini Act (2015), and the Criminal Code Act (2002), include provisions related to gender-based violence, including protection to sexually and physically abused children, and survivors of family and sexual violence.

The general principles that underpin the work of the Provincial GBVAC Secretariats include:⁴

1. SURVIVOR CENTRED

Survivors' rights, needs and wishes are prioritized at all times. The PGBVAC Secretariat will create a supportive environment in which survivors' rights are respected, and in which they are treated with dignity and respect. This will promote survivors' recovery, and their ability to identify and express their needs and wishes, as well as to reinforce their capacity to make decisions about possible interventions.

2. SAFETY

The safety of people affected by gender-based violence, their children, relatives and associates, and the safety of workers, is given the highest priority at all times. PGBVAC Secretariat staff must consider the safety needs of survivors, their children, both at home and when attending services. Staff must ensure that safety assessments are undertaken to identify potential safety risks and to ensure that appropriate referrals are made.

The Secretariat must ensure the safety of staff and that the premises are safe for staff and clients.

3. RESPECT

Survivors are treated with dignity, respect and sensitivity. In order for staff to establish a trusting and empowering relationship, they must be empathetic and sensitive and must respect the experience, diversity, history and cultural background of each survivor.

All aspects of services must reflect a commitment to the survivor's right to self-determination. This involves enhancing their ability to make their own choices at all stages, through respectful and supportive processes.

4. ACCESS AND EQUITY

Services for survivors are free, accessible, welcoming and relevant to a diverse range of people, and any barriers to accessing the service are identified and addressed.

5. EMPOWERMENT

Survivors are assisted in identifying and expressing their needs, and supported in decision-making in a non-judgemental environment. PGBVAC Secretariat staff has a responsibility to ensure that all information provided to survivors is accurate, timely, relevant, easy to understand and up-to-date.

6. CONFIDENTIALITY

Survivors have their right to confidentiality respected and observed. They are informed of situations where that confidentiality may be limited.

Confidentiality is an extremely important issue when responding to people affected by gender-based violence. A breach of confidentiality can potentially jeopardize the safety of survivors, their family, or associates and staff assisting them.

PGBVAC staff are required to have effective practices in place for documenting and storing client information, and that staff advise survivors of situations where their right to confidentiality cannot be guaranteed.

7. COORDINATION

Services operate within a context of interagency cooperation, collaboration and coordinated service delivery.

The PGBVAC Secretariat represents a holistic approach in addressing the needs of gender-based violence survivors. It works together with other agencies, ensuring that available resources are used in the best possible way to meet the needs of survivors. It also aims to empower survivors, reduce duplication of services, and eliminate any victimization of survivors by the system.

8. ADVOCACY

Survivors affected by gender-based violence are supported in advancing their rights, including advocacy in enhancing the system that responds to people affected by gender-based violence.

PGBVAC Secretariat staff builds relationships with other stakeholders and agencies in order to gain specialist knowledge about service systems. Advocacy involves using this specialist knowledge in a respectful collaborative way to support and assist women in negotiating these systems effectively. This may involve assisting the survivors to advocate on their own or on their children's behalf, advocating on behalf of a survivor with their consent, with other stakeholders, or advocating for system change.

9. PREVENTION

A culture of intolerance towards gender-based violence is developed in individuals and communities. Activities undertaken by the PGBVAC Secretariat must reinforce the right of all people to live in an environment free from violence. Activities must promote positive and healthy relationships, acknowledge that many forms of violence are criminal offences and should be dealt with as such, and reinforce the principle that the responsibility for the violence lies with the perpetrators of gender-based violence.

10. ACCOUNTABILITY

The PGBVAC Secretariat has mechanisms for regular monitoring, evaluation and continuous improvement of the service. The PGBVAC Secretariat encourages feedback from clients, key stakeholders and referral agencies. The service has a complaint mechanism that is made available to clients and stakeholders.

The PGBVAC Secretariat works in line with the strategic plan, regularly reviews it to ensure its goals reflect survivors' needs, and its activities reflect the objectives of the service.

11. SERVICE ENVIRONMENT

Survivors access a service environment that enables effective service provision.

The PGBVAC Secretariat adheres to all legal requirements, internal policies and protocols to deliver a high level of service to survivors, including child protection, confidentiality and safety. It has policies and procedures in place for recruitment, the management of work performance, staff grievances and termination of employment.

⁴ Practice Standards for Working with Women Affected by Domestic and Family Violence, Queensland Government, Department of Families, 2002.

Working with Persons with Disabilities⁵

1. Respect for inherent dignity and individual autonomy, including the freedom to make one's own choices, and independence of persons;
2. Non-discrimination;
3. Full and effective participation and inclusion in society;
4. Respect for difference, and acceptance of persons with disabilities as part of human diversity and humanity;
5. Equality of opportunity;
6. Accessibility;
7. Equality between men and women;
8. Respect for the evolving capacities of children with disabilities, and respect for the right of children with disabilities to preserve their identities.

Working with Children

All children's cases brought to the attention of the PGBVAC Secretariat that are identified as children in need of protection, are referred to Child Protection Officers for specialist support and case management. When the PGBVAC Secretariat comes into contact with children whilst dealing with adult survivors, staff will be guided by the following principles:

1. Promote the child's best interests.

A primary consideration for children is securing their physical and emotional safety. Staff must evaluate the positive and negative consequences of actions, with participation from the child and his/her caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that children's rights to safety and on-going development are never compromised.

2. Ensure the safety of the child.

All actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short- and long-term.

3. Comfort the child.

Children who disclose sexual abuse require comfort, encouragement and support from staff. This means that staff is trained in how to handle the disclosure of sexual abuse appropriately. Staff should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced.

4. Ensure appropriate confidentiality.

Ensuring 1) the confidential collection of information during interviews; 2) that sharing information happens in line with the law and on a need-to-know basis, and only after obtaining informed consent from the child and/or caregiver; and 3) that case information is stored securely. Staff is required, under the Lukautim Pikinini Act (2014), to report child abuse to Family Services. Mandatory reporting procedures should be communicated to the children and their caregivers from the start. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

5. Involve the child in decision-making.

Children have the right to participate in decisions that have implications on their lives. Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While staff may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent/caregiver manner with maximum respect. In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

6. Treat every child fairly and equally.

All children should be offered the same quality care and treatment, regardless of their race, ethnicity, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities; thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.

7. Strengthen children's resiliencies.

Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of staff to identify and build upon the child's and family's natural strengths as part of the recovery and healing process. Factors that promote children's resilience should be identified and built upon during service provision. Children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from abuse.

The protocol of responding to children's cases refers to Section 7 on Child Survivors.

Working with Survivors of Trafficking⁶

1. Respect for and protection of human rights.

Trafficking in persons represents a grave violation of human rights, one that takes away the dignity of the trafficked person. The officials who deal with the survivors should be empathetic and understand the concerns and issues from the perspective of the survivor. To this end, decisions and future plans should be based on the 'best interests of the survivor'. Survivors have the right to be protected, consulted and informed on all actions being taken on their behalf.

2. Survivor centered approach.

The survivor is at the centre of any response. This requires that:

- a. The survivor should not be detained, charged or prosecuted for irregularly entering or remaining in a state, or other illegal acts including crimes he/she has committed as a direct result of having been trafficked;
- b. The survivor should have access to adequate physical and psychological care;
- c. All services to survivors of trafficking are provided on the basis of the informed consent of the survivor;

- d. All information and communication regarding the survivor must be treated with due regard for the survivor's right to confidentiality and privacy;
- e. The survivor should be provided with access to effective and appropriate legal assistance.

3. Multi-disciplinary approach.

A multi-disciplinary and interagency approach is needed to enable an appropriate response that will address the complexities of human trafficking and allow for the protection of the survivor and efficient law enforcement responses.

4. Best interests of the child.

In cases of children who have been trafficked, it is crucial to incorporate the 'best interests' principle and to consult the child (in accordance with their age and level of maturity) when determining a durable solution for their care and protection. A best interest determination should include a risk assessment to determine whether family reunification is suitable. Furthermore, different alternatives should be considered which take into account the child's voluntary repatriation to and re-integration in her/his country, or place of origin, or resettlement and integration in a third country.

5. Do no harm.

In the response to trafficking in persons, it is important to adhere to the 'do no harm' principle through ensuring a consistent survivor-centred and rights-based approach that avoids certain strategies, interventions and campaigns that may adversely affect the rights or safety of survivors of trafficking, as well as other vulnerable or marginalized groups.

6. Gender Sensitivity.

When managing cases of trafficking it is important to ensure that the support and assistance provided to victims is carried out in an appropriate manner which is responsive to the gender differences and disparities of women, girls, men and boys.

⁵ General Principles of the United National Convention on the Rights of Persons with Disabilities, 2006.

⁶ Standard Operating Procedures (SOP) for the Identification, Referral and Prosecution of Human Trafficking Cases in Papua New Guinea, DJAG, 2015.

Working with Survivors from Key Populations⁷

1. Human rights.

This includes the rights to: non-discrimination; security of person and privacy; recognition and equality before the law; due process of law and the highest attainable standard of health; freedom from cruel and inhumane treatment; and protection from violence. Gender equality is promoted by challenging unequal gender roles, social norms and distribution and control of resources and power. Services should aim for more equitable power relationships between sex workers and others in the wider community.

2. Access to quality health care.

This includes the right of members of key populations to appropriate quality health care without discrimination. Healthcare providers and institutions must serve people from key populations based on the principles of medical ethics and the right to health.

3. Access to justice.

Due to high rates of contact with law enforcement services and the current illegality of their behaviours, access to justice is a major priority for people from key populations. Access to justice includes freedom from arbitrary arrest and detention, the right to a fair trial, and freedom from torture and cruel, inhuman and degrading treatment. The protection of human rights, including the rights to employment, housing and health care for people from key populations requires collaboration between health-care and law enforcement agencies, including those that manage prisons and other closed institutions. Detainment in closed settings should not impede the right to maintain dignity and health.

4. Respect the rights of persons from key populations to make informed choices about their lives.

This may involve not reporting or seeking redress for violence, not seeking violence-related services, or remaining in an abusive relationship.

5. Acceptability of services.

Interventions to reduce the burden of HIV among people from key populations must be respectful, acceptable, appropriate and affordable to recipients in order to enlist their participation and ensure their retention in care. Services for members of key populations often employ appropriate models of service delivery but lack expertise in HIV. Conversely, people from key populations may not find specialized HIV services acceptable. There is a need to build service capacity on both fronts. Consultation with organizations of people from key populations, and involving peer workers in service delivery, are effective ways to work towards this goal. A mechanism of regular and on-going feedback from beneficiaries to service providers will help inform and improve the acceptability of services to key populations.

6. Health literacy.

People from key populations often lack sufficient health and treatment literacy. This may hinder their decision-making on HIV risk behaviours and their health-seeking behaviour. Health services should regularly and routinely provide accurate health and treatment information to members of key populations. At the same time, health services should strengthen providers' ability to prevent and to treat HIV in people from key populations, including adolescents.

7. Integrated service provision.

People from key populations commonly have multiple co-morbidities and poor social situations. For example, HIV, viral hepatitis, tuberculosis, other infectious diseases and mental health conditions are common in key populations. Integrated services provide the opportunity for patient-centred prevention, care and treatment for the vast array of issues affecting key populations.

4. The National FSVAC⁸

The National Family and Sexual Violence Action Committee (FSVAC) is one of the twelve sectoral committees of the Consultative, Implementation and Monitoring Council (CIMC) which is tasked with the long term goal of working towards reducing the occurrence of and the suffering caused by physical, sexual and psychological violence, especially between family members at the home environment. The GBVAC does this by implementing the integrated long-term strategy, which recognizes that the problems of family and sexual violence need an integrated multi-sectoral approach.

⁷ Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, WHO, 2014.

⁸ The role of the National GBVAC may change following the endorsement of the National Strategy to Prevent and Respond to GBV 2016 – 2025.

5. Provincial GBVAC and GBVAC Secretariat

The Provincial GBVAC is a coalition of entities – government, non-government and private sector – which focuses on coordinating work to prevent and respond to GBV. It works through a holistic and integrated approach, addressing a number of areas including legal and policy reform, referral networks, service provision, access to justice, addressing child sexual violence, advocacy, monitoring and research, and promoting male champions.

The Provincial Gender Based Violence Action Committees are set up in each province to coordinate and guide GBV projects and programmes at provincial level in collaboration with relevant government, private sector and civil and faith based organizations.

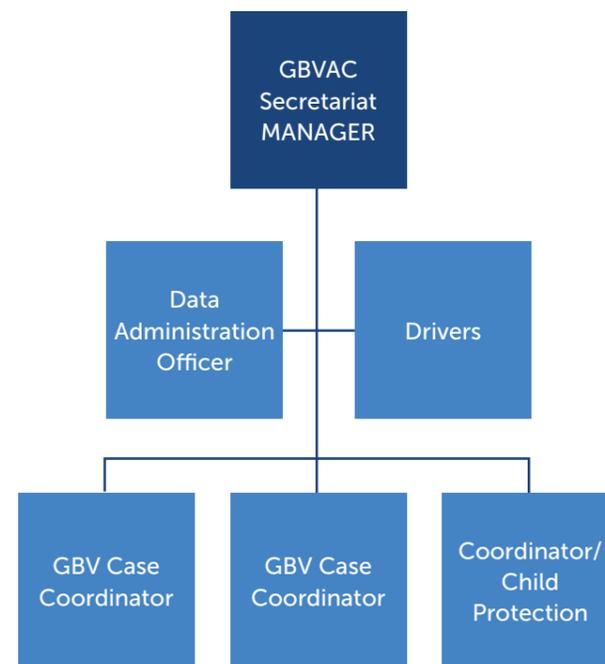
The Department for Community Development and Religion in partnership with the National GBVAC has taken the lead to establish provincial GBVAC Secretariats in the provinces. The PGBVAC Secretariats support PGBVACs by liaising with the provincial authority to secure adequate and on-going budgetary commitment from provincial government.

The Provincial GBV Secretariats are entities established through the respective provincial authorities as a response to the NEC directive 151 (2013). They aim to support the Provincial GBV Action Committees with secretarial facilities, coordination and monitoring of quality services around GBV work, and ensure coordinated data collection. The work of the Secretariats is guided by provincial GBV strategies, plan of actions and budgets established through an inclusive and holistic approach. The Secretariat establishes a strong working relationship between the government, NGOs, CSOs, FBOs, and private sector. The secretariats report to the provincial administration and the newly established National GBV Secretariat (see the National Strategy to Prevent and Respond to GBV 2016 – 2025).

The Provincial GBVAC Secretariats in the provinces have seven key responsibilities:

1. **GBV Case Coordination**
2. **GBV Prevention Coordination**
3. **Quality Monitoring**
4. **Data Collection, Analysis and Reporting**
5. **Secretarial Support to PGBVAC**
6. **Facilitation and Coordination of Capacity Building of the PGBVAC**
7. **Resource Mobilization**

The Provincial GBVAC Secretariats are made of the PGBVAC Secretariat Manager, GBV Case Coordinators, the Data Administrator and Drivers. Where there are no Child Protection Officers in the province, a GBV Case Coordinator is assigned specifically to respond and coordinate child cases.



5.1. GBVAC Secretariat Manager

The Manager reports to the Provincial Administrator and/or the Provincial Division of Community Development and the National GBVAC for management and development of the NCD GBVAC Secretariat and its efficient running.

Secretariat Oversight and Development:

- Oversee the day-to-day running of GBV case coordination activities;
- Manage the GBV case coordination delivery to fulfil the requirements of national policies and protocols;
- Monitor the Secretariat's delivery, identifying risks and alerting National GBV Secretariat as appropriate;
- Complete annual assessment of GBV service provision in the province and advocate on its development;
- Develop, produce and document practices to enhance provision;
- Coordinate the development and implementation of GBV prevention interventions in the province;
- Coordinate and manage one-stop-shop services, ensuring a regular presence of agencies at the Secretariat to attend to survivors of GBV;
- Participate in all discussions towards development, ensuring GBV prevention and response approaches are continually evolving;
- Participate in strategic development of the secretariat, leading to continuance and expansion of GBV services, informed by evidence, in the province;
- Support the development and implementation of the Provincial GBV Strategy;
- Network with agencies to develop holistic and far reaching presence of the Secretariat in the province to further support survivors of GBV;
- Participate in strategic planning with the Provincial Administration, and National GBV Secretariat and PGBVAC;
- Manage the Secretariat's budgets;
- Produce monthly monitoring reports for the

Provincial GBVAC, National GBV Secretariat, and the provincial administration.

Staff Oversight:

- Co-ordinate required case load staff supervision;
- Supervise staff to help them fulfil their own terms of reference in line with policies and protocols;
- Engage in staff development practices that seek effectiveness in staff training and appraisal processes;
- Organize and lead staff meetings, e.g. fortnightly team meetings and weekly planning;
- Manage staff rotas and leave, ensure appropriate level of staffing at all times, ensure planning is done well in advance and a 24/7 on-call service is provided.

Quality Standards:

- Collate GBV case coordination data to review;
- Coordinate regular monitoring and evaluation activities;
- Work with team members to improve the quality of service provision;
- Identify resources to meet the needs of the GBV survivors and communicate with the National GBV Secretariat regarding their implementation;
- Attend trainings and share good practice with the team members;
- Oversee the functioning of the Secretariat's premises and related maintenance issues;
- Set a good example in terms of dress, language, punctuality and attendance;
- Abide by the Code of Conduct, which is informed by the zero tolerance to violence principle.

Required Skills and Experience:

1. Over ten years of experience in the field of GBV/FSV or other related social work area;
2. A Degree in Management, Public Administration, Social Science, Social Work, Political Science or in other related social or economic field;
3. Ability to demonstrate leadership and innovation;
4. Over five years of experience in staff management;
5. Excellent organizational, planning skills to manage the day-to-day running of an office;
6. Knowledge of budget planning, implementing and monitoring;
7. Excellent written and verbal communication skills in Tok Pisin and English;
8. Proven track record of good negotiation and conflict resolution skills;
9. Experience in leading and implementing advocacy activities;
10. Excellent analytical skills and a good eye for detail;
11. Ability to network and build strong working relationships across different sectors, and represent at provincial, national, regional and global government levels;
12. Strong IT Skills.

5.2. GBV Case Coordinator

The GBV Case Coordinator reports to the GBVAC Secretariat Manager to coordinate the intake of GBV cases through risk assessments. The GBV Case Coordinator also monitors the referral pathway and chairs the multi-agency case conferences.

Service Delivery

- Receive and manage high risk GBV referrals;
- Facilitate Multi-Agency Case Conferences;
- Support PGBVAC partners to report to the PGBVAC Secretariat;
- Monitor all GBV cases allocated by the Manager and track the achievements;
- If and when required, provide an outreach service to GBV survivors to ensure their access to the services and completion of the referral pathway;
- Provide response and on-call support through the 24/7 SMS alert system;
- Advocate on behalf of the GBV survivor to guarantee their needs are met and best support provided by legal, justice, health and other services;
- Coordinate participation of GBV survivors' views of the services and report feedback to the manager;
- Report to the Manager on the GBV service providers' compliance with protocols, standards and procedures;
- Work to agreed targets and strategies;

- Implement these strategies;
- Facilitate and coordinate training and workshops to the PGBVAC partners, as directed by the PGBVAC and PGBVAC Secretariat Manager;
- Liaise and network with relevant agencies to support and provide most up-to-date information to service users.

Administration

- Collect and enter data as required and complete necessary reports;
- Develop, produce and document practices to enhance GBV provision;
- Use appropriate paperwork and keep clients' files in timely and orderly fashion;
- Support PGBVAC in developing and implementing the Provincial Strategy.

Quality and Standards

- Work in line with internal policies and protocols;
- Set a good example in terms of dress, language, punctuality and attendance;

- Collate delivery data to review;
- Participate in monitoring and evaluation;
- Abide by the Code of Conduct, which is informed by the zero tolerance to violence principle.

Development

- Participate in creative meetings and discussions towards development of GBV service and prevention;
- Implement any agreed developments;
- Devise strategies to develop the service in terms of numbers of GBV survivors benefiting from direct support;
- Attend and contribute to team meetings and support other team members;
- Initiate new strands to the service to meet the changing identified needs of GBV survivors;
- Work with team members to improve the quality of services;
- Attend required training and share good practice with the team members;
- Identify resources to meet the needs of GBV survivors and communicate with the Manager regarding their introduction.

Required Skills and Experience

1. Over five years of experience in the field of family and sexual violence, gender-based violence or other related social work area;
2. Degree in Social Work, Psychology, Community Work, Social Science or other related social field;
3. Working knowledge of relevant legislation;
4. Able to work on own initiative and manage complex and difficult situations;
5. Experience in working in partnership with other agencies to achieve effective outcomes;
6. Demonstrate integrity, sensitivity and understanding;
7. Is approachable, adaptable and assertive;
8. Is a problem-solver and decision-maker;
9. Has excellent negotiating and influencing skills;
10. Has high productivity and takes initiative;
11. Is a team member and works collaboratively with others;
12. Communicates effectively;
13. Able to keep and maintain records;
14. Strong IT Skills.

5.3. Data and Administration Officer

The Data and Administration Officer reports to the Secretariat Manager for the data collection and entry, and day-to-day running of the Secretariat's office.

Service Delivery

- Receive incoming referrals made to the GBVAC Secretariat;
- Liaise with service users and professionals as required;
- Enter GBV data and produce regular reports;
- Ensure that data entry is completed accurately and within the required timescale;
- Support PGBVAC in facilitating and running monthly PGBVAC Steering Committee meetings;

- Take minutes and letters as required;
- Handle mail;
- Order and maintain stationary supplies;
- Document presentation, including binding, photocopying and filing;
- Manage utility supplies;
- Coordinate IT maintenance, anti-virus support and back-up;
- Support the Manager in coordinating usage, storage and layout of the building;
- Support maintenance schedules.

Quality Standards

- Coordinate a healthy, safe environment for clients and visitors and maintain the building;
- Support and update display boards at the Secretariat to ensure that they are relevant and current;
- Set a good example in terms of dress, language, punctuality and attendance;
- Be proactive in matters relating to the health and safety requirements of the building;
- Develop and improve administrative systems to enhance provision;
- Manage clients and partners' feedback on services provision and response;
- Manage bookings of one-stop-shop activities/venues.
- Abide by the Code of Conduct, which is informed by the zero tolerance to violence principle.

Development

- Develop systems for recording and reporting as required;
- Attend supervisions and team meetings;
- Participate in creative meetings and discussions towards development;
- Respond to system and organizational changes as required.

Finance

- Petty cash management;
- Adhere to set budgets when purchasing equipment or services;

- Obtain a selection of quotes when purchasing equipment or services, analyse data, make recommendations;
- Report on spending;
- Coordinate any quotes for purchasing of equipment, maintenance, services, etc.
- Ensure all expenses are authorized by the Manager;
- Be economical with resources;
- Comply with the finance policy in relation to petty cash and staff expense procedure.

Required Skills and Experience

1. Educated to diploma level as a minimum;
2. Has at least two years of experience in an administrative role;
3. Able to accurately key in data;
4. Able to create and edit word-processed documents;
5. Able to create and edit spreadsheets;
6. Confident at using e-mail and the Internet;
7. Able to file accurately;
8. Able to organize small scale events;
9. Able to create and edit databases;
10. Is motivated and keen to learn;
11. Can use own initiative and work as part of a team;
12. Is dependable, reliable and highly organized;
13. Good at time management;
14. Has great verbal and written communication skills;
15. Able to quickly follow verbal and written instructions.

5.4. Driver

Under the guidance and supervision of the Secretariat Manager, the Driver provides reliable and safe driving services to GBV survivors to/from the Secretariat and other PGBVAC stakeholders, ensuring the highest standards of discretion and integrity, a sense of responsibility, and excellent knowledge of protocol and security issues.

Responsibilities and Job Specifics

- Ensure provision of reliable and safe driving services on a rota basis by driving vehicles for the transport of GBV survivors, the GBVAC Secretariat team and delivery and collection of mail, documents and other items;
- Pick up GBV survivors from incident location in partnership with other stakeholders and in line with protocols and procedures;
- Ensure cost-savings through proper use of vehicle and through accurate maintenance of daily vehicle logs, and prepare and adhere to vehicle maintenance plans and reports;
- Ensure proper day-to-day maintenance of the assigned vehicle through timely minor repairs, arrangements for major repairs, timely changes of oil, tyre-checks, brake-checks, and car washing, etc.;
- Ensure availability of all the required documents/ supplies, including vehicle insurance, vehicle logs, office directory, and map of the city/country, first aid kit, and necessary spare parts, in the assigned vehicle.
- Ensure that all immediate actions required by rules and regulations are taken in the case of involvement in accidents;
- Perform any clerical duties as assigned by the supervisor;
- Abide by the Code of Conduct, which is informed by the zero tolerance to violence principle.

Required Skills and Experience

1. Educated to Grade Ten as a minimum;
2. Holds a valid driver's license;
3. At least three years of work experience as a driver;
4. Safe driving record;
5. Has skills in minor vehicle repair;
6. Has an ability to perform a variety of repetitive and routine tasks and duties;
7. Demonstrates excellent knowledge of driving rules and regulations, and skills in minor vehicle repair;
8. Demonstrates excellent knowledge of protocol;
9. Demonstrates excellent knowledge of security issues.

6. GBV Case Management and Coordination

One of the key roles of the Provincial GBVAC Secretariat is providing inter-agency case coordination services for GBV survivors, with the aim of improving the safety and access to justice of child and adult survivors through a collaborative approach that focuses on timely intervention following an incident.

Inter-agency case coordination is an integrated, multi-agency approach supporting people at high risk of serious injury, harm or death due to gender-based

violence. Inter-agency case coordination is a critical feature of an effective integrated response. It provides a platform for agencies to share information, develop comprehensive risk assessments, plan strategies to mitigate risks and work towards child and adult survivor safety and perpetrator accountability. It is also important for creating transparency and accountability between agencies about their roles and responsibilities in responding to gender-based violence.

THE DIFFERENCE BETWEEN CASE COORDINATION AND CASE MANAGEMENT:

CASE COORDINATION	CASE MANAGEMENT
Support the PGBVAC agency to assist GBV clients they work with	Working directly with GBV clients

STAGES:

1. GBV case reported
2. Case is entered in a database
3. Cases reported assessed and reviewed
4. MACC is called
5. Follow up on MACC Action Plan Activities
6. Case progress recorded
7. Reports produced

To support seamless survivors' pathways through the service system and coordinated actions and activities between agencies, the PGBVAC Secretariats will work closely with other agencies in the province. This may include 1) referral of a survivor and/or; 2) inviting an agency to contribute information to and participate in multi-agency case conferences.

The PGBVAC Secretariat does not replace the work of individual agencies, nor does it eliminate the need for agencies to work in collaboration outside of the GBVAC Secretariat's role.

The PGBVAC Secretariat monitors and processes all GBV cases in the province. All cases are risk assessed by PGBVAC partners and reported to the PGBVAC Secretariat. GBV cases assessed as 'high risk' are referred to the PGBVAC Secretariat for the Multi Agency Case Conference. Those identified as 'medium risk' or 'low risk' are reported to the Secretariat only for monitoring.

In some cases, where it is necessary, and as directed by the PGBVAC Secretariat Manager, the GBV Case Coordinator will undertake case management activities to prevent a survivor from serious future harm.

- The PGBVAC Secretariat will process referrals by receiving:
1. Direct referrals, where GBV survivors walk in or call the office directly (Refer to Case Management Section).
 2. High risk referrals from other PGBVAC partners for facilitating a Multi-Agency Case Conference (Refer to Multi-Agency Case Conference Section).
 3. All other medium and low risk cases from PGBVAC agencies for monitoring (Refer to GBV Data Section).



NOTE: Under the Lukautim Pikinini Act 2015, all children age 18 and below in need of protection are legally required to be referred to the Family Services for child protection assessment and safeguarding plans. However, if there are no available functioning child protection services in the province, the case is referred to the PGBVAC Secretariat, an immediate risk management plan is implemented and a Multi-Agency Case Conference is called.

6.1. GBV Disclosure and Intake

A survivor has the freedom and the right to disclose an incident to anyone. They may disclose their experience to a trusted family member, friend or seek help from a trusted individual or organization in the community. They might choose to seek some form of legal protection and redress by making an official report to police, or other local authorities. Anyone the survivor tells about their experience has a responsibility to give honest and complete information about services available, to encourage them to seek help, and to accompany them and support them through the referral pathway in line with the policies and guidelines.

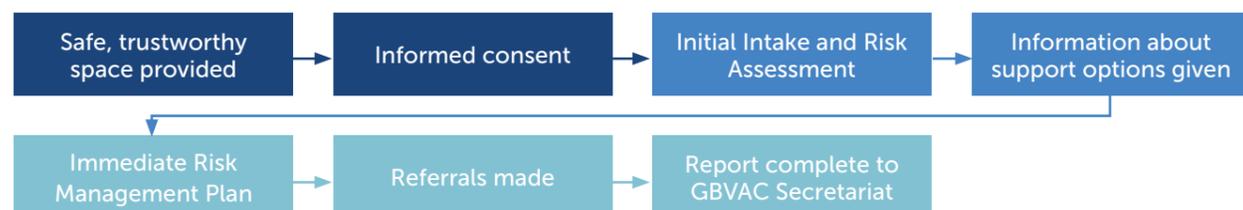
The PGBVAC and the Secretariat coming into contact with GBV survivors is responsible for knowing the GBV referral pathways and the forms of assistance available. The appropriate referral pathway for a GBV response is shown in Section 6.1.1.

The PGBVAC or Secretariat requires the survivor's informed consent (APPENDIX 2) to make contact with a primary focal point on the GBV referral pathway and facilitate the contact between service provider and survivor. If a survivor consents to share their information, the referral should be made using the coded Inter-Agency GBV Referral Form (APPENDIX 5), which also notes whether the risk assessment has been completed in the last two weeks. This is to ensure the survivor is not required to answer the same questions more than once.

The wishes of the survivor must always be respected as to where or with whom to seek help. He/she should not be urged into a particular course of action. All information should be kept confidential, even if family or community members request feedback on support given.

When the PGBVAC Secretariat receives cases directly, staff must ensure that:

1. The GBVAC Secretariat office is accessible, safe, private, confidential and trustworthy. Survivors are more likely to come forward to seek help and report a GBV incident under such conditions;
2. The survivor accessing services is comfortable. Ask if he/she has someone they trust and is supportive, and who will wait with him/her, with their permission;
3. Informed consent (APPENDIX 2) is obtained before any intervention and referral;
4. Initial emotional support and information about the support options (medical, psychosocial, legal, safety, and security) is provided. Benefits and consequences of such support are discussed.
5. The importance of receiving medical attention as soon as possible after an incident of sexual violence is explained to the survivor to prevent tetanus, STIs, HIV/AIDS and unwanted pregnancy;
6. The GBV Intake and Assessment Form (APPENDIX 1) and Inter-Agency Referral Form (APPENDIX 5) are completed only after having discussed all options with the survivor and agreed upon a safety plan.
7. A risk management plan (APPENDIX 3) is established together with the survivor to address their needs. If the survivor is in imminent danger, develop a safety plan based on the best interest of the survivor to maximise safety;
8. A referral is made to relevant agencies (APPENDIX 5);
9. The number of people informed of the incident and the information shared is limited; and
10. Information that makes a survivor identifiable should never be shared in meetings, and individual cases should never be discussed.



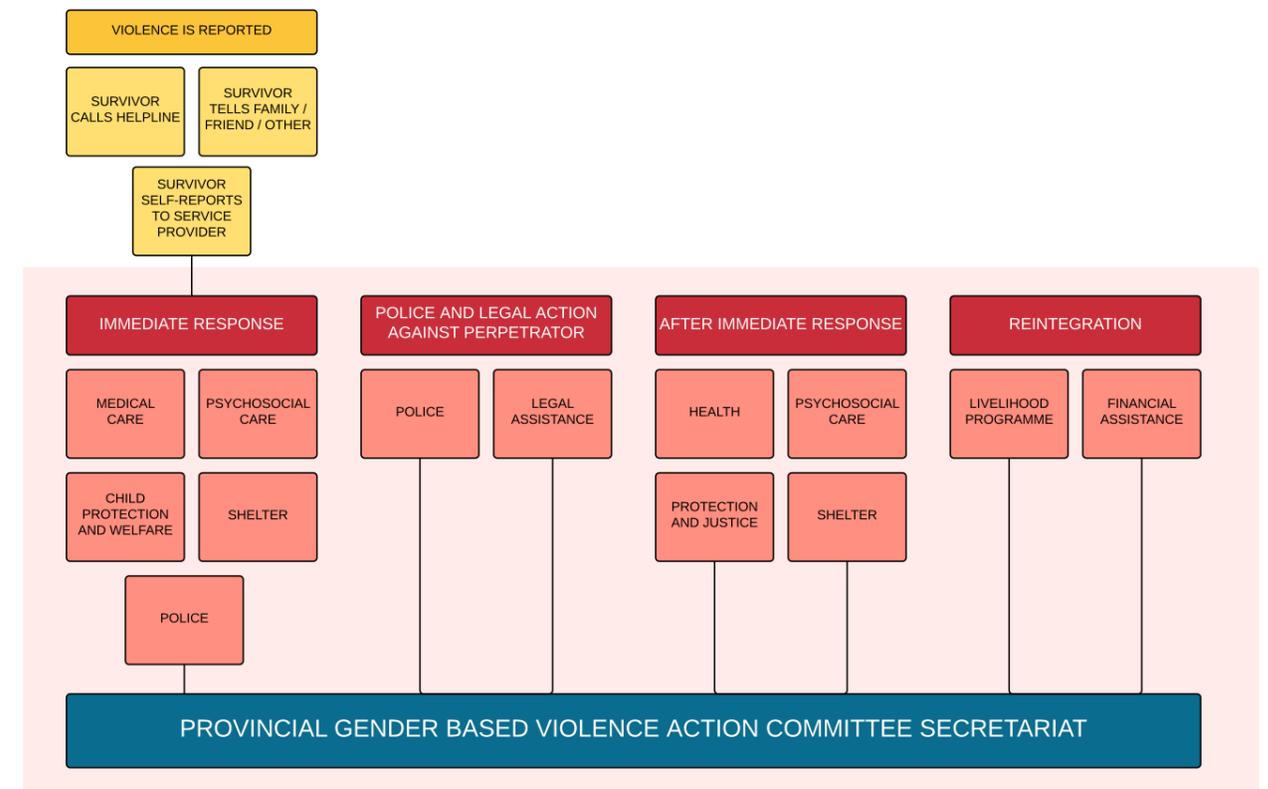
6.1.1. Referral Pathway

A referral pathway describes the processes by which survivors make contact with an individual professional, or institution, about their case, and how professionals and institutions communicate and work together to provide them with support. Partners in a referral network include different government departments, community and faith-based organizations, and others.

A referral pathway is an institutional framework that connects various entities with well-defined mandates,

responsibilities and powers into a network of cooperation. The overall aim is to ensure the protection and assistance of survivors, to aid in their full recovery and empowerment, to prevent GBV, and to prosecute perpetrators.

The below graph outlines the general steps of a referral pathway: from the survivor reporting the violence that occurred, to his or her reintegration, and the closure of the case.



6.1.2. What to do if Referral is Declined

The reasons why some survivors decline offers of assistance to deal with gender-based violence are complex. They can include (but are not limited to) reasons related to culture, religious beliefs, fear, finances, previous experience with support agencies, concern about losing children, or a combination of any of these and other factors.

When an initial interview has confirmed that violence is occurring and the client declines referral, it should be reiterated that they do not have to endure the violence. It is also important in these circumstances to let the client know that services are available to offer further support.

They should be encouraged to accept information as a minimum support that will enable them to access help if they later change their mind and if their circumstances deteriorate. This should include a police contact number and the 1-Tok Kaunselin Helpim Lain (7150 8000). It is important to remain supportive and non-judgemental when assistance is declined, in order for the client to feel that the door is open should they return.

6.2. Consent and Information Sharing

The survivor should be given honest and complete information about possible referrals for services. If he/she agrees and requests referrals, he/she must give his/her informed consent before any information is shared with others. The survivor must be made aware of any risks or implications of sharing information about their situation. He/she has the right to place limitations on the types of information to be shared, and to specify which organizations can and cannot be given the information.

6.1.3. When Referral is Declined and Children are Involved

When screening confirms that violence is occurring and that children have been harmed or threatened with harm, and the survivor declines offers of assistance, referral should be made to the Office of Family Services (established under the Lukautim Pikinini Act 2015) if the view is that remaining in the family home presents an on-going risk to any children's safety and wellbeing. This does not require the survivor's permission, but they should be advised of the concerns for the children's safety and wellbeing as a result of their decision not to accept referral, and that Family Services will be contacted.

In dealing with this sensitive situation, it is also important to reassure the survivor that he/she is not being held responsible for the children's experiences: that the violence and its consequences for the children are the responsibility of the perpetrator. The survivor should also be informed that under the Lukautim Pikinini Act (2015) the Office of Family Services has the power to remove children from the unsafe environment through application to the court. Children removed are placed in a safe environment and are in the care of the state.

For further information on responding to children's cases, refer to Section 7 on Child Survivors.

Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely, (see also the guiding principles in Section 3.)

The survivor must also consent to the sharing of non-identifying data about the case for data collection and security monitoring purposes.

6.3. Risk Assessment

Risk assessment (APPENDIX 1) is the process of identifying the presence of a risk factor and determining the likelihood of an adverse event occurring, the consequence of that event and the timing of when that event may occur.

It is very important to ask all of the questions on the risk assessment. The 'n/a' option is included where the survivor does not know the answer to a specific question and where ticking 'no' would give a misleadingly low risk level. The risk assessment should be carried out with every client disclosing abuse, which will assist in identifying the levels of risk a client may be exposed to and what appropriate services to offer.

Completed risk assessment needs to be submitted to the PGBVAC Secretariat Data Administration Officer.

The PGBVAC agency completes the risk assessment form (APPENDIX 1) to assess the level of risk in GBV cases. The risk assessment is a list of questions. If the survivor answers yes to at least one of ten high risk indicators their case will be determined as high risk and a referral to MACC will be made.

If a professional has concerns that a survivor will be seriously harmed by the perpetrator, they should refer the case regardless of the risk assessment score. Serious harm is defined as a risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible. All cases referred under this criterion will automatically be discussed at a full MACC meeting.

The initial aim of the assessment is to encourage the survivor to tell their story and define the problem in their own words. The risk assessment conversation should be introduced to the survivor with an

explanation about the purpose of the assessment, the possible outcomes of the assessment, and any actions that may be taken after the assessment.

The assessor must engage the survivor in a conversation that will explore the presence of risk factors and the survivor's sense of their own risk. The list of 'do's' and 'don'ts' on communicating with survivors is in Appendix 6.

When introducing the risk assessment to the client it is important to explain confidentiality, information sharing and the MACC referral before beginning to ask these questions. This will create transparency and clarity for the client about how and when the information they disclose might be used and shared. The client should also sign a form confirming that they understand and consent (APPENDIX 2).

Before you begin the risk assessment it is also useful to:

- Determine how much time the client has to talk;
- Determine whether the perpetrator is around, due to return or expected back at a certain time;
- Introduce the concept of risk to your client and explain why you are asking these questions.

It is important to be aware that Lesbian Gay Bisexual or Transgender (LGBT) persons and Men who have Sex with Men (MSM) who are accessing services will have to disclose both their abuse and their sexual orientation or gender identity. Creating a safe and accessible environment where survivors feel they can do this and using gender-neutral terms such as partner/ex-partner is essential.

6.3.1. Protective Factors

It is important to determine whether protective factors are present that may serve to mitigate the risk. Protective factors may include, but are not limited to:

1. A survivor's decision to move away from the perpetrator. (This factor can, however, significantly increase the level of risk and must be carefully examined, because it is only protective if there is no chance of the perpetrator locating the survivor);
2. The perpetrator being incarcerated or otherwise prevented from approaching the survivor.

Other protective factors to consider may include the survivor being employed (and therefore being less isolated), having a well-developed social network and having access to resources such as money, transport or a place to stay.

6.3.2. Professional Judgement

Professional judgement is needed to analyse the information obtained through the conversation with, and observation of, the survivor (and perpetrator if appropriate). It is also required to determine the significance of risk and vulnerability factors in the overall presentation of the survivor, because the presence of some risk factors should be indicative of risk. The likelihood of the risk factors re-occurring may

also help to determine whether the survivor is in need of immediate protection or at elevated risk.

While the presence of any risk factor indicates that some risk is present, professional judgement is required to determine the significance of this and the resulting risk level.

6.3.3. Determining the Level of Risk

Having collected as much information as possible about the survivor and their situation, an assessment of the level of risk should be made.

The risk should be assessed as:

1. High Risk or requires immediate protection, where at least one out of ten high risk factors have been identified, which signifies further serious violence is imminent and immediate action is required to prevent this from occurring;
2. Medium Risk or elevated risk, where there are over 16 risk factors identified as present that are likely to continue, indicating the need to initiate safety planning;
3. Low Risk or at risk, where some violence risk indicators are present (up to 15 factors) but where structures are already in place to manage the risk, or the risk can be managed through survivor support and referral.

6.4. Immediate Risk Management

Immediate risk management is the process of coordinating efforts to minimize, monitor and control the likelihood of an adverse outcome. Following the risk assessment, a risk management plan is required for each survivor, regardless of their risk level (see Appendix 4).

The risk management plan should be developed in consultation with the survivor, except in cases where the assessor believes:

1. The survivor to be at extreme risk but unwilling to take action and a police response is required to secure their safety. Referral to police is required;
2. A child's safety is at risk. Referral to Child Protection is required;
3. The survivor is in need of urgent medical or psychiatric care. Referral to the Family Support Centre (FSC) or hospital is required.

Effective risk management planning requires the person undertaking the risk assessment to be aware of other service providers, their role, the services they provide and their referral processes, (refer to the FSV Referral Pathway Guidelines.)

All decision-making about referrals should occur in consultation with the survivor, and they must consent to sharing their information with another person or service (except in instances detailed above). It is important, therefore, to canvass referral options with the survivor and clearly explain the service options.

Effective referral requires:

1. Information sharing between agencies to ensure survivor safety;
2. The risk assessment should form part of the referral;
3. Minimizing the need for survivors to repeat previously disclosed information;
4. Telephone contact and consultation with the agency where the referral is to be made to ensure it is appropriate and to ascertain any waiting list issues, the need for completion of any referral forms, which should be done in conjunction with the survivor, and consultation with the service to discuss roles and responsibilities.

When working with people who are experiencing abuse it is important to provide them with options and support them in making their own decisions. Generally, it is important that the survivor is empowered to make their own decision about whether leaving the abusive situation is an option for them.

All risk management must involve some level of safety planning, and the survivor must participate in and understand this process. All safety planning must be completed urgently without waiting for the MACC to take place.

Mobile Phones: Survivors should be made aware that the perpetrator is able to access information about calls from mobile and land-line telephones, as well as pages accessed via the Internet. Services should encourage survivors to regularly clear the 'recently dialled numbers' log of their mobile telephone and dial another 'safe' number after contacting services via the land-line.

Separation: This is a time of extreme danger. Separation includes the survivor leaving the perpetrator, or the perpetrator being removed from the home due to a Protection Order, police charges or holding powers, or otherwise against their will. It may be appropriate and empowering for some survivors to develop their own safety plan with minimal assistance, while other survivors may need considerable assistance. The assessor must judge the survivor's level of risk and provide the appropriate level of assistance.

The risk management plan must be documented and include a statement that summarizes the current risk level of the survivor. It should also include what took place and whether it was successful, partially successful or unsuccessful (APPENDIX 3).

The below table lists key actions in response to a particular level of risk, as well as children’s cases.

ALL CASES

1. Provide the survivor with contact details for specialist support agencies (see the PGBVAC Services Directory).
2. Ask the survivor if they consent to a referral support service. If yes, make the referral.
3. Consider the needs of any children involved: does the referral to Child Protection need to be or can be made?
4. Are there any vulnerable adults involved (disabled, elderly, MARPS)? Is referral needed to specialist services?
5. If the person is hurt, refer for urgent medical assistance to FSC/Hospital.
6. Does the person have somewhere safe to stay tonight? Can they stay with friends or family? Do they need temporary accommodation?
7. Has a crime been committed or is it likely a crime will be committed? Contact the FSVU/Sexual Offences Squad (SOS)/Police.

LOW RISK	<ol style="list-style-type: none"> 1. Information and advice about their legal rights, including protection orders; 2. Advice about possible referral pathways for counselling or other appropriate service responses; 3. The names and telephone numbers of people they can call if they believe their level of risk has altered; 4. Advice on how to develop a safety plan for themselves and any children involved; 5. Advice about appropriate on-going support options. 	CHILDREN'S SAFETY	<ol style="list-style-type: none"> 1. Identify a safe place to go when things at home become unsafe; 2. A trusted friend to go to for help, their telephone number, a code word to indicate the need for help and directions about what type of action to take (for example, call the police, tell an adult, call a helpline, meet the child at a certain location); 3. Provide them with access to money to make phone calls, catch public transport or take a taxi. 		
	MEDIUM RISK		<ol style="list-style-type: none"> 1. Information and advice about their legal rights, including protection orders; 2. Advice about possible referral pathways for counselling or other appropriate service responses; 3. The names and telephone numbers of people they can call if they believe their level of risk has altered; 4. Help and support to develop a safety plan for themselves and any children involved; 5. Report to Child Protection if required; 6. On-going contact and support from the appropriate service provider. 	CHILDREN'S SAFETY	<ol style="list-style-type: none"> 1. Identify a safe place to go when things at home become unsafe; 2. A trusted friend to go to for help, their telephone number, a code word to indicate the need for help and directions about what type of action to take (for example, call the police, tell an adult, call a helpline, meet the child at a certain location); 3. Provide them with access to money to make phone calls, catch public transport or take a taxi.
			HIGH RISK		

If appropriate, ensure the survivor knows how to contact one of the staff members. Consider whether the strategy is aimed at trying to REMOVE, AVOID, REDUCE or ACCEPT the risk.

Risk management responses must be undertaken in conjunction with any criminal and/or court action that may already have been taken by police.

It is important to offer advice on how people can keep themselves safe within their households, and also what to consider if they do decide to leave.

**THINGS TO CONSIDER IF SURVIVOR IS LEAVING AN ABUSIVE RELATIONSHIP
REMEMBER THE RISK WILL INCREASE**

Money	Ensure they have enough money saved in case they need a taxi/ bus quickly. Bank cards.
Passport, other identification documents	Children’s passports if they have them.
Other legal, financial papers	Medical, baby books, marriage and birth certificates.
Keys	Have an extra set of house, car and office keys made and keep them somewhere safe – can they leave these with a friend or relative?
Emergency addresses and contact numbers	1-tok Kaunselin helpim line, school, doctor, solicitor, ensure that they are always with the survivor.
Medicine and baby provisions	Prescriptions, glasses, medications, nappies, baby milk, food etc. Diabetes, Malaria, TB, HIV prophylaxes medications.
Clothes	Take essential items and extra clothes for any children.
Children’s toys	Children may be confused and upset by what is happening and a special toy can help settle them.
Personal items	Photographs, diary, jewellery, small items of sentimental value.

The survivor needs to leave some items with a friend or relative so they can escape quickly.

IN AN EMERGENCY it is always better to leave something or everything behind, rather than put themselves and their children’s safety at risk.

Referring a high risk survivor to MACC is a key action following this outcome from a risk assessment. However the next MACC meeting may not be for a number of weeks and it is important that immediate safety measures are always taken in addition to making the MACC referral.

After the risk management planning ensure the following:

1. Have you got all of the necessary information for a MACC referral in case you are unable to contact again?
2. Have you got their consent for the MACC referral?
3. Have you updated any colleagues on the situation should you be unable to return to work?

6.4.1. The Perpetrator

The future safety of survivors begins with interventions for perpetrators, in order to remove the threat, or possibility of further harm. For many reasons, however, intervening with perpetrators is itself a risk. Violence often escalates once the violent relationship is made known to others. An effective response to violence should anticipate an escalation of the violence once it is disclosed.

A proactive response to the source of the violence, the perpetrator, is a part of the risk management process. For women's and children's services, information about perpetrators is to be obtained from women and children in order to develop an informed and effective safety plan. Reports to police will be necessary when further violence is anticipated, and information from police about perpetrators is relevant to providing safety for survivors.

Referral pathways for the perpetrator may be considered once the survivor risk assessment is complete and a plan is in place.

The risk management plan may include contact with the perpetrator (though only ever with the survivor's consent) and discussion about suitable referral options, which may include:

1. *Participating in a men's behaviour change group;*
2. *Undergoing individual counselling for behaviour change, drug and alcohol abuse or past violence.*

Contact with the perpetrator is vital when the survivor is in a relationship with them, or when there are children involved and access/contact needs to be arranged. Service pathways should be discussed with the perpetrator and the survivor and consent obtained for a suitable referral.

6.5. Multi-Agency Case Conferences

Multi-Agency Case Conferences (MACCs) are regular multi-agency meetings to be held at least fortnightly. They provide a forum for sharing information and taking action to reduce harm to the highest risk survivors of gender-based violence. MACCs are outcome based, and have a unique format, primarily focused on the needs and safety of the survivor, and linking where required to other multi-agency forums, to address safeguarding the needs of adults and children.

The key aims of the MACC are:

1. To share information to increase the safety, health and wellbeing of survivors;
2. To jointly construct and implement a safety plan that provides professional support to all those at risk and that reduces the risk of harm;
3. To reduce repeat victimization;
4. To improve agency accountability;
5. To improve support for staff involved in high risk cases;
6. To work in partnership, where necessary, to safeguard children and adults; and
7. To determine whether the perpetrator poses a significant risk to any particular individual or to the general community.

At the heart of the MACC process is the understanding that no single agency or individual can deliver a range of professional services or can see the complete picture of the life of a survivor. All service providers involved may have insights that are crucial to a survivor's safety.

6.5.1. MACC Meeting Coordination and Administration

The focus of MACC meetings is on addressing any immediate protection problems and coordinating response actions for each individual case. The survivor must consent to information sharing with all participants in case conferences. If consent has not been given, then the individual case must not be discussed.

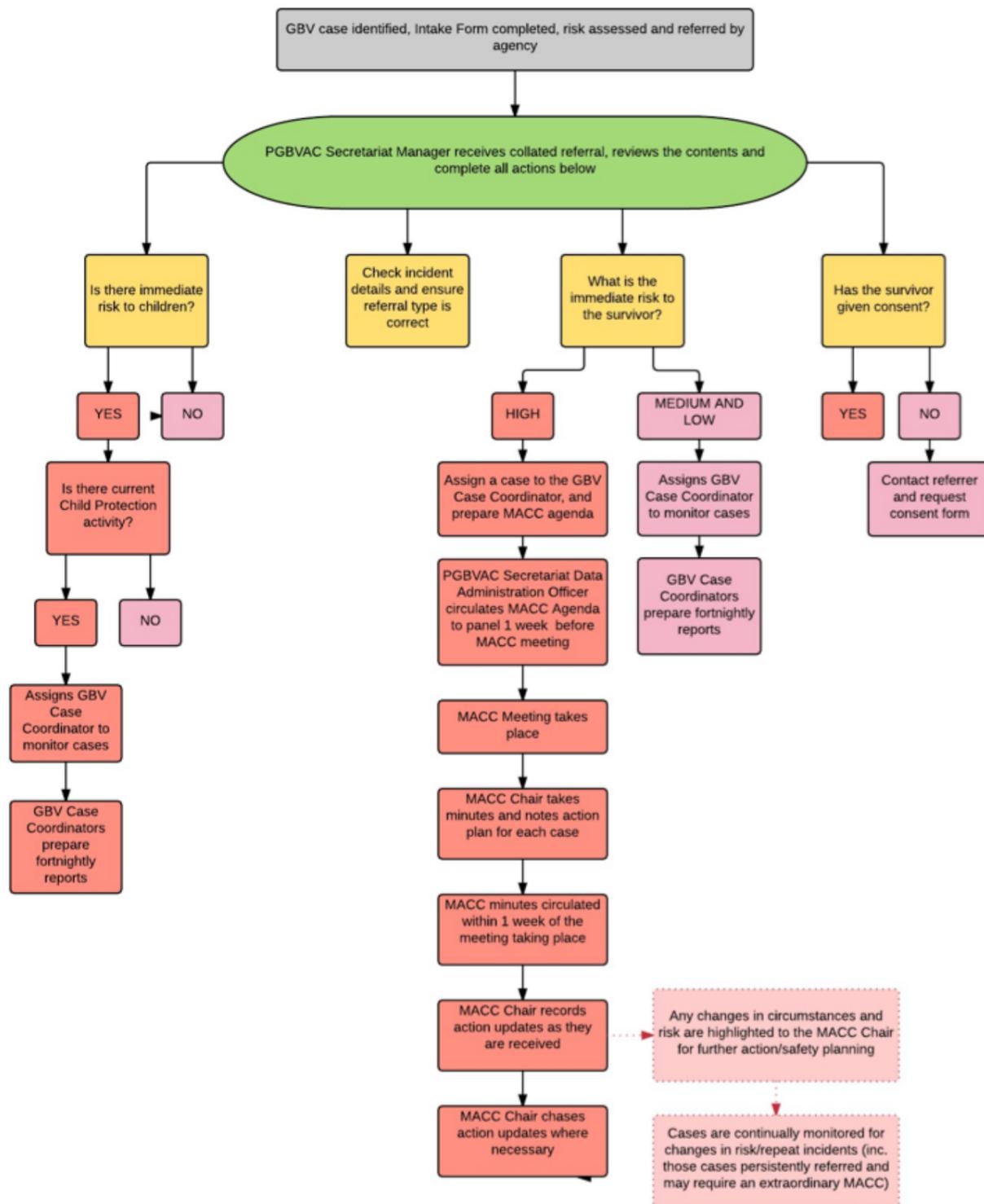
Agencies may participate in case conferences by invitation only. Those invited to the case conferences are the agencies directly involved in the case. It should only include PGBVAC members with permission to receive/share information about a specific survivor. The information shared at this meeting is strictly confidential and will focus on actions taken and actions needed.

It is the responsibility of the PGBVAC agency which referred the case being discussed to ensure that information sharing has been duly pre-authorized by the survivor (APPENDIX 2). The referring agency also keeps the survivor informed of decisions and progress made.

The PGBVAC Secretariat will receive high risk cases of gender-based violence and convene a Multi-Agency Case Conference. The PGBVAC Secretariat GBV Case Coordinators will chair the meetings.

The PGBVAC Secretariat Data Administrator will collate all the relevant information from MACC referrals received and forward to the Secretariat Manager to assign cases to GBV Coordinators and develop the MACC Agenda (APPENDIX 7). The MACC Agenda requires circulation to all MACC panel members seven working days prior to the MACC meeting (APPENDIX 8).

The below graph illustrates the steps taken by the PGBVAC Secretariat team upon receiving the GBV Intake form from one of the GBVAC agencies.



6.5.2. The MACC Agenda

The MACC agenda is in the form of an Excel spreadsheet workbook. The first worksheet provides the basic information on all cases to be heard at the MACC meeting; this forms the general agenda for the meeting. There are further worksheets provided for each individual case-by-case unique identifying number. These additional worksheets contain all information provided by the referring agency, including any action already taken. Following the meeting, the information provided at the MACC meeting, together with any actions delegated, will be recorded within these individual case worksheets. As action updates are received, this information is then also added to the individual case worksheets.

The MACC agenda will be ordered to ensure that 'New Cases' are heard first, followed by 'Repeat Cases' and then 'Cases for Mention'. The order of cases is subject to change. In the event that a service provider or PGBVAC Secretariat staff member may only hold information for one case, they may request their case to be heard at a more suitable point in the agenda to ensure that they can be in attendance. In these circumstances the PSVAC Secretariat must be informed prior to the agenda being circulated to ensure that cases can be appropriately ordered.

Referrals received after the deadline, which have not been agreed by the Chair to be included within the formal MACC agenda, will not be added to the case workbook. These cases will instead be mentioned at the meeting to ensure the MACC Panel are aware of the case and can take any necessary action. The case will then feature within the formal agenda of the next full MACC meeting.

A MACC research form (APPENDIX 9) is available to MACC panel members to assist in completing their research prior to the MACC meeting. This form also contains an action log for MACC panel members to record actions delegated to them at the meeting, and the deadline for their completion.

6.5.3. MACC Agencies: Actions Following Receipt of Agenda and Prior MACC

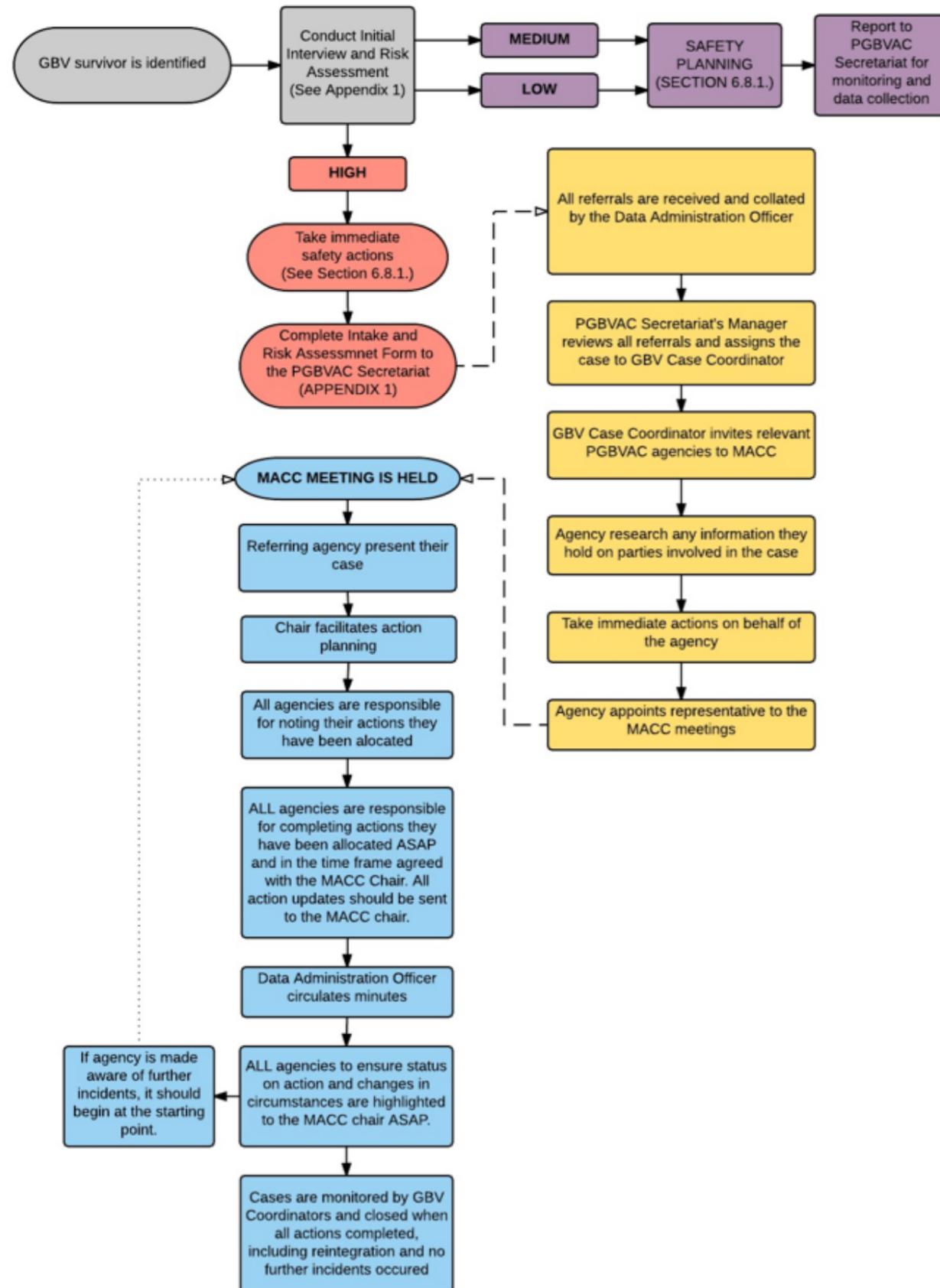
Agencies attending MACC are expected to (even if they have not directly referred cases):

1. Implement any necessary immediate actions to increase safety;
2. Collate relevant information held by their agency in relation to the survivor, children and perpetrator, including up-to-date contact details, information about agency involvement and risks;
3. Identify an agency representative to attend the MACC meeting and ensure they are fully briefed prior to the meeting;
4. Notify the PGBVAC Secretariat GBV Case Coordinator if they are unable to send a representative to the meeting, and arrange to provide an information update in another format, e.g. a written report or attendance by conference call.

6.5.4. The MACC Meeting

MACCs are held every two weeks or as required. The meeting lasts for approximately three hours and held at a secure venue. Details of the venue are confirmed by the PGBVAC Secretariat Data Administrator upon an agency officially joining the MACC, or accepting an invitation to attend a meeting, in order to limit any potential security risks. The meeting venue has to ensure confidentiality of the cases being discussed: no one should be allowed to walk in or out freely, walls need to reach the ceiling and floor.

The Chair of the MACC is one of the GBV Case Coordinators of the PGBVAC Secretariat. The below graph illustrates the processes prior, during, and post MACC meeting.



6.5.4.1. What to Expect at a MACC Meeting

MACC involves a large number of agencies, most of which have allocated the same individual to be their representative at every meeting. For MACC to be as efficient as possible and to aid the development of professional relationships, it is preferable that agencies identify a consistent MACC representative to attend meetings.

You can expect approximately ten agency representatives to be in attendance, possibly with additional individuals observing the meeting.

MACCs are held in a 'boardroom' style layout. The Chair will take a record of the information shared and actions agreed at the meeting, usually directly onto a laptop computer.

The MACC meeting follows a set format (see Appendix 10). This begins with an introduction from the Chair who reads the Confidentiality Declaration (see Appendix 11) and clarifies the purpose of the meeting. The Chair will then ask everyone to introduce themselves and the Confidentiality Statement is circulated for signatures of all present acknowledging their agreement to abide by the principles listed in the aims of the meeting.

The Chair will also ask for any conflicts of interest to be declared at this point. If there is a conflict of interest because one of the panel members is personally connected to any individual/s involved in a MACC case, or because of previous professional involvement, they must declare it. It is advised that they contact the MACC Chair as soon as they are aware of this conflict of interest so it can be managed appropriately.

Whether it is a referring agency or a participating agency they should consider doing the following in the instance of a conflict of interest:

1. Informing the manager as soon as possible that they have a conflict of interest and the nature of it;
2. Discussing the conflict with the MACC Chair, if they feel more comfortable doing so in the first instance, rather than with the manager;
3. Jointly agreeing if it is appropriate that someone else deals with the case, including making the referral/collating information and attending the MACC, or whether it is feasible for them to be excused from the section of the meeting where the case is discussed;

4. Jointly agreeing if the conflict of interest should be declared to the MACC panel. It may be agreed that as long as the conflict is noted, no other action is required; and
5. It may also be advisable for the paperwork for this case to be stored elsewhere.

Cases are heard in the order they are listed on the agenda, starting with 'New', then 'Repeat', then 'Mention' cases. The referring agency will introduce the case, providing a brief synopsis of the situation, headline risk factors, up-to-date information and survivor views (if applicable). Much of the referring information is provided in the agenda, making it available to agencies prior to the meeting. Time should not be spent repeating this information, but summarizing it.

The Chair will then ask all agencies in attendance if they have additional information. Once all available information has been presented the Chair will then facilitate the development of an action plan and allocate deadlines to these actions. A key action in all plans will be identifying an individual from an agency to act as the lead in communicating with the survivor.

Once the plan has been formulated the Chair will clarify that no agency has anything additional to add and will then move on to the next case.

6.5.4.2. MACC Meeting Etiquette

The MACC meeting needs to run as efficiently as possible; there will be many cases to cover within a limited time and it is important that the last case is given as much attention as the first. It is vital that agencies present their information in a concise and factual way. Professional judgement is encouraged, however 'hearsay' is of limited use. Agencies are politely requested to not speak over their colleagues or to conduct other conversations whilst an agency is presenting information.

The Chair will facilitate contradictions of information to be explored, and agencies are encouraged to respectfully challenge their MACC colleagues if they disagree with their views, e.g. an agency may believe a certain action is not fruitful, while another may disagree. If an agency is unhappy with the conduct of another MACC agency during the MACC process, they should take this up with the agency directly.

6.5.4.3. Attendance at MACC

When agency representatives are unable to attend a MACC it is expected that they will brief an appropriate deputy to attend in their place. If it is not possible to send a deputy, a written submission should be sent in advance to respective GBV Case Coordinator, outlining all information collated and actions implemented to-date.

The agency's representative will then be responsible for reading the minutes of the MACC and ensuring any actions they have been allocated are completed, and that any additional actions they feel are relevant are completed and updated.

An action update should then be provided to the PGBVAC Secretariat GBV Case Coordinator within the timescales set at the meeting. As a matter of course, the PGBVAC Secretariat GBV Case Coordinator should be updated if an action cannot be completed within the deadline set at the meeting, or if it cannot be completed at all.

Sending information to the PGBVAC Secretariat GBV Case Coordinator, or in the event that the agency representative and the deputy cannot attend, should be considered the minimum standard of participation at the MACC. If the agency is the one who made the referral to the MACC they must attend to present the case.

6.5.4.4. Information Shared At The MACC Meeting

Decisions to disclose must be necessary and proportionate, taking into account:

1. The prevention or detection of crime, including risks to someone's safety and/or child protection needs;
2. If it is in the public interest;
3. The right to life and to live free from inhuman and degrading treatment and torture;
4. If it is needed in order for confidential counselling, advice and support to take place.

Information shared at MACC should be relevant, proportionate and differentiate between fact and opinion. The information presented by each agency should be accurate and directly relevant to the safety of the survivor and their children. This information falls into the following categories:

1. Basic demographic information including any pseudonyms used and the ages of any children;
2. Information on key risk indicators including, where appropriate, professional opinion;
3. Any relevant history of abuse or other associated behaviour by the perpetrator or survivor;
4. The 'views and wishes' of the survivor; and
5. Actions taken by the agency already and those that could be taken.

The information shared at MACC should be strictly limited to the aims of the meeting.

Below is a list of information that may be shared at a MACC meeting. This list provides examples, and other information not included on the list may be shared during certain cases if it is deemed to be relevant, proportionate and factual. Information shared at MACC should be accurate and directly relevant to the safety of the survivor and their children.

Demographic Information	<ul style="list-style-type: none"> • Age • Residential location • Sex • Disability • Ethnicity • Sexual orientation • Housing situation • Health history/mental health • School details (attendance, behaviour etc.)
Risk Factors	<ul style="list-style-type: none"> • Pregnancy • Escalation of violence/abuse • Drug/alcohol misuse • Mental health concerns • Parties involved have recently separated • Sexual assaults • Suicide (threats, or attempts) • Whether a weapon has been used • Cultural/diversity issues • Stalking • Child care issues • Whether children have been present during incidents or directly involved • Survivor engagement with agencies • Child protection issues • Internally displaced person • Tribal conflict
History of Abuse/Significant Behaviour	<ul style="list-style-type: none"> • Previous incidents • Relevant criminal convictions • Professional encounters with any party involved and their perception of the situation and behaviours displayed • Current involvement with agencies
Views and wishes of the survivor	<ul style="list-style-type: none"> • The survivor's involvement with agencies • The survivor's views on what support can be put in place to ensure safety • The survivor's wishes for housing support • Any concerns the survivor has • Action the survivor would like to take (i.e. to support police action etc.)
Actions taken by agencies prior to MACC	<ul style="list-style-type: none"> • Child protection referrals • Referrals to other specialist agencies • School updated on any issues • Safety plan for the survivor • Housing support (emergency transfer etc.) • Security at the survivor's home/current address • Financial support

The information that agencies present at MACC is considered to be owned by that particular agency, not by MACC itself. In the event that an agency needs to share information presented at MACC outside of the MACC meeting, they must contact the agency to whom the information belongs and request permission to use the information they hold.

6.5.4.5. Storage of MACC Information

Information shared under the remit of MACC contains personalized information and is therefore highly confidential. Where there is a need to print MACC information, there is a minimum security requirement for all agencies to store the information in a lockable cabinet, within a room with a door that is locked and secured when the premises are vacant. Storage and security of information is crucial at all stages of data handling, in particular when individuals are transporting information in paper copy to and from locations.

Once paper copies have fulfilled their use they must be disposed of as confidential waste by shredding or other means.

All MACC agencies will retain and review the material in line with their own data storage and information security policies and procedures. If a breach of data security is identified this should be reported through the appropriate channels of that agency. All agencies must have internal disciplinary policies in place for dealing with security breaches. It may also be deemed necessary to notify the MACC panel of any breaches of data security. This should be done by contacting the MACC Chair in writing.

It is the responsibility of each signatory to the agreement to ensure that their staff and any individual having access to information produced as a result of the MACC have been vetted to a satisfactory standard, and have received sufficient training to enable them to handle such information.

The MACC Chair will also periodically remind partner agencies at the MACC meeting that they should ensure their e-mail accounts are being managed effectively, and seek assurances from managers that this is being done.

Particular care must be taken when agencies are disposing of old hard drives that have been used to store information relating to the MACC. A suitably approved device must be used to wipe the memory, or the hard drive must be physically destroyed to prevent third parties gaining access to this sensitive information.

6.5.4.6. The Survivor's Voice at the MACC

The survivor is not invited to attend the MACC meeting. Due to the volume of cases discussed per meeting it requires a business-like and formal approach. It may involve sensitive intelligence previously unknown to the survivor and is time-restricted. To this end it is not set-up to provide the environment that may be required or expected by survivors.

The views and wishes of the survivor are, however, crucial to enabling effective risk management and intervention. These views are predominantly represented at the meeting by the agency referred, unless a representative of another agency has been identified as more suitable.

The person advocating for the survivor will:

1. Contact the survivor a minimum of 48 hours in advance of the MACC meeting to ascertain a current status update of the survivor's needs, wishes and situation;
2. Notify the PGBVAC Secretariat if unable to make contact with the survivor prior to the MACC meeting;
3. Represent and advocate these views at the MACC meeting;
4. Update the survivor a maximum of three working days after the MACC meeting, (unless this action is allocated to another participating agency);
5. Notify the PGBVAC Secretariat of any changes in the survivor's circumstances, which may effect the successful implementation of the safety plan.

6.5.4.7. Sharing MACC Information with the Survivor

An effective MACC relies on regular communication and consultation with the survivor. It is the responsibility of the MACC Chair to designate a MACC representative to update the survivor on the outcome of the MACC meeting, in particular the details of the safety plan.

6.5.4.8. Sharing MACC Information with the Perpetrator

There may be occasions when the alleged perpetrator within the MACC case becomes aware that they have been discussed at a MACC meeting and requests information in relation to this. It is key to remember that the information is owned by each agency and not by the MACC.

If a perpetrator seeks confirmation on their 'MACC status' and/or requests information from the MACC meeting, it is advised that, if possible, agencies do not confirm whether their case was discussed at MACC.

6.5.5. Macc Risk Management Plans

A tailored action plan (APPENDIX 11) will be developed for each case presented at MACC to ensure the safety of the survivor, children and other vulnerable parties is increased. Actions designated to each case must be SMART (Specific, Measureable, Achievable, Realistic, Time-limited), effective in reducing repeat victimization and, where appropriate, demonstrate the use of coordinated resources.

It is essential that actions are completed in a timely manner, within the agreed timescales set by the Chair. Actions will usually be categorized into the following:

- ⇒ Standard Actions: To be completed as soon as possible, or within one week of the MACC taking place (unless otherwise specified);
- ⇒ Urgent Actions: The MACC Chair will provide a deadline for completion of urgent actions, usually within a maximum of 48 hours of the MACC taking place.
- ⇒ Survivor Updates: Actions to update the survivor on the outcome of MACC are to be completed as soon as possible, or within at least three working days after the MACC has taken place.

Confirmation of completion and action updates should be sent to the PGBVAC Secretariat as soon as actions have been completed, and within the deadlines set at the meeting. Incomplete actions should be considered the exception, with agencies ensuring that if an action is not achievable that the PGBVAC Secretariat is informed immediately to enable alternative arrangements to be explored.

It is the responsibility of each agency, and not that of the PGBVAC Secretariat or its Chair, to ensure that their actions have been completed within the timescales set.

In the event that the PGBVAC Secretariat has not been informed that actions have been completed, contact will be made with the relevant agencies requesting this information, with a copy to be sent to the head of the agency.

Agencies must ensure that the PGBVAC Secretariat is informed of their action updates before the next scheduled MACC meeting. With prior agreement the agency lead may update on the action at the meeting. Action updates will be recorded by the PGBVAC Secretariat GBV Case Coordinator within the minutes of the MACC meeting.

6.5.6. Actions Following The MACC Meeting

Minutes of the MACC will be circulated within a week of the meeting. Therefore, agency representatives will be responsible for noting any urgent actions they are required to complete to ensure a timely response. In addition, following the MACC agencies will be expected to:

1. Complete any actions they have been allocated within agreed timescales;
2. Update the PGBVAC Secretariat when actions have been completed, or of any reasons why actions remain uncompleted;
3. Update any internal agency colleagues, working with the individual or family, with any relevant information pertaining to safety of service users and practitioners;
4. Update the PGBVAC Secretariat of any change in circumstances that may impact on risk to MACC cases, e.g. perpetrator released from prison, pregnancies etc.; and
5. Make a Repeat referral to MACC as required using the Intake and Risk Assessment Form (APPENDIX 1).

Following the MACC, an agency will be allocated the responsibility of updating the survivor. It is vital that this agency provides an update as soon as possible and within three working days of the MACC. If they are unable to make contact they should notify the PGBV Case Coordinator as a matter of urgency.

6.5.7. Minutes and Administration

The PGBVAC Secretariat Data Administration Officer is:

1. The first point of contact for referrals to MACC; and
2. Responsible for taking and circulating minutes.

The PGBVAC GBV Coordinator is:

3. The contact for all action updates; and
4. The point of contact for any MACC enquiries.

The PGBVAC Secretariat Administrator will ensure that the minutes (APPENDIX 7) of the MACC meeting are circulated within one week of the MACC taking place, by e-mail or as a hard copy and only to those who were present at the MACC. It is the responsibility of each agency representative to note their own actions at the meeting so that there is no delay in the completion of actions, and therefore the implementation of a risk management plan. Deadlines for actions to be completed are from the date of the MACC meeting and not from the date of receipt of the minutes. All action updates should be sent to the PGBVAC Secretariat GBV Case Coordinator as soon as they are complete, and these will be recorded within the minutes.

The PGBVAC Secretariat GBV Case Coordinator will send a reminder to those MACC attendees who have not updated on the status of their actions seven working days following the MACC meeting. This ensures that all actions are complete, and they therefore do not need to be discussed at the next MACC meeting. Agencies must not wait for this

reminder to complete their actions and should be updating the PGBVAC Secretariat Administrator prior to this reminder being issued. If agencies continue to need reminding this will be referred to the PGBVAC Secretariat Manager for their consideration and action.

As stated above, if an agency is unable to complete their designated action, they should notify the PGBVAC Secretariat GBV Case Coordinator as soon as possible. This will enable the action to be reallocated or amended as appropriate, so that the risk management plan is not negatively affected. In this instance the PGBVAC Secretariat GBV Case Coordinator will update the minutes and notify the MACC representative who is updating the survivor of any amendments, so the survivor is kept fully informed.

The PGBVAC Secretariat holds an access database for all MACC cases to be listed. This system is used by the PGBVAC Secretariat to ensure referrals are categorized correctly. If referrals received are categorized as 'Repeat' cases, these will be checked via the database, to ensure the case has been heard previously within the last 12 months. When cases fall outside of this 12-month bracket, they will be added to the MACC agenda as a 'New' case, highlighting to the panel the reasons for this. In these instances, the cases will still be given the same case number, but it will be noted in the minutes the reasons for it being classified as a 'New' case.

The process of planning, holding and following up of MACC is illustrated in Appendixes 8, 10 and 12.

6.6. Healing, Recovery and Reintegration

The GBV survivors can be further protected and the adverse effects of the abuse may be reduced through programmes and services designed for the recovery and reintegration with the family and the community. The GBV Case Coordinator, with the help of the other MACC members, plays a crucial role in determining other psychosocial interventions geared towards healing, recovery and reintegration. These psychosocial interventions, however, must be commenced immediately after the first contact with the survivor, and not when the survivor is about to be reintegrated to the community.

The GBV Case Coordinator must consider the following:

1. Convene the MACC to discuss the case reintegration plan with specific goals and interventions for the protection, recovery and reintegration of the survivor.
2. Actively involve the participation of the survivor, the survivor's family and community leader if appropriate in the development of the recovery and reintegration plan.
3. If there are children involved in the case the parenting capability of parents or guardians must be fully assessed. If found to be lacking or poor, the parents and guardians must be enrolled in a parenting capability enhancement programme, if available.

If the child is under protective custody in a child-caring agency/facility, appropriate interventions need to be identified to address the needs of the child, such as individual and group counselling, therapeutic activities, life skills education, vocational training, etc.

The interventions must prepare the child for reintegration with the family, if they are found to be capable of the care, nurture and protection of their child. Otherwise, placement in other parental arrangements, or adoption, shall be explored.

The child, who is nearing 18 years old and who expressed a desire for independent living after discharge from the temporary shelter, shall be given assistance and sufficient information to help him/her make such a transition.

4. The reintegration plan is required to assist the survivor to address their identified problems, such as inadequate income to meet basic needs, poor health, out-of-school children, lack of knowledge on proper parenting, and the rights of children, etc. Interventions may be in the form of parent education, self-employment assistance, vocational/skills training, family counselling/therapy, and educational assistance for the children, etc.
5. Before any reintegration is done, there must be assurance that family members and community are able to provide a safe, protective and nurturing environment for the survivor.
6. One of the GBVAC agencies participating in the MACC should be assigned to regularly monitor the survivor's progress in the community.
7. If both the survivor and the perpetrator live in the same community, repatriation arrangements should be considered and planned.
8. The survivor should be prepared before repatriation to address fears, apprehension and doubts, etc. to build and sustain the survivor's and family's trust of the receiving PGBVAC Secretariat, or other agency.

In case of repatriation the following should be accomplished:

- Reports and records submitted to the agency receiving the case; and
- A MACC called for the repatriation.

The MACC shall be convened after the receiving agency is in receipt of the reports/records. The social worker that will transfer the case shall accompany the child to the receiving agency at which the conference may be conducted.

7. GBV Child Survivors Case Coordination

Case coordination for GBV child survivors should be provided by a GBV Case Coordinator trained in dealing with children. In addition to the general skills described in Section 6, case coordinators dealing with child protection cases should be able to:

1. Apply the guiding principles in working with children (see Section 3);
2. Be familiar with child development and children's wellbeing;
3. Communicate and work with children of various ages and families, including those who have experienced very difficult situations;
4. Identify strengths and needs to engage the child and family in the process;
5. Understand resources and abilities in children and families, even in difficult circumstances;
6. Assess risks, needs and strengths and develop the appropriate response in consultation with the child and/or his/her caregiver(s);
7. Follow informed consent procedures for children, (see Section 7.2. on obtaining informed consent from children and caregivers and Section 7.1. on mandatory reporting);
8. Be guided by the best interest of the child in all actions at all times, (the principles are specified in the LPA Operational Manual 2015); and
9. Ensure that cases are handled confidentially.

7.1. Reporting

Children who have experienced violence may be referred by service providers, community members, or may make themselves known directly to the PGBVAC Secretariat staff.

Under the LPA Section 38, any person who performs professional duties with respect to a child, and in the course of that person's professional, official, or community duties, finds reason to believe that the child is in need of protection, shall immediately report the matter to the Office of Family Services or, if not available, to the PGBVAC Secretariat.

The professionals who must notify of a child in need are:

- a. Any health care professional
- b. Dentist
- c. Psychologist
- d. Counsellor
- e. Social worker
- f. Principal, teacher
- g. Member of the clergy – priest, pastor
- h. Lawyer
- i. Police officer
- j. Community based corrections officer
- k. Juvenile justice officer
- l. Correctional services officer
- m. Community development officer
- n. Community development office worker
- o. Community child protection volunteer
- p. Operator/employee of a child-minding centre or child-care service
- q. Operator/employee of a place of safety or out of home care.

If any of the above professionals fail to report a child who is in need of protection, PGBVAC staff are required to report it to the Office of Family Services, who may instigate a civil proceeding against that professional.

In the provinces where child protection officers exist, all suspected child abuse cases should be sent to the Family Services Office. The Office will report all cases back to the PGBVAC Secretariat for data collection and monitoring of the referral pathway.

7.2. Informed Consent from Children and Caregivers

The PGBVAC Secretariat staff will seek informed consent from the child or family in order to call MACC and devise a risk management plan:

- If 18 years and over, written consent should be given. A consent form (APPENDIX 2) should be used;
- If 18 to 14 years, written consent should be given. A consent form (APPENDIX 2) should be used;
- If under 14 years, written consent is not necessary, but the GBV Case Coordinator should explain the need to disclose the information and seek the agreement of the parent/guardian/family member.

Under the LPA 2014, Child Protection Officers or the GBV Case Coordinator designated under the LPA, DO NOT NEED INFORMED CONSENT to disclose information of a child in need of protection,

in the following circumstances:

1. If the child's health and safety would be in danger if the information was not disclosed to an appropriate professional or government officer;
2. If the health and safety of other children in the family would be in danger if the information was not disclosed to an appropriate professional or government officer;
3. If the health or safety of an adult in the family, either parent, guardian or sibling would be in danger if the information was not disclosed to an appropriate professional or government officer; and
4. If the disclosure is about the sexual abuse of the child, other children in the family, or adults in the family.

Informed consent MUST be voluntary. It is unethical to refuse to give someone support or provide a service if they do not consent to information about them being given to someone else.

7.3. Multi-Agency Case Conference

MACC will be convened for all GBV child cases. It will invite professionals, such as the Child Protection Officer, doctor, police, and representatives of the temporary shelter directly involved in handing a child who is, or is believed to be, a survivor of child abuse. Other officers, such as a councillor and a lawyer, if available and involved, may also be invited. The procedures of the MACC are as for all other GBV cases, described in Section 6.9.

In addition to the general MACC procedures, the following must be observed in child survivors' Multi-Agency Case Conferences:

1. MACC is convened at the earliest possible time, specifically as follows:
 - Before placing the child under protective custody;
 - Immediately after investigation of serious physical or sexual abuse; and
 - For periodic assessment of the case, and planning and monitoring of interventions and progress.
2. The GBV Case Coordinator shall only invite those who directly work with the child or have relevant knowledge about the child and family. Other professionals who may likely be involved in any follow-up action may be invited.

3. In any context other than that of child protection, information given and shared during the MACC is confidential and shall not be disclosed to any other person or agency without the permission of the contributor.
4. The focus of the case conference is not only the prosecution of the abuser but primarily for the protection of the child.
5. It is not only the subject child who shall be the sole focus of intervention, but all the other children in the household. There must be risk and needs assessment of all the children in the household.
6. The MACC members shall consider the following:
 - The level of risk to the child and other children in the household;
 - Welfare planning to protect the child, such as,
 - i. To return the child to live with parents guardian,
 - ii. To live with relatives,
 - iii. To remove from the home and place in a temporary shelter;
 - Parenting capability;
 - The opinion of the subject child; and
 - The need to involve other members of the family.
7. During the MACC meeting members shall:
 - Examine the cause for concerns and analyse the available information;
 - Share, if available, the results of the joint investigation/interview and the decision of the immediate case assessment;
 - Assess the level of risk and whether the child and siblings should be placed under protective custody;
 - Agree and record clearly an inter-agency plan to protect the child(ren);
 - Identify other professionals and/or agencies who may be necessary to implement the welfare plan and follow-up interventions to protect the child; and
 - Decide how the child and the child's parents will be informed of the case conference outcome and decisions.
8. Parents or guardians may be required to appear in the MACC, especially in cases as follows:
 - When their views on the child's custody is necessary, particularly when suspension or termination of parental authority would be the likely recommendation;
 - When their views are necessary for planning appropriate interventions for the child's best interest; and
 - When monitoring actions are taken, or progress of actions are taken in relation to the intervention plan.

8. Data Collection, Management and Monitoring

Data collection and analysis is the backbone of results-based response. It is critical to the effectiveness of targeted service delivery, advocacy, policy development, and accountability and monitoring.

By monitoring GBV response activities through collection of quality data, the Government and service providers can:

- Ascertain whether programming priorities are evidence-based;
- Ensure that project development and implementation, policy work, funding solicitation, etc. are all rooted in identified problems and related needs;
- Monitor the impact and effectiveness of interventions and strategies and ensure they are effective;

- Show accountability and good governance;
- Provide decision makers with information required for planning, resource allocation, programme design, programme improvement and effectiveness of the programme; and
- Correctly assess whether minimum standards exist for comprehensive prevention and response.

In order to build the GBV Database, Intake Forms and Risk Assessment Forms (APPENDIX 1) will be used for data collection by the Provincial GBVAC stakeholders and Secretariat. The GBVAC Secretariat will compile GBV data onto an electronic centralized database and complete data analysis of received reports. The PGBVAC Secretariat will provide reports to the National GBV Secretariat, the Provincial GBVAC and the Provincial Executive Council.

8.1. Completing the Intake Form

The form has a dual function in that it is used for the initial reporting of all GBV cases reported, regardless of which stakeholder the case is reported to, and also for tracking individual cases through the referral pathway up to and including the closure of the case.

This form is designed to support the PGBVAC Secretariat's data requirements. Stakeholders will require further data for their own purposes. For example, the Family Support Centre will require medical data that this form does not support. In all such cases it is for the individual stakeholders to collect and store their own data, in addition to the data supplied to the GBVAC Secretariat

FIRST PAGE

The Name of the organization:

Input the name of your organization.

Contact person name, number and e-mail address:

Input the name, the phone number and e-mail address of the person completing the form. The Secretariat must have the contact details of the person who made the referral in case they have questions or queries regarding the form. The person who completed the form is the best person to answer these questions. If you do not have an e-mail address, please note, 'no e-mail'.

Unique Identifying Code:

Question 1	Question 2	Q 3	Question 4	Q 5	Question 6

The Unique Identifying Code (UIC) is designed to identify the client, whilst at the same time maintaining confidentiality.

The UIC is based upon six questions that the client will provide the answers to. The answers to the questions generate the UIC. Regardless of where the client enters the referral pathway, using the UIC makes it possible to track the client's progress from the initial incident reporting, through to the completion of the case.

Every time the client meets with any of the service providers, the service provider will ask the client if they know their UIC. If the client knows the UIC it is recorded on the FSV/GBV Data Collection Form. If the client does not know their UIC, then the service provider asks the client the six questions and generates the UIC, which is then recorded on the FSV/GBV Data Collection form.

The six questions are as follows:

Question 1: What are the last two letters of your last name at birth?

Question 2: What is your district of birth? (Use first two letters.)

Question 3: Are you left- or right-handed?

Question 4: What is your order of birth? (01, 02, 03, etc.)

Question 5: What is your gender? (1 for male, 2 for female, 3 for transgender.)

Question 6: What are the last two letters of your first name at birth?

Unique Identifying Code Generation Example:

The following is an example of how the six questions are used to generate the UIC:-

The answer to Question 1 is TH (the client's last name at birth is Smith, the last two letters are TH)

The answer to Question 2 is GO (the client was born in Goroka district, the first two letters are GO)

The answer to Question 3 is R (the client is right-handed)

The answer to Question 4 is 03 (the client was the third child born; the client has an older brother and an older sister)

The answer to question 5 is 2 (the client is female, therefore 2)

The answer to question 6 is RY (the client's first name at birth is Mary, the last two letters are RY)

We then take the answers to generate the UIC and complete the UIC box on the FSV/GBV Data Collection Form. When completed the UIC box looks like this:

Unique Identifying Code:

Question 1	Question 2	Q 3	Question 4	Q 5	Question 6
T	H	R	O	3	2

Risk Level Assessed:

Use the Risk Assessment to assess the level of risk that the client is in. When the Risk Level has been established please tick the appropriate box, i.e. High, Medium or Low.

If the risk to a survivor is assessed as High, it is the responsibility of the service provider to respond immediately and refer the survivor to the PGBVAC Secretariat, which will facilitate MACC for the case.

Age:

Ask the client their age. If they are unsure of their exact age, ask them to take a best estimate. Write out the client's age in both letters and numerals, i.e. Twenty-six (26).

Sex:

Tick the box that corresponds to the client's sex, i.e. Female, Male, Transgender, or Not Disclosed.

The Type of the Most Recently Reported Incident:

Record the type of incident here. Many clients will have experienced multiple GBV incidents in their life. However, we need to record only the most current incident, and not previous incidents. Many incidents are of more than one type. For example, a client may have suffered Rape/Penetration, Physical Assault and Removal or Damage to Property, all within the same incident. In a case such as this all the boxes that apply need to be ticked, ensuring that all the boxes ticked apply only to this most current incident. If the client reports a type of incident that is not on the form, then tick the 'Other' box and specify the type within the space provided.

Dependent Children Impacted:

Record here any children impacted by the incident; either the client's children or any other children. If children were impacted, tick the 'Yes' box; otherwise tick the 'No' box.

Number of Children:

If the answer to Children Impacted was 'Yes', then write out the number of Children Impacted in both letters and numerals, i.e. Five (5). If the answer to Children Impacted was 'No', then put N/A in the space provided.

Referral Made To:

If the answer to Children Impacted was 'Yes', then record here to where the children were referred and tick the appropriate box. If the answer to Children Impacted was 'No', then put N/A in the space provided.

Date of Referral:

If the answer to Children Impacted was 'Yes', then record here the date on which the children were referred. If the answer to Children Impacted was 'No', then put N/A in the space provided.

Perpetrator's Details:

Input here whether the perpetrator was male, female, transgender or not known, by ticking the appropriate box.

Number of Perpetrators:

Input here the number of perpetrators the client is reporting for this incident. Use the space provided to write out the number of perpetrators in both letters and numerals, i.e. Five (5).

Age:

Tick boxes as appropriate for 'Under 18' or 'Over 18', or 'Not Known'. If there is more than one perpetrator tick as many as apply.

Relationship of the Perpetrator to the Client:

Establish with the client the nature of their relationship to the perpetrator, then tick the appropriate box. If the perpetrator is known to the client and is neither an Intimate Partner nor a Person of Authority, then tick the 'Known' box and specify the type of relationship in the space provided, e.g. friend, uncle. If the perpetrator is unknown to the client then tick the 'Unknown' box.

Referral Received From:

Input the date that the referral was received in the space provided. Tick the box indicating the type of organization who made the referral.

Referred To:

Input the date that the referral was made in the space provided. Tick the box indicating the type of organization to whom you are referring the client.

Current Case Status:

Input the Current Status of the Case by ticking the appropriate box. Add the individual's date of referral next to the referred agency.

SECOND PAGE**High Risk Factors:**

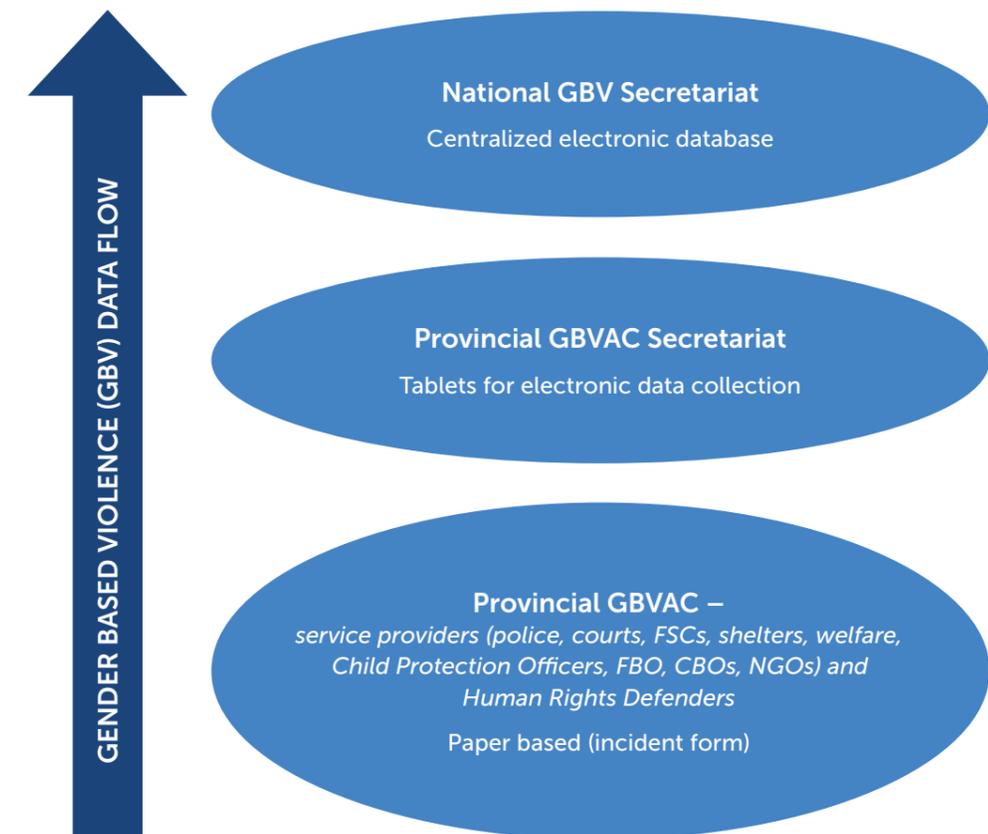
Establish with the client whether any of the ten conditions listed in the High Risk Factor section are applicable in this case. For all ten conditions tick one of the three boxes associated with the condition. If one or more of the boxes is ticked 'Yes', then the client must be considered at High Risk and the appropriate action must be taken.

Other Risk Factors:

Establish with the client whether any of the 32 conditions listed in the Other Risk Factor section are applicable in this case. For all 32 conditions tick one of the three boxes associated with the condition. If 15 or less of the boxes is ticked 'Yes', then the client must be considered at Low Risk and the appropriate action must be taken. If between 16 and 32 boxes are ticked 'Yes', the client must be considered at Medium Risk and the appropriate action must be taken.

8.2. Data Collection

The Intake Form will provide data that can be used to report valuable indicators. This is important in order to measure the quality and effectiveness of services for the individual survivor, and will also help to analyse the context, situation and needs.

DATA FLOW

8.2.1. Data Collection, Management and Monitoring at the Service Provider Point

The service provider points constitute provincial GBVAC stakeholders responding to GBV through provision of different services to survivors. They are the points of entry, where GBV survivors report their experience of violence and are able to access and receive necessary services and support.

The service delivery points include:

- Police/SOS/FSVU;
- Courts: village court, district court, national court;
- Public solicitors;
- The Public Prosecutors Office;
- Family Support Centres/hospital/clinic/other health facilities;
- Child and Family Support Services;
- Shelters;
- Provincial GBVAC Secretariats;
- Counselling services;
- NGOs, Community Based Organisations, Faith Based Organisations;
- Human Rights Defenders;
- Others (schools, churches etc.).

Data collection at the Provincial GBVAC service provider point is the sole responsibility of the agency's staff. Data management and monitoring are the responsibilities of a designated data officer, if available, or the head of the service provider.

- At the services provider point data collection is done by using the paper based Intake Form.
- The Intake Form is a one-page form with additional pages for a risk assessment.
- The Intake Form must be filled for every individual for the most recent incident reported at the service delivery point.
- The Intake Form is a data collection form and does not replace any other forms already used by the service provider.
- The Intake Form must be completed in the presence of the survivor to ensure that all collected information is accurate as per the survivor's report.

- All agency's staff who deal directly with survivors must be trained on how to fill in the Intake Form to ensure consistency in data collection.
- Data may be managed electronically or be paper based at the service delivery points, depending on the available resources and capacity.
- Data management and monitoring must be assigned to particular staff trained in data management and monitoring.
- Data has to be protected. If electronic, data must be protected using passwords and access restricted to service delivery staff only. If paper based, the data must be kept in a safe lockable place and access restricted to service delivery staff only.
- Data sharing protocols with other agencies should be documented, agreed and followed.
- Where data is needed for purposes other than data collection, consent must be sought from the survivors for its use.

8.2.2. Data Collection, Management and Monitoring at the Provincial Gbv Secretariat

- The Provincial GBVAC Secretariat will transfer paper-based data from the service provider into an electronic format.
- Data collection, management and monitoring are the sole responsibilities of the Data Administration Officer. If not present, the role is allocated to the GBV Case Coordinator.
- Data collected using the Intake Form will be transferred to smartphone or tablet by the PGBVAC agency or the PGBVAC Secretariat Data Administration Officer on a fortnightly basis by visiting service providers.
- The smartphone/tablet will be equipped with an application installed to display the same questions and data elements in the paper Intake Form.
- The Data Administration Officers will be trained on how to use the application, (to enter data and update the services received by the survivor).
- Once entered or updated in the tablet, the data will be sent to the central database at the National FVSAC Secretariat.

- The tablet must have a password to ensure the protection of the data and only used by authorized personnel.
- The tablet shall not be used for other services, other than entering and updating the data. This is to ensure the safety of the device and the information contained in it.

8.2.3. Data Collection, Management and Monitoring at the National Gbv Secretariat

The National GBV Secretariat will host the electronic centralized database, and will be managed by the Data Administration Officer at this level.

- The Data Administration Officer will be in charge of controlling access and use of the application.
- He/she will be singularly responsible for changing usernames and passwords for the tablets.
- He/she will be responsible for authorizing access to the web-based format of the application.
- He/she will assess the performance of different provinces.
- He/she will be responsible for ensuring that the centralized electronic database is up-to-date.
- He/she will be responsible for aggregating and tabulating data for reporting and other purposes.
- He/she will oversee the overall data collection, management and monitoring process.
- He/she must be computer literate and will be trained and coached on managing the database.
- He/she will make national and international reports on GBV.

8.2.4. Standard Guidelines for GBV Data Collection, Management and Monitoring

Collecting information on GBV is a fundamental part of the Monitoring and Evaluation (M&E) of interventions. The World Health Organization's eight recommendations outline safety and ethical issues that are typically associated with the planning, collection and use of GBV information. These recommendations must be followed for all GBV programming and M&E activities relating to data collection, storage, use and dissemination.

The recommendations include:

1. The benefits to respondents or communities of documenting gender-based violence must be greater than the risk to respondents and communities;
2. Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound and builds on current experience and good practice;
3. Basic care and support for survivors must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of gender-based violence;
4. The safety and security of all those involved in information gathering about gender-based violence is of paramount concern and should be continuously monitored;
5. The confidentiality of individuals who provide information about gender-based violence must be protected at all times;
6. Anyone providing information about gender-based violence must give informed consent before participating in any data gathering activity;
7. All members of the data collection team must be carefully selected and receive relevant and sufficient specialized training and on-going support; and
8. Additional safeguards must be put in place if children are to be subjected to information gathering.

8.3. Reporting

After collection of GBV data from the service providers the Provincial GBVAC Secretariat will provide monthly and annual reports. Monthly and annual reports (APPENDIX 12) are produced by the Manager of the Secretariat and include the following statistics and data:

1. Total number of cases reported;
2. Who are the first entry points for the cases;
3. Number of high risk cases;
4. Age of survivors;
5. Age of perpetrators;
6. Survivor's relationship with the perpetrator;
7. Number of Interim Protection Orders (IPOs) issued;
8. Number of cases referred to shelter;
9. Number of perpetrators arrested;
10. Number of court cases closed (perpetrator sentenced, fined or doing community service); and
11. Number of cases reintegrated safely in the community.

The annual reports include:

1. Total number of cases reported;
2. Who are the first entry points for the cases;
3. Number of high risk cases;
4. Percentage of re-victimization cases – repeated abuse;
5. Age of survivors;
6. Age of perpetrators;
7. Number of dependent children impacted;
8. Number of perpetrators per incident;
9. Survivor's relationship with the perpetrator;
10. Number of IPOs issued;
11. Number of permanent protection orders issued;
12. Number of IPOs breached;
13. Number of cases referred to shelter;
14. Number of perpetrators arrested;
15. Number of GBV related deaths;
16. Number of withdrawn cases;
17. Number of court cases closed (perpetrator sentenced, fined or doing community service);

18. Number of repatriations;
19. Number of cases reintegrated safely in the community; and
20. Number of perpetrators referred to support services.

The Manager will also include automatically generated statistical reports from the database, which will be compiled and submitted by the Data Administration Officer.

The reports will be shared with:

1. The Provincial Administrator, and presented at PEC meetings;
2. The Provincial GBVAC, and presented at the monthly GBVAC meetings; and
3. The National GBV Secretariat.

9. Appendices

Appendix 1: Intake Form



PROVINCIAL FSVAC SECRETARIAT Intake Form and Risk Assessment (Data Collection Form)

WRITTEN CONSENT RECEIVED FROM SURVIVOR: YES NO

The name of the organisation: _____

Contact person name, number and e-mail address: _____

Unique Identifying Number (UIN):

Q1	Q2	Q3	Q4	Q5	Q6

Risk Level Assessed: HIGH MEDIUM LOW

DOB (best guess if unknown): _____

Sex: Female Male Transgender Not disclosed

Q1 - last two letters of last name, at birth	Q2 - first two letters of District at birth	Q3 - Left or right handed? (R / L)	Q4 - Order of birth? – 01, 02, 03 etc.	Q5 - Gender: 1 – Male, 2 - female, 3 - transgender	Q6 - last two letters of first name at birth?
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The type of the most recent reported incident (tick as many as apply):

<input type="checkbox"/> Rape/Penetration	<input type="checkbox"/> Forced Marriage	Date of the incident:
<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Denial of Resources, Opportunities, Services	
<input type="checkbox"/> Physical Assault	<input type="checkbox"/> Psychological/Emotional Abuse	
<input type="checkbox"/> Trafficking/ Abduction	<input type="checkbox"/> Removal or damage to property	
<input type="checkbox"/> Sorcery Accusation	<input type="checkbox"/> Other (specify) _____	

Depended children Impacted: <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral Made To:	<input type="checkbox"/> Shelter or other safe place _____	Date of Referral:
Number of Children: _____		<input type="checkbox"/> Unsafe (specify) _____ <input type="checkbox"/> Office for Family Services	

Perpetrator's details: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Not Known	Age: <input type="checkbox"/> 18 and under <input type="checkbox"/> 19 and over <input type="checkbox"/> Unknown	<input type="checkbox"/> Known (specify) _____ <input type="checkbox"/> Intimate Partner <input type="checkbox"/> Person of authority (police, teacher, leader, etc.) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown
Number of perpetrators: _____		

Referral received from:	Referred to:	Current Case Status:	Date:
Date received:	Date Referred:	<input type="checkbox"/> Services delivered & completed at our agency	
<input type="checkbox"/> Self-referred	<input type="checkbox"/> FSVAC Secretariat	<input type="checkbox"/> Interim protection order (IPO) issued	
<input type="checkbox"/> Health/medical	<input type="checkbox"/> Health/medical	<input type="checkbox"/> Permanent protection order (PPO) issued	
<input type="checkbox"/> Counselling	<input type="checkbox"/> Counselling	<input type="checkbox"/> IPO breached	
<input type="checkbox"/> Police/SOS/FSVU	<input type="checkbox"/> Police	<input type="checkbox"/> Arrest made	
<input type="checkbox"/> Shelter	<input type="checkbox"/> SOS	<input type="checkbox"/> Perpetrator sentenced in jail	
<input type="checkbox"/> Legal Services	<input type="checkbox"/> FSVU	<input type="checkbox"/> Perpetrator fined by court	
<input type="checkbox"/> Village Court	<input type="checkbox"/> Shelter	<input type="checkbox"/> Perpetrator sentenced to community service	
<input type="checkbox"/> District Court	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Client withdrew the case	
<input type="checkbox"/> National Court/PPO	<input type="checkbox"/> Village Court	<input type="checkbox"/> Case was dismissed	
<input type="checkbox"/> Office for Family Services	<input type="checkbox"/> District Court	<input type="checkbox"/> Commenced child in need investigation	
<input type="checkbox"/> Community Based	<input type="checkbox"/> National Court/PPO	<input type="checkbox"/> Civil case opened (maintenance, divorce etc.)	
Corrections	<input type="checkbox"/> Office for Family Services	<input type="checkbox"/> Out of court mediation completed	
<input type="checkbox"/> Church	Services	<input type="checkbox"/> Out of court compensation paid to client/family	
<input type="checkbox"/> School	<input type="checkbox"/> Community Based	<input type="checkbox"/> Client repatriated to another province	
<input type="checkbox"/> Community Leader	Corrections	<input type="checkbox"/> Client returned to a safe place	
<input type="checkbox"/> Human Rights Defender	<input type="checkbox"/> Church	<input type="checkbox"/> Client returned to not a safe place	
<input type="checkbox"/> Family	<input type="checkbox"/> NGO	<input type="checkbox"/> Client reintegrated safely in the community	
<input type="checkbox"/> Friend	<input type="checkbox"/> CBO/FBO	<input type="checkbox"/> Client missing	
<input type="checkbox"/> NGO/CBO/FBO	<input type="checkbox"/> Other(specify) _____	<input type="checkbox"/> Client died	
<input type="checkbox"/> Other(specify) _____		<input type="checkbox"/> Perpetrator referred to support services	
		<input type="checkbox"/> Other(specify) _____	

HIGH RISK FACTORS		
<i>If you ticked at least one of the below factors, this is a 'High Risk Case' and requires referral to PFSVAC Secretariat</i>		
1	Survivor has suicidal ideas or tried to commit suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
2	Survivor accused of sorcery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
3	Forced exploitation (sexual, labour etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
4	Forced marriage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
5	Use of weapon in most recent event	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
6	Perpetrator caused grievous bodily harm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
7	Has ever threatened to kill	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
8	Sexual Penetration (rape)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
9	Previous or current breach of protection order	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
10	Escalation – increase in severity and/or frequency	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
Survivor is under the age of 18 (child).		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
<i>If answered YES, refer to Child Protection Officer</i>		
OTHER RISK FACTORS		
<i>0 – 15 YES's = Low Risk Case</i>		<i>16 – 32 YES's = Medium Risk Case</i>
1	Survivor is pregnant/recently gave birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
2	Survivor abuses drugs and/or alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
3	Survivor has a depression/mental health issue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
4	Survivor is HIV/AIDS positive	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
5	Homeless	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
6	Asylum seeker/refugee	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
7	Isolation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
8	None or low level of literacy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
9	Resident not in the province of origin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
10	No family ties or support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
11	Survivor is unemployed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
12	Survivor has physical disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
13	Sex worker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
14	Lesbian, Gay, Bisexual	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
15	MSM (Men who have sex with men)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
16	Transgender	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
17	Perpetrator has access to guns and armoury	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
18	Has ever physically assaulted survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
19	Has ever harmed or threatened to harm or kill other family members	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
20	Perpetrator has ever threatened or tried to commit suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
21	Stalking of survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
22	Drug and Alcohol misuse/abuse by perpetrator	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
23	Obsession/jealous behaviour toward survivor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
24	Controlling behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
25	Perpetrator is unemployed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
26	Perpetrator has a depression/mental health issue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
27	Perpetrator has a history of violent behaviour (not family violence)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
28	Perpetrator denies resources, opportunities, services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
29	Recently separated	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
30	Perpetrator/Survivor has more than one wife/husband	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
31	Financial difficulties	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a
32	Adultery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> n/a

HIGH	Requires Immediate Protection	1. Make referral to PFSVAC SECRETARIAT for MACC 2. Complete Consent Form 3. Complete risk management plan
MEDIUM	Elevated risk of future violence	1. Complete risk management plan 2. Report to PFSVAC SECRETARIAT
LOW	At risk of future violence	1. Complete risk management plan 2. Report to PFSVAC SECRETARIAT

Appendix 2: Consent Form



PROVINCIAL GBVAC SECRETARIAT Consent Form for Release of Information

It should be clearly explained to the client that she / he can choose any or none of the options listed.

Unique Identifying Number (UIN):

Q1	Q2	Q3	Q4	Q5	Q6

I give my permission to share information about the incident I have reported as explained below:

1. I give my permission for GBVAC Secretariat to store my details in their system.

Authorization to be marked by client: **YES** **NO**

2. I understand that in giving my authorization below, I am giving permission to share the specific case information from my incident report with the service provider(s) I have indicated, so that I can receive help with safety, health, psychosocial, and/or legal needs. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below. **I would like information released to the following (Tick all that apply, and specify agency/organization as applicable):**

YES NO

- Medical (specify): _____
- Police (specify): _____
- Shelter (specify): _____
- Welfare (specify): _____
- Legal (specify): _____
- Psychosocial (specify): _____
- Livelihood assistance (specify): _____
- Other (specify): _____
- Other (specify): _____

Authorization to be marked by client: **YES** **NO**

3. I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

Authorization to be marked by client: **YES** **NO**

Signature/Thumbprint of client or guardian	
DATE	

Appendix 3: Immediate Risk Management Plan



PROVINCIAL GBVAC SECRETARIAT Immediate Risk Management Plan

Unique Identifying Number (UIN):

Q1	Q2	Q3	Q4	Q5	Q6

Age (best guess if unknown): _____

Sex: Female Male Transgender Not disclosed

Risk Level Assessed: HIGH MEDIUM LOW

DATE SAFETY PLAN FILLED: _____

Safety Measures	Action Taken
Access to Practical/Emotional Support: 1. Identify professional who can help, e.g. medical 2. Identify / confirm friends who are safe to confide in 3. Identify others she/he can safely tell 4. Set up emergency code word with relevant people 5. Provide information on emergency help lines	
Safety: 1. Identify dangerous areas of the house and in public 2. Safe use of computers, phone, covering your tracks 3. Emergency mobile phone (different to usual, fully charged) 4. Useful phone numbers stored fictitiously 5. Spare set of keys 6. Liaison with Police/FSVU 7. Are there bail conditions? Are professionals aware of them? 8. Are breaches happening? Are these being reported?	
Crisis Plan / Emergency Accommodations Plan: (Things to prioritize taking with you if you leave) 1. Safe place (friends / family) how will they get there? 2. Documents e.g. passport, birth certificates, drivers license 3. Access to money 4. Supply of clothes / toiletries 5. Spare set of keys 6. Transport 7. Important (prescription) medication and glasses 8. Children's favorite toy	
Children's Safety: 1. Contact arrangements 2. Risk of 'abduction' 3. Help for children's wellbeing – other key support people 4. Inform key professionals e.g. welfare, school.	
Keeping Safe at Work and in Public Places: 1. Informing employer / college 2. Changing routines (journeys / shops)	
Agreement for ongoing contact with agency: 1. Safe contact arrangements 2. Code words	
Referral to other agencies: (specify) (Consent to share information confirmed with signature)	

Appendix 4: Risk Assessment Poster



ASSESSING RISK

INTAKE FORM RISK ASSESSMENT:

HIGH RISK - At least 1 out of 10 high risk factors are identified in the Intake Form

HIGH RISK - all children's cases

MEDIUM RISK - Over 16 risk factors indicated as present

LOW RISK - Less than 16 risk factors indicated as present

PROTECTIVE FACTORS:

FOR EXAMPLE:

- The perpetrator is incarcerated or otherwise prevented from approaching the survivor
- Survivor is employed and therefore less isolated
- Survivor has well-developed social network
- Survivor has resources, such as money, transport or a place to stay
- Survivor's decision to move away from the perpetrator (this can also significantly increase the risk, hence needs to be carefully examined)

PROFESSIONAL JUDGMENT

- Analyse information obtained through the conversation with, observation of, the survivor.
- Determine significance of risk & vulnerability factors in the presentation of the survivor.
- The likelihood of the risk factors reoccurring may also help to determine whether the survivor is in need of immediate protection.

Before starting the risk assessment:

1. Find out how much time the survivor has to talk?
2. Is perpetrator around, due back or expected back at a certain time?
3. Explain what risk means and why are you asking these questions?

Appendix 5: Inter-Agency Referral Form



PROVINCIAL GBVAC SECRETARIAT Inter-Agency Referral Form

To (Service Provider): _____

From (Referring agency, Referrer's name and contact details): _____

Unique Identifying Number (UIN):

Q1	Q2	Q3	Q4	Q5	Q6

Date received: _____

Risk Level Assessed: HIGH MEDIUM LOW

Date Risk Assessment Completed: _____

Age (best guess if unknown): _____

Sex: Female Male Transgender Not disclosed

Number and ages of children in client's care:

The type of the most recent reported incident:

<input type="checkbox"/> Rape/Penetration	<input type="checkbox"/> Forced Marriage
<input type="checkbox"/> Sexual Assault	<input type="checkbox"/> Denial of Resources, Opportunities, Services
<input type="checkbox"/> Physical Assault	<input type="checkbox"/> Psychological/Emotional Abuse
<input type="checkbox"/> Trafficking/ Abduction	<input type="checkbox"/> Removal or damage to property
<input type="checkbox"/> Sorcery Accusation	<input type="checkbox"/> Other (specify) _____

Any other agencies involved?

<input type="checkbox"/> Health/medical	<input type="checkbox"/> Community Based Corrections
<input type="checkbox"/> Counselling	<input type="checkbox"/> Church
<input type="checkbox"/> Police/SOS/FSVU	<input type="checkbox"/> School
<input type="checkbox"/> Shelter	<input type="checkbox"/> Community Leader
<input type="checkbox"/> Legal Services	<input type="checkbox"/> Human Rights Defender
<input type="checkbox"/> Village Court	<input type="checkbox"/> Family
<input type="checkbox"/> District Court	<input type="checkbox"/> Friend
<input type="checkbox"/> National Court/PPO	<input type="checkbox"/> NGO/CBO/FBO _____
<input type="checkbox"/> Welfare	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Lukautim Pikinini Office	

Reasons for referral:

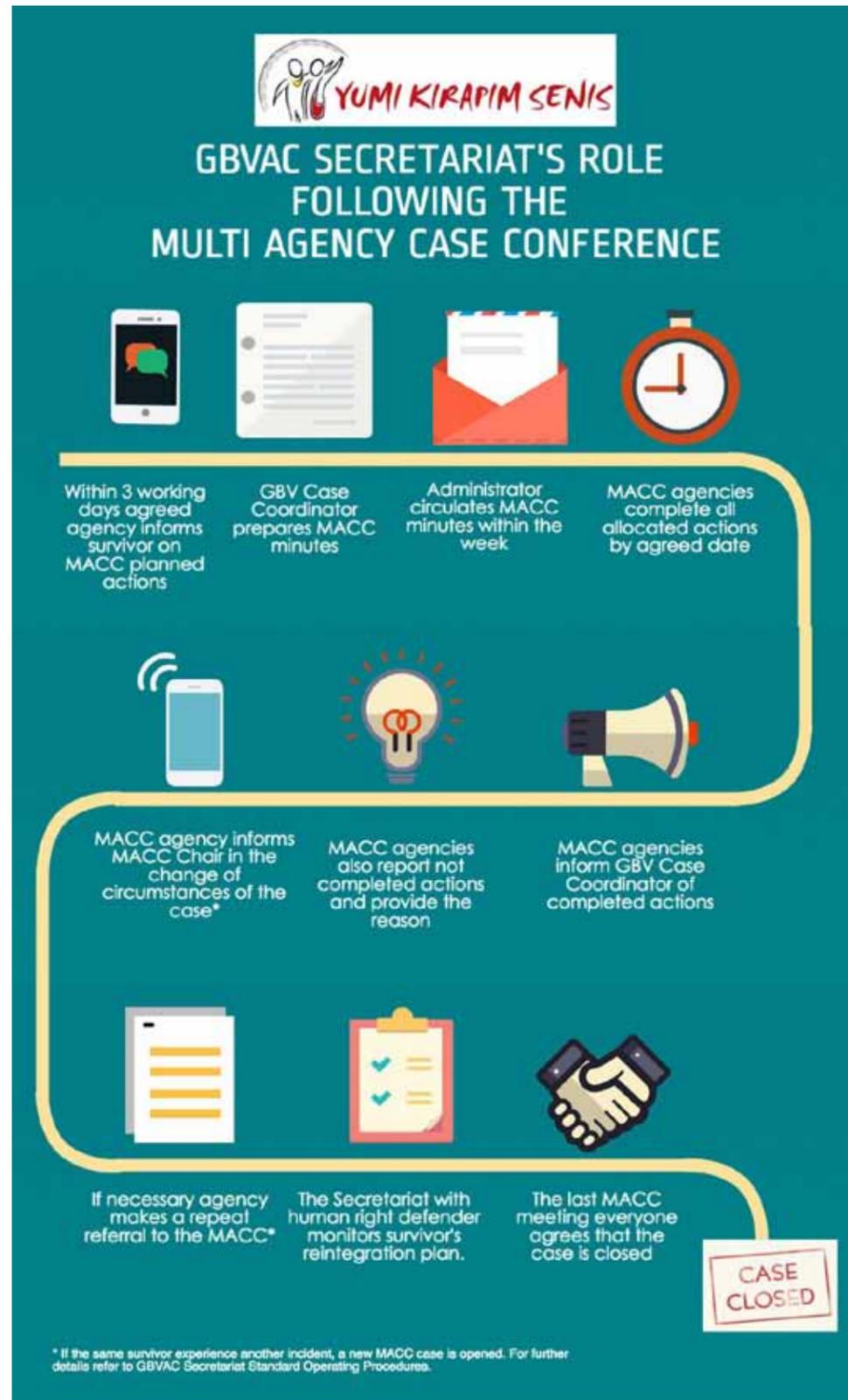
<p>Survivor agrees that I can follow up with your agency?</p> <p style="text-align: center;">YES / NO (circle)</p>	<p>Referrer's signature and date:</p> <p>_____</p>
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Appendix 8: Planning for MACC

Appendix 9: MACC Research Form



Appendix 12: MACC Follow Up



Appendix 13: Monthly Report Template



Provincial GBVAC Secretariat
MONTHLY COORDINATION ACTIVITY REPORT

(Month, Year)

1. Data summary

	Total number of reported cases
	Number of reported high risk cases (sorcery/rape/forced marriage/exploitation/serious bodily harm/threatened to kill/use of weapon)
	The number of reported children cases
	The number of interim protection orders issued
	The number of cases accommodated in shelter
	The number of perpetrators arrested
	The number of court cases closed (perpetrator sentenced/fined/in community service)
	The number of cases reintegrated safely in the community

2. GBV Case Coordination

Multi – Agency Case Conferences

	Number of Case Conferences Called
	Number of Cases Discussed with Action Plans Drawn

Monitoring of the Referral Pathways

Identified blockages:

- 1.
- 2.
- 3.
4. ..

Actions taken to address blockages:

