Annex 3.1
Accessibility and Reasonable Accommodation

What is accessibility?

Accessibility is one of the eight principles under which all rights in the Convention on the Rights of Persons with Disabilities should be interpreted, and is the right that persons with disabilities have to *"access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas*."[1] Accessibility is a precondition to the inclusion of all persons with disabilities.

What is reasonable accommodation?

Reasonable accommodation means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.[2]

How are accessibility and reasonable accommodation different?

Both strategies aim to guarantee equal access and avoid discriminatory situations, however, they are different in the way they apply. Accessibility applies without regard to the need of a particular person with a disability, for example, to have access to a building, a service or a product, on an equal basis with others, following Universal Design principles.

Universal design is an approach to increasing accessibility and means "the design of products, environments, programmes and services to be **usable by all people**, to the greatest extent possible, without the need for adaptation or specialized design."[3] The principles of universal design, when applied in accessibility, facilitate access to a larger population, including persons with disabilities.[4]

Therefore, accessibility comes first. Reasonable accommodation must be provided from the moment that a person with a disability requires access to non-accessible situations or environments, or wants to exercise his or her rights. Therefore, reasonable accommodation is provided ad hoc and can vary based on an individual person's needs, even if accessibility overall has been addressed. The table below provides more information on how accessibility and reasonable accommodation are different:

Bridging the gap between accessibility and individual adjustments

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

Accessibility and reasonable accommodation are not exclusive to each other; rather, they are strategies that should be combined to effectively address barriers, guarantee access, and improve participation of all IRC's clients. At a minimum, IRC's case management processes should aim to improve accessibility through universal design, while also instituting a process for reasonable accommodation to address situations when people with disabilities, older people, and other people in all their diversity report a lack of access.

Accessibility/ Universal design

Reasonable accomodation

Equal access

Examples of accessibility and reasonable accommodation?

- A woman with a physical disability requires access to a building where IRC services are provided. She is able to enter to the building (e.g. there are no steps, or there is a ramp), circulate through the building (there are elevators, or services are in the first floor, doors are wide, handles easy to open), or use all facilities and services (information is provided in different formats, displayed at a level where it can be read - video announcements have subtitles, leaflets are easy to read, toilets are accessible) without requiring any support. This is an example of **accessibility**, as the building has followed universal design principles: parents with their children, older people, and pregnant women will also benefit from this accessible environment that welcomes all.
- A second woman with a physical disability comes to the same building to attend a consultation, but finds it difficult to circulate through all facilities, and requires a support person to come with her to open doors or provide support to use the toilets. Paying for the costs of that support person is an example of providing **reasonable accommodation**.

- An outreach team refers a girl with an intellectual disability to come to the same service; the costs for a family member to come with her are covered; this is providing **reasonable accommodation**.
- The NGO organizes a consultation in this building, and a participant who is deaf is invited to participate. The team gets in touch with the participants to check for reasonable accommodation requirements, confirms if they would like a sign language interpreter and if so, covers the costs of a sign language interpreter for her; this is providing **reasonable accommodation** for participation.
- If the building above was not accessible at all, we could **retro-fit accessibility** (if there is time and resources for it, as it tends to be more expensive), or provide **reasonable accommodation measures**: having a transportable ramp, providing services in out-reach capacity or other facility (e.g. a tent outside).
- **Remember!** All reasonable accommodation measures should be dignified! (e.g. avoid segregating measures: do not open a "tent for persons with disabilities" only, if possible, prioritize solutions which persons with disabilities can use independently.)

As you see in the examples above, even in accessible infrastructures, there can be a need for additional support to ensure access for individual people. ***Accessibility*** refers to how a space is designed and whether the design allows for most people to easily access the space; ***reasonable accommodation*** provides support to ensure that individuals with specific needs can fully access services.

Endnotes

1 CRPD, art. 9.

2 CRPD, Art 2

3 CRPD, art. 2.

4 http://universaldesign.ie/What-is-Universal-Design/The-7-Principles/

Annex 3.2
Guidance Note on Provision of Assistive Devices

This guidance note is based on the Global report on assistive technology by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), which provides data, evidence, and recommendations on how to achieve universal coverage of assistive technology. Assistive technology is essential for the well-being of a diverse range of people across the life cycle, as it enables and promotes their inclusion, participation, and engagement in society.

By facilitating better functioning and participation, accessing assistive technology can also have protection outcomes – especially for groups at risk of marginalization, discrimination, and exclusion – by empowering them to navigate their environments, communicate effectively, and access essential services. For example, children and adults accessing spectacles can access lifesaving information and educational and economic opportunities, while replacing lost assistive devices to persons with disabilities fleeing conflict ensures their mobility, communication, and independence, mitigating protection risks.

However, many people who need assistive technology do not have access to it, due to various barriers and challenges, such as lack of awareness, affordability, quality, availability, services, policies, and human resources.

Some of the people who may need to be referred to services to access assistive technology can include:

- People who have lost their assistive devices because of the crisis.
- People who have sustained recent injuries.
- People who evacuated their home with built-in accommodations. For example, an older client with low vision may not have needed assistance in his own home but would need assistive device or other supports in a large congregate shelter.

People who face a lot of difficulties in doing functional activities or can't do at all based on answering the Washington Group Short Set of Questions. This can include older persons and women and girls with sexual and reproductive health related conditions, such as obstetric fistula, incontinence, and other conditions that adversely affect their lives.

Assistive technology should not be seen as 'products to be dispensed' but as a set of interventions that require assessment, fitting, education of the people who need them and their carers, as well as ongoing follow up. Protection case workers often work closely with persons who may benefit from assistive devices, however it is essential that they link with the appropriate skilled personnel in the health sector to provide assistive devices safely and effectively. **Due to the potential for harm associated with the incorrect use or unsuitable prescription of such aids, ONLY health workers and trained workers**[1] **with some experience in providing assistive technology should facilitate access to these products.** Protection case workers with adequate training can provide referrals or use cash to support the purchase of assistive devices, again, only if in coordination with specialized service providers.

Assistive technology' is an umbrella term for assistive products and their related systems and services. It enables and promotes the inclusion, participation and engagement of people with disabilities, older people, people with communicable and noncommunicable diseases (including neglected tropical diseases), people with mental health conditions, and people with gradual functional decline or loss of intrinsic capacity[2].

Assistive devices can improve a person's functioning in areas such as cognition, communication, hearing, mobility, self-care and vision. They can be physical products like wheelchairs, glasses, hearing aids, prostheses, orthoses, walking aids or pads; or digital products like software and apps that help with communication and time management. They can also be changes to the physical environment, such as ramps or rails.[3]

Many people use more than one type of assistive product, depending on their needs.

The main types of assistive products provided in an emergency context are:

- **Mobility aids:** Used for sitting, walking, or standing with assistance (elbow crutches, wheelchair)
- **Prefabricated splints:** Used for upper limbs, lower limbs, and the trunk and neck (ankle-foot orthoses, wrist splint)
- **Specific items:** Assist with Activities of Daily Living (ADL), positioning (grab claw, wedge pillow)
- **Consumable:** Hygiene materials (disposable gloves, adult diapers)

If the assistive **product is not well matched** to the needs of individuals, or they are not given enough education and fitting to use the product safely and comfortably:

- The assistive product will likely go unused,
- It may even cause serious harm
- Deteriorate the situation of the person
- Increase unreversed complications such as bone deformities.

Due to the potential for harm or deterioration associated with the incorrect use or unsuitable prescription of such aids, its recommended that ONLY health workers/ trained workers[4] with some experience in providing assistive technology should facilitate access to these products.

Endnotes

1 For example, WHO's online Training in Assistive Products (TAP) is designed to prepare primary health and other personnel to fulfil an assistive technology role. This may include identifying people who may benefit from assistive technology; providing simple assistive products such as magnifiers, cruthes and dressing aids; or referral for more complex products and other services.

2 Global report on assistive technology-WHO

3 https://cdn.who.int/media/docs/default-source/assistive-technology-2/3128-emp-summary-landscape-local-print-081222.pdf?sfvrsn=37f41429_5

4 For example, WHO's online Training in Assistive Products (TAP) is designed to prepare primary health and other personnel to fulfil an assistive technology role. This may include identifying people who may benefit from assistive technology; providing simple assistive products such as magnifiers and dressing aids; or referral for more complex products and other services.

This form has been adapted from the Child Protection Case Management Supervision Package developed by the Child Protection Case Management Task Team

Annex 3.3
Staff Roles and Responsibilities

	Major Responsibilities
Role	**Responsibility**
Caseworker	• Identify and receive referrals of persons at heightened risk • Conduct household visits and center-based interviews to assess the needs of individuals and families • Provide information to individuals and families about their rights and entitlements, including what services are available • Work with identified individuals and families to develop and implement an action plan in accordance with their needs, capacities and goals • Assess risk and support clients to understand risks relevant to their situation • Maintain a supportive therapeutic relationship with the client and provide MHPSS services and referrals as needed
Protection Case Management Officer (Supervisor)	• Ensure case management interventions adhere to international best-practice standards and guiding principles • Oversee the development, maintenance and rollout of case management processes (service mapping, protocols, referral pathways, SOPs, etc.) where necessary • Provide support to case workers in handling complex cases and depending on the complexity of the case seek guidance from the specialist • Coach, train, supervise and mentor direct-report staff • Ensure caseworkers have access to staff wellbeing services including MHPSS services • Develop a case management quality strengthening action plan and schedule based on identified need and gaps • Conduct trainings as identified in the capacity building plans • Lead in the organization, development and facilitation of training, technical support provision, regular coaching sessions

Major Responsibilities

Role	Responsibility
Information Management Officer	• Support the development and implementation of regular monitoring and evaluation activities for case management activities • Ensures quality information management including case management databases
Volunteer	• Provide information to community members about how to access protection case management services and refer cases to caseworkers • Liaise with community leaders and members to introduce program activities and encourage community involvement in program implementation and activities • Facilitate client's access to services through the dissemination of up to-date information • about existing local services that are available within their communities

Major Responsibilities

Role	Data and Reporting
Caseworker	• Ensure complete and updated documentation related to each individual case • Manage, file and store data, ensuring the confidentiality of the information collected • Prepare and submit weekly and monthly work plans • Support the implementation of monitoring and evaluation tools and report on problems in the implementation of the program
Protection Case Management Officer (Supervisor)	• Ensure that the case management teams maintain complete, accurate, and confidential-case files • Compile and produce weekly and monthly protection case management reports • Support the implementation of monitoring and evaluation tools • Input into donor reporting on activities, indicators and achievements, particularly around case management staff capacity development • the supervisor analyze data collected through the supervision tools
Information Management Officer	• Identify and execute strategies to improve data collection methodology • Identify any new or potential risks to clients and staff due to data collection • Conduct data quality checks and regular data cleaning • Manage the development of protection case management databases • Analyse qualitative data collected from site visits, focus group discussions, key information visits and other qualitative methods; identify relevant trends and patterns.

Major Responsibilities

Role	Coordination
Caseworker	• Contribute to the maintenance of an up-to-date service mapping of the service providers • Receive cases referred from other agencies • Advocate on behalf clients to access services and support clients to effectively represent their views, needs and capacities in all meetings affecting them.
Protection Case Management Officer (Supervisor)	• Work with service providers to implement standard operating procedures and monitor adherence to referral pathway • Participate in local working groups
Information Management Officer	• Support the timely information sharing regarding challenges and needs at the field level

Qualifications

Role	Work Experience
Caseworker	• At least two years of experience in counseling or humanitarian assistance. Experience working within relevant context preferred.
Protection Case Management Officer (Supervisor)	• Proven practical experience of providing direct case management. Demonstrated understanding of case management processes, protocols, service provision and referral systems. At least three to five years' experience providing technical coaching and mentorship for case management or MHPSS programs. Practical experience providing direct case management. Previous experience in managing a team.
Information Management Officer	• At least two years of experience working with data analysis. Experience producing quantitative analysis and reports. Full professional competency in Microsoft Office Suite, especially Word, Excel, Outlook, and PowerPoint.

Qualifications

Role	Demonstrated Skills and Competencies
Caseworker	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients at all times. Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility. • Works effectively with people from all backgrounds, and develops strategies to address barriers faced by individuals most at risk of discrimination. • Communicate without judgement and demonstrate empathy.
Protection Case Management Officer (Supervisor)	• Ability to maintain confidentiality, respect, non-discrimination and safety of clients, staff, and volunteers at all times. Good communication skills. • Excellent interpersonal and problem-solving skills, creativity and flexibility. • Works effectively with people from all backgrounds, develops strategies to address barriers faced by individuals most at risk, and identifies and addresses discriminatory biases in supervised staff. • Communicate without judgement and demonstrate empathy.
Information Management Officer	• Strong analytical and reporting skills with attention to detail. • Excellent organizational and time management skills. • Good interpersonal skills and ability to work as part of a team.
Volunteer	• Well respected by the community. • Committed, motivated and willing to learn. • Good communication skills including the ability to gain trust and build relationships with the community. • Excellent interpersonal and problem-solving skills, creativity and flexibility.

Annex 3.4
Caseworker Capacity Assessment[1]

Purpose of the Form:

This helps supervisors to understand the extent of newly recruited caseworker's attitude, knowledge and skills. It contains minimum competency standards for all caseworkers providing client-centered case management services. The results of the assessment should inform the capacity building and development actions that a supervisor provides in individual and group supervision sessions.

How to administer the form:

Before:

The Supervisor Should
Step 1: Organize an individual supervision session in a comfortable and private space. The supervisor should set aside between 2-3 hours for this assessment or if it is preferred, this process can be broken down into 2 or 3 separate sessions.

During:

The Supervisor Should
Explain the purpose of the assessment to staff and ask staff to answer honestly and be self-reflective. This will be most helpful in identifying areas where staff can benefit from further coaching and staff development**.**

Supervisor can say: *"This form has been developed to capture some of the key standards that are expected of a protection caseworker. We don't expect you to be an expert and have perfect*

answers from the very beginning. It takes time to understand protection case management guiding principles and how to apply them with clients. During our first weeks together, this assessment will determine the areas where we can provide you with more technical support. After the assessment, we will continue working together to build your knowledge and skills. After a few months, we will revisit the assessment to see how you are progressing."

Step 3: Explain the form is divided into three sections (attitudes, knowledge and skills). Explain that the attitude assessment is a self-administered assessment where the caseworker will be given 20 minutes alone to answer these questions. Once this has been completed, the knowledge and skills assessment will be administered through a verbal interview with the supervisor. Explain that you will be taking notes in order to remember her/his responses. Invite the caseworker to raise any questions about the form or the process to ensure s/he feels comfortable. The supervisor should ask the questions on the questionnaire in order and give the caseworker time to explain/describe their answer. Allow the caseworker to speak openly and ask clarifying questions. Supervisors are encouraged not to provide answers, but should respond if there are some alarming issues that require immediate discussion and direction. For the attitude scale simply mark the scoring and don't ask for further elaboration.

Once the assessment is complete, the supervisor and caseworker should discuss what are the suggested priorities in each area for technical capacity building and development.

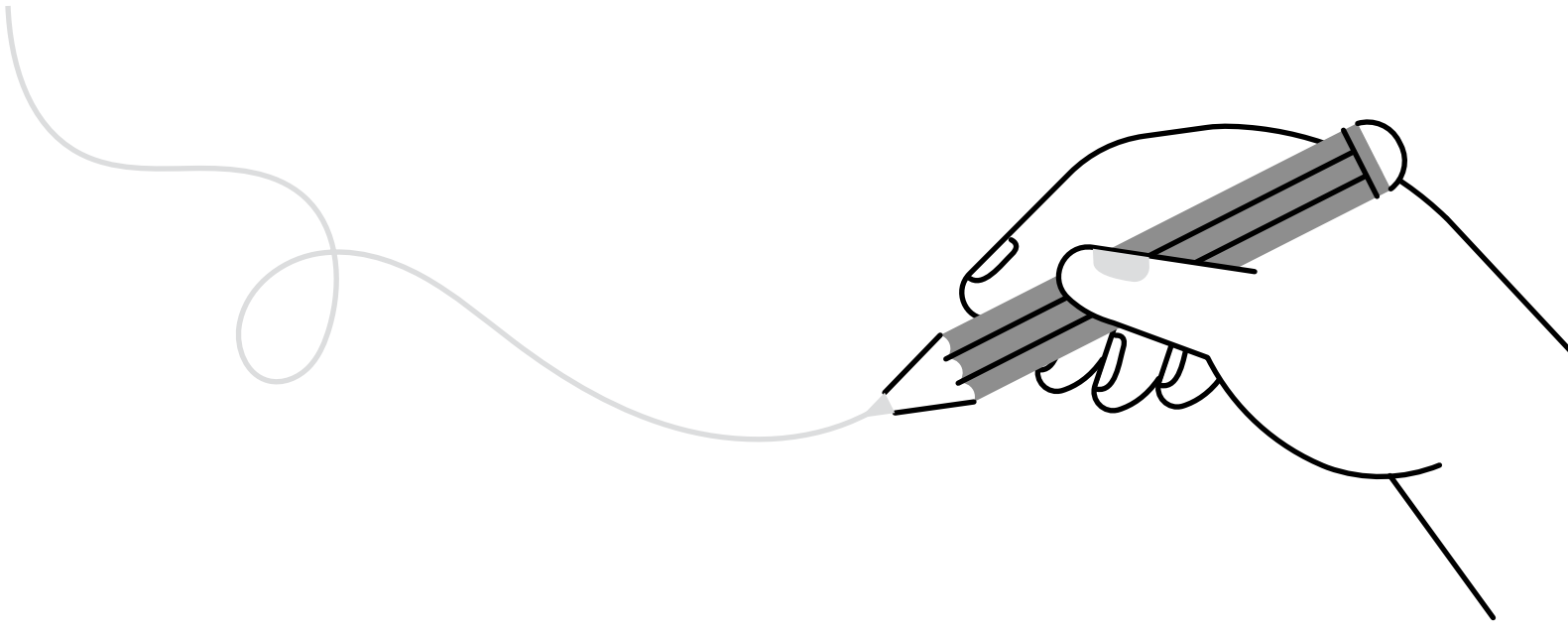
If the staff member does not meet, or only partially meets the required attitudes, knowledge and skills it may not be appropriate for them to work with persons at heightened risk until s/he undergoes personal reflection of the harmful values and/or beliefs or reviews the way case management services should be delivered. If this is the case, supervisors will need to handle this conversation carefully and sensitively.

After:

The Supervisor Should

During regular individual supervision sessions, the supervisor should refer back to the capacity assessment in order to provide ongoing coaching to the caseworker. If several caseworkers need guidance in the same area, the supervisor can organize a training or development session during group supervision. The supervisor should also arrange shadowing sessions for the caseworker to observe the application of guiding principles in practice.

After approximately 3-6 months, the supervisor should re-assess the caseworker to determine her/his progress and continuous development needs.



Caseworker Capacity Assessment

Date: _____

Caseworker: _____

Supervisor: _____

Part One: Protection Attitudes and scoring

This is made up of 15 statements to assess personal beliefs and values. The scale can measure their attitudinal readiness for working directly with persons at heightened risk and highlight areas for further learning and training.

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
1. People with developmental disabilities and mental health conditions have something to offer the community and should be able to move freely	4	3	2	1		
2. Violence can sometimes be a person's own fault and is justified	1	2	3	4		
3. People of all political and religious beliefs and values have the right to express them and live in safety and dignity.	4	3	2	1		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
4. People who experience traumatic events cannot recover or become productive members of society.	1	2	3	4		
5. A caseworker should always consider a person's opinion and wishes when making a decision that will affect them.	4	3	2	1		
6. It is acceptable for caregivers to make decisions and provide consent on behalf of a person with developmental disability or and older person because they know best.	1	2	3	4		
7. Violence within a household is a family matter and should be handled within the family	1	2	3	4		
8. Services should always be designed with persons with permanent disabilities in mind	4	3	2	1		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
9. Retaliation from community members against former combatants is acceptable	1	2	3	4		
10. Men don't experience mental health concerns	1	2	3	4		
11. It is my job to determine whether a client is telling the truth	1	2	3	4		
12. Poor people often say that they have been excluded from assistance or don't have support so that they can get attention or money	1	2	3	4		
13. If a person can't answer the question properly or needs time, he/she is making up the case	1	2	3	4		
14. Locking someone up with a disability or mental health concern is normal in some situations	1	2	3	4		

Statements	Does the caseworker:				Caseworker's Response and Notes from Discussion	Development Priority?
	Strongly Agree	Agree	Disagree	Strongly disagree		
15. A former member of an armed group should not be accepted for protection case management	1	2	3	4		
Total Score (supervisor should sum the total score in each column and then add these together for the total score)						

The below scores should be used as a guide but are not definitive.

- **50-60:** Scores in this range indicate that the caseworker has a person at risk friendly attitude –they have positive beliefs and values for working with people at heightened risk. However, you can still consider supporting the caseworker on certain issues as needed.
- **35-50:** Scores in this range indicate some troubling attitudes that may be harmful to clients. Managers and supervisors should use their discretion in allowing staff to work on cases and may want to consider "coaching" the staff person before they work independently with person at risk.
- **34-0:** Scores in this range indicate that an individual is not ready to work with person at risk. Managers and supervisors should work independently with an individual who scores below 34 to address negative beliefs and attitudes and identify immediate actions to address these gaps.

Actions to be taken	Supervisor:	Caseworker:

Part Two: Case Management Knowledge

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
1. What are the Guiding Principles for working with people at heightened risk?	1. Respect confidentiality and its limitations 2. Promote client safety and security 3. Everyone is entitled to human rights equally and without discrimination 4. Participation: Clients should be supported to make their own decisions, their views and opinions should be respected 5. Empowerment: I should look to enhance a person's strengths and capacities for coping 6. Do not harm 7. Client-centered approach		
2. What can be possible consequences of violence for a person	1. Physical harm such as injury or disability 2. Psychological harm such as mental health problems (depression, anxiety, low self-esteem, isolation, hopelessness) 3. Difficulty trusting people and maintaining relationships 4. Difficulty accessing services 5. Stigma		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
3. What are the limits to confidentiality when working with persons at heightened risk?	1. If there are mandatory reporting laws in place 8. If the client is at risk of harming themselves 9. If the client is at risk of harming another person (possible homicidal) 10. If a person has been legally assessed to lack capacity for consent and all possible steps have been taken to support informed consent process with him/her 1. Where the client is a child and is at risk of harm we must act in the child's best interest		
4. Why might it be difficult for someone to leave an abusive situation?	1. Has nowhere safe to go 2. No economic resources of their own. Dependant on the abuser economically 3. Has hope that things will change 4. Is scared no one will provide care or support 5. Worried about breaking up the family 6. Worried what people in the community will say (stigma) 7. Unable to independently move or voice their concerns due to barriers		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
5. When and how should a caseworker obtain informed consent/assent?	When: 1. Before the identification meeting prior to intake into case management services for permission to hear the persons story, record and take notes 2. After the identification meeting prior to intake into the case management services to request for permission to participate in services 3. For referrals to other services providers How: 1. Address any barriers identified for informed consent with the client 2. Ensure the client fully understands the case management process 3. Ensure that the client fully understands confidentiality including how their information will be collected, stored and shared 4. Ensure the client fully understands the limits to confidentiality 5. Ensure the client fully understands their options and the potential risks and benefits of them 6. Provide time for any questions 7. Ask the client whether he/she wishes to proceed by signing/verbal consent		
6. What are the possible consequences of sexual violence on men?	1. HIV/AIDS or other STIs 2. Mental health problems (depression, anxiety, other) 3. Stigma 4. Relationship problems 5. Isolation in community		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
7. What are some of the reasons a client may not want to report violence or tell you their story?	1. Fear of retaliation from the perpetrator 2. Fear or worry that no one will believe them 3. Shame 4. Self-blame 5. Lack of transportation 6. Lack of money to pay service fees 7. Do not trust the authorities or service providers 8. Believe agencies only support certain people like children		
8. What are the steps of case management?	1. Identification and registration 2. Risk assessment 3. Case action planning 4. Safety planning 5. Implementation of the case action plan 6. Follow up and monitoring 7. Case closure 8. Case management service evaluation		
9. What body language can you use to make the client feel more comfortable (for example, how you are sitting)?	1. Sit face to face with client, but not at a desk 2. Make eye contact appropriately according to local customs 3. Keep a calm and relaxed body posture 4. Lean in toward the client as she/he speaks 5. Nod your head to show understanding 6. Keep a warm and friendly disposition		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
10. What are some things you can do to create trust and show respect to a client during your meeting?	1. Give full attention to client (don't take phone calls, etc.) 2. Don't interrupt; give time to talk and don't be in a rush 3. Use respectful language which mirrors the clients 4. Don't promise anything you cannot do 5. Give complete and honest information 6. Follow through - do what you say you will do 7. Don't tell them what they "should" do, give information to help them make their own choice.		
11. Describe how you should start your first meeting with the client (introduction, identification)	1. Greet the client 2. Introduce yourself, role and agency as well as anyone else present 3. Create a private and safe space 4. Assess any immediate risk to personal safety and security 5. Address any barriers to participation 6. Explain the case management process and the persons rights (can stop, refuse to answer, ask any questions) 7. Explain confidentiality and its limits including data protection 8. Explain any potential risks or benefits 9. Understand the persons general situation 10. Identify whether the person is at risk of/has experiences a rights violation 11. Determine the risk-level 12. Ask permission to proceed either for intake into case management services or to conduct a quality referral only		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
12. What are some key considerations when developing a case plan?	1. Develop within two weeks of the risk assessment 2. The client should drive the process of setting their goals 3. We should build on the client's strengths 4. Content of case plan should reflect the clients risk assessment 5. Should set specific, time-bound actions outlining who is responsible for what		
13. How can a caseworker support client-centered approach to case management ultimately support the client's empowerment process	1. View people as rights claimants and support them to access their rights 2. Listen to the client's opinions and requests without judgment and action their wishes 3. Assess a person's individual and environmental risk-factors and protective-factors to a violation and address these 4. Support clients to draw on their protective factors such as the resilience, strengths and resources inherent within them and household or community to build the action plan 5. Provide full information to the client of the types of services available, how to access them and possible risks 6. Where appropriate, safe and requested by the client support the families/household's commitment to the outcomes, goals and tasks outlined in the case plan		

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?
14. What are key healing statements you can use with clients	1. I believe you 2. You are not to blame 3. I am here to support you 4. What you are feeling is a very normal reaction to this situation 5. I am sorry you are in this situation/ this happened to you		
15. What are the main criteria for knowing when to close a case?	1. Goals within the case plan have been met as much as possible and follow up is complete 2. The client explains that they are able to address on-going challenges now themselves 3. The child and family relocate and the case file can be closed or transferred as appropriate 4. The client is transferred to another case management stream or due to relocation 5. No client contact for more than a specific period (i.e 2 months) 6. The death of a client		

Where a caseworker is able to answer most of these questions with the possible correct responses or similar responses (such as 5 criteria per answer) it indicates that the member of staff meets the core case management requirements and is able to work independently with person at risk with ongoing supervision. Where they were consistently below this level of response only providing 3 criteria or less and/or completely unable to answer some of the questions this indicates that a capacity building plan should be in place as there is not sufficient knowledge as well as where necessary one on one mentorship and trainings and shadowing staff.

Knowledge Questions	Does the caseworker:	Caseworker's Response and Notes from Discussion	Development Priority?

Overall Final Evaluation

Actions to be taken:	Supervisor signature:	Caseworker signature:

Part Three: Case Management Skills

This form is intended to guide a **process** of learning allowing a case worker to put their knowledge and attitude to practice. It is not an evaluation of the caseworker's performance. These questions can guide a discussion or role play. It lists skills associated with good case management practice and describes the correct answers/approach to look for. The form is for the supervisor only and is intended to help the coaching process because it provides a structured method to identify in which topics/issues caseworkers the most need support.

Please note: It is very important that the form itself and the written comments are not shown to the caseworker (so as not to make them nervous). Supervisor should take notes separately and once the supervision session is finished document their feedback on the form

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
1. Show how you would introduce yourself to a potential client in your first meeting.	1. Introduce themselves warmly as well as their role and agency 2. Ask the person what their name is 3. Check the space and ask whether the client feels comfortable, private and safe 4. Check whether there are any immediate safety concerns 5. Ask whether they need any support to fully participate in the meeting		
2. Show how you would use your body language to help a client feel safe and comfortable	1. Uses appropriate eye contact 2. Mirrors the words and phrases you use 3. Stays calm and comforting throughout the interaction 4. Using a short and gentle voice 5. Friendly facial expression 6. Leans towards you when speaking		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
3. Show how you would explain confidentiality and its limits to the client?	Explaining that confidentiality means that *"I won't tell anyone what you tell me"* *Exceptions when confidentiality has to be broken. "There are a few situations in which I may have to tell someone else what you share with me but it is only for safety reasons-- if I think you may hurt yourself, or hurt someone else.* Ask if the client has any questions		
4. Explain what you would do if a client walks-in and starts to talk about what happened to him/her immediately	1. Let the client finish what she/he is saying. But do not ask further questions. 2. Politely let them know that you understand that she/he is in distress and that you would like to listen and help 3. Explain that before you can do that you need to explain a few things which are important for her/him to know.		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
5. How should a caseworker respond if a client becomes hostile or angry during an interview?	1. Remain composed and calm 2. Do not raise your voice 3. Attempt to calm the person down; try determining what is causing the anger and recognize their feelings 4. Give the person space and time to think 5. Be alert for possible aggression and 6. leave the situation if it feels unsafe 7. Carry a cell phone and use it (where appropriate) 8. Conduct interviews with a colleague to mitigate risks if needed and as advised by your supervisor		
6. What are some important considerations when interviewing a client who has experienced abuse?	1. Do not push the client to speak about their experience 2. Tell the client they can take their time 3. Do not ask heavy questions that might re-traumatize the client they will speak to you about these issues at their own accord 4. Tell the client that you are here to help		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
7. How can a you demonstrate empathy and respect for clients	1. Pay attention to verbal and nonverbal cues 2. Determine what is important to the client 3. Show a genuine desire to understand their situation 4. Keep an open mind 5. Create an environment of respect and acceptance 6. Listen for an acknowledge difficult feelings and encourage honest discussion		
8. Can you demonstrate with a few questions how you would start a discussion with a client about what happened to him/her?	Tell me about what brought you here today / I'd like to hear about what brought you here today Would you like to tell me about what happened? Use an open tell, explain or describe question.		
10. Can you show me how you would assess safety and do a safety plan?	1. Ask the client how safe they feel at home or in the community 2. With the client identify strategies and resources in the client's life that can help reduce the risk for harm 3. Use safety assessment or suicide assessment as needed		

Skills Questions	Listen & Look for responses	Caseworker's Response and Notes from Discussion	Development Priority/ Continued support needed?
11. Can you explain to me how you would come up with a coping skills plan with a client?	1. Ask the client 'when you feel sad or lonely or scared, who can you talk to?' Have the client (or you write down) list the people they feel comfortable with. 2. Identify the activities the client enjoys and the feelings associated with those activities. Build on the information you gathered from the psychosocial assessment. 3. Based on the client's answers, help them come up with a plan to talk to, spend time with the people they identified and to do the activities that make them feel better. Explain that they can use this plan whenever they feel [insert appropriate feeling]. 4. Ask the client if there is anyone, they would like to share their plan with who can help remind them of it.		
Actions to be taken	**Supervisor:**	**Caseworker:**	

Annex 3.5
Standard Operating Procedure Data Management and Protection

SCOPE

This SOP applies to all data managed by staff involved in Protection Case Management. The following datasets are included within the scope of this SOP:

Dataset(s) name(s)	Description	Sensitivity level
Client Protection Case Management Forms	• Registration • Intake and Protection Assessment • Safety Plan • Action Plan • Follow up • Case closure	High
Protection Outcome Forms		High
Supervisor forms	• Capacity Assessment (knowledge and attitude • Case File Check List • Observation Form • Shadowing Form • Case Discussion Form	Medium
Client Feedback Form		High

PURPOSE SPECIFICATION

The data will be collected, stored, and analyzed for the following purposes:

- To provide continuity of services to the client through the documentation of case characteristics.
- To analyse case progress and gaps
- In support of donor reporting and engagement

ROLES AND RESPONSIBILITIES

See Roles and Responsibilities

Case Manager

- Is responsible for ...

Supervisor

- Is responsible for ...

Coordinator

- Is responsible for ...

IT Focal Point

- Is responsible for ...

Protection Information Manager / MEAL staff

- Is responsible for ...

DATA RESPONSIBILITY IN THE PROTECTION CASE MANAGEMENT DATA CYCLE

1. **Planning**
   a. [X] will conduct a Data Risk Analysis of the Protection Case Management initiative.
   b. [X] will conduct a minimization exercise, review of the data fields to ensure only the necessary data is collected.
   c. [X] will ensure that all staff involved in protection case management are trained and aware of the data protection protocols, the security implications of sensitive data and have a strong understanding of the importance of confidentiality.

d. [X] will ensure there is an obligation to adherence to data protection policy in staff contracts.
e. [X] will ensure that all clients and caseworkers will be allocated a code based upon an agreed standard coding format.
f. [X] will ensure that data protection protocols are followed and updated regularly (i.e. when contextual changes occur).

2. **Collecting/Receiving**
   a. [X] will confirm the data protection measures are implemented during the protection case management process.

3. **Storing**
   a. [X] will store the data on the following secure storage modality: [STORAGE MODALITY]
   b. [X] will ensure that all data protection measures within the data protection checklist are implemented and updated when required.
   c. [X] will monitor whether access to the data to staff is limited to that needed to fulfill the purpose of the data management activity.

4. **Assuring Quality**
   a. [X] will revise protection case management data using the following methods and tools: [METHODS AND TOOLS FOR QUALITY ASSURANCE].

5. **Sharing**
   a. [X] will share the data for referral using [INSERT CHANNEL].

6. **Analyzing**
   a. [X] will take the following measures to prevent exposure of sensitive data during analysis or visualization: [RISK MITIGATION MEASURES].

7. **Retaining and Destroying**
   a. [X] will be responsible for retaining the data as needed and destroying the data once the retention period ends. The retention period of the data is the following: [RETENTION PERIOD].
   b. For the duration of the retention period, the data will be retained on the following infrastructure: [Infrastructure].
   c. [X] will regularly reassess the value and sensitivity of retained data to ensure that retention is still appropriate.

d. [X] will destroy data at the end of the retention period using a tool such as ¨Secure Erase¨, preventing data retrieval, rather than just deleting the data.

DATA BACK UP

Two backups exist of all data in table 1:

- **One site:** one stored in the location of the database and backed up each week data is entered. The on-site back up is an external hard drive which is kept locked in a filing cabinet, and the off-site back up is done through emailing the database to the designated receiver (most likely Head of Program) as an encrypted, password-protected file.
- **Off-site:** the database copy sent to Head of Unit or the Information Management Officer once a month. This off-site back-up ensures that the main database can be restored in case of technical problems, or destroyed in an emergency evacuation without this meaning the loss of all electronic data.

EMERGENCY EVACUATION/RELOCATION

In the event of an evacuation/relocation, the following actions will take place:

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

Evacuation/relocation drills are carried out on a [X] monthly basis.

INCIDENT NOTIFICATION

Data incidents are events involving the management of data that breach the data protection protocols. All staff involved in PCM are responsible to report any breach to their supervisor. [X] should be informed within 24 hours in case of the following data incidents: unwarranted or unauthorized disclosure of data, or; loss, destruction, damage, or corruption of data.

GOVERNING LAW

Actors involved in the [ACTIVITY] may be subject to different national and international legal frameworks and should consult their legal focal point to identify any specific legal requirements or restrictions related to data management for the [ACTIVITY].

Annex 3.6
Staff Data Protection Agreement

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

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

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

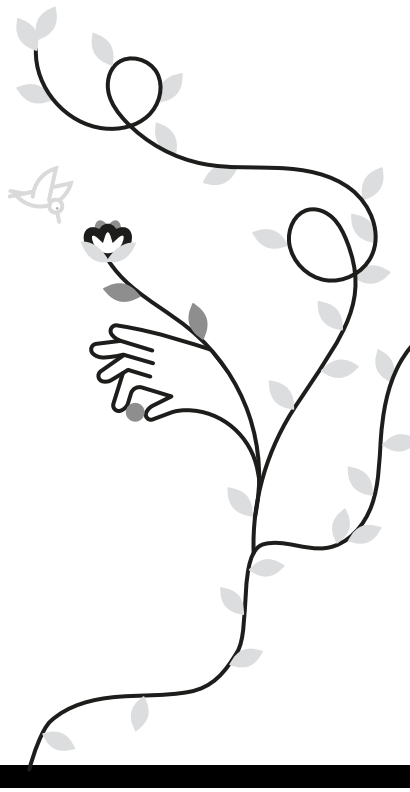
- I understand that my access to data, information, and records containing information about clients is limited to my need for the information in the performance of my job duties.

- I will not disclose information about clients without their appropriate and informed consent. I understand and agree that my obligation to avoid such disclosure will continue even after I leave my employment.

- I will be careful to protect information against accidental or unauthorized access, disclosures, or destruction.

- I agree to abide by all organizational data protection policies.

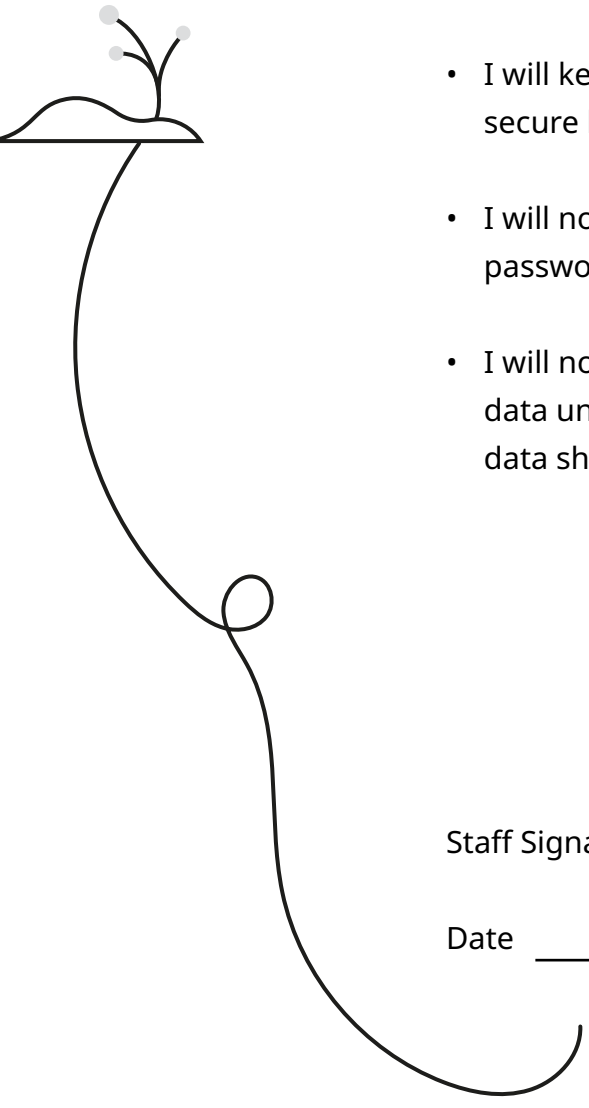
- I will not access the protection information management database(s) or other client files or records in a public, non-private setting. I will not connect to a public WiFi network with the device used to access client files.



- I will not share any personally identifiable client data with anyone outside of my organization without the express written permission of the client and a data sharing agreement in place.

- I will not share any aggregate anonymized client data without following the proper protocols at my office. Inter-agency data sharing must go through/be approved by a central focal point, for example, the head of unit.

- I know that clients have a right to access their personal information therefore I will be accurate and non-judgmental in what I write about clients and other organizations.



- I will keep all paper files containing personal information locked in a secure location (lockable filing cabinet, safe) per the office protocol.

- I will not share my log-in information or passwords. I will update my password regularly, as per the office protocol

- I will not leave the screen or open documents containing sensitive data unattended. I will not print out sensitive data - only de-identified data should ever be printed out.

Staff Signature _____

Date _____

Annex 3.7
Software Requirements Specifications

Purpose

The purpose of this document is to provide a detailed description of the recommended software specifications required for a digital PCM information management system. These software requirements operationalize the core case management principles, including “privacy” for the client and “do no harm”. This document is based on consultation sessions with users and technical experts and should be complemented with any additional organization and country specific requirements.

I. Software System Attributes

I.I. Availability and resources required

- Ability to collect data offline and through standard mobile devices.
- Ability to host media and documents.
- Configurable workflows/processes following the steps of case management.
- Ability to be customize to country contexts
- Country level customization and maintenance is user friendly and tailored to the resource constraints protection organizations face, including for teams without advanced programming capacity, using drag and drop and bulk upload functionalities to tailor global tools to country level requirements.
- Crisis level license costs or payment structure are not prohibitive for smaller response organizations.
- Interoperability with outside systems for referral purposes.

I.II. Security

- Access to client-specific information limited to need to know basis.
- Ability to hide client identifying information from anyone beside the individual service provider assigned.

- Administrator controlled username and password access
- Automatic timeout/log-off
- Administrator controlled user level read, write, edit, and delete capabilities.
- Administrator controlled user level module and sub-module access
- Automated audit trail
- Security industry standard encryption and SSL certifications
- Back-end server(s), including data encryption and transmission.

II. User Interfaces

II.I. Login Interface

- Web interface login screen to enter username and password.

II.II. Form Selection

- User interface is role specific: users can access relevant forms based on their role.

II.III. Data Entry and Validation

- Available to use on mobile devices and desktop.
- Data entry and validation is possible offline.
- System possible in multiple languages.
- Questions and response options are locally customizable based on country/project contexts.
- Client Listing and Detail
- Caseworkers and supervisors can filter and see a listing of clients' case files and their status.
- Selecting a client/case file enables user to see more detail about the client/case.
- Caseworkers and supervisors can track specific cases over time, and update or add to the information about the case that is saved.
- Once a client/case file is selected, a caseworker can edit existing information .

II.IV. Supervisor performance monitoring and feedback

- The system provides some level of performance monitoring for the supervisors.
- Interactivity between supervisors and caseworkers

- Supervisor feedback can be tracked as part of the case file.
- Supervisors can re-allocate cases to other caseworkers.

II.V. Data Presentation and Dashboards

- Aggregated anonymized information is available to support decision making, donor reporting and general programming protection activities.

II.VI. Data Export

- Filter and search options for clients and case files
- Ability to select specific and all case files to export aggregate, anonymized datasets

III. Functional Requirements

III.I. User class 1: The case worker

III.I.I. Administering consent

- Ability for case worker to administer consent to:
  1. Proceed with intake and
  2. Share information to support referrals.
  3. Share information as part of donor reporting
  4. Participate in client feedback mechanisms.
  5. Informed consent (talking through client with risks and benefits) for service (updateable as new courses of action come up)
  6. This consent is verbal, or documented as part of the case file via a digital signature or by uploading a picture of the signed form.

III.I.II. Engage an interpreter.

- Ability for case workers to engage an interpreter, take the interpreter's name and contact details.
- Administer non-disclosure agreement (NDA) to interpreter.

III.I.III. Search and Register

- Ability to search for case before starting a new one to determine if client has been registered in the system.
- Identification and registration of an individual for case management (tracking of individual and their protection issues after enrollment)

III.I.IV. Assessment and enrollment

- Conduct a protection case management intake.
- Ability for case work to capture both individual and group reporting of incidents.
- Ability to adjust small errors in previously entered data.
- Ability to update data in case of a change in client conditions.
- Ability to halt intake and return to unfished intake at a later date.

III.I.V. Action planning

- Assessment of client needs and desired outcomes.
- Ability to propose actions, including steps, responsibilities persons/organizations.
- Ability to pause any form at any time to conduct a safety assessment and return to complete the original form afterwards.

III.I.VI. Safety Planning

- Assessment of client safety needs when required during the process.
- Ability to propose actions, including steps, responsibilities persons/organizations.

III.I.VII. Follow-up

- Ability to document the status of each goal
  - Document if there's progress in the case.
    - Including outside services received/not received.
  - Document any challenges faced and resolutions made.
- Ability to document specific assistance the case worker provided during the follow-up.
- Ability to upload any new documents/ evidence.
- Ability to document next steps/ actions taken.

III.I.VIII. Referral

- Referral outside of the system
- Ability to track referrals, including type of service provision and successfulness of the service.
  - Ability to refer a client for services not provided by the IRC project, clearly indicating the referral method.
  - Ability to share client-level information across agencies/ organizations to facilitate a referral.
  - Ability to document contact details of the receiving officer, and a short description of the case as part of the referral.

- Ability to share relevant materials (evidence) as part of the referral.
- Ability to document and retain history of client specific referrals, including follow up.

III.I.IX. Case Closure

- Ability for a case worker to mark a case for closure documenting if case was resolved and how it was resolved.
- Ability to ask for approval of case closure documentation from supervisor.
- Ability for case worker to enquire if client wants to participate in a satisfaction survey which can be self-administered, conducted by either the case-worker's supervisor, a different case worker or by the M&E department

III.I.X. Performance Metrics

- Ability for case worker to see a snapshot of key performance indicators on cases (open, closed)including case profiles

III.II. User class 2: Supervisor

III.II.I. Case review and feedback

- Ability for a supervisor to assess the sensitivity/risk of a case prior to intake.
- Need supervisors to be able to give feedback on cases.
- Need case staff to receive feedback on cases.
- Need role-based access to limit viewing to those in supervisory chain.

III.II.II. Re-assign cases

- Need ability to reassign cases to a different case worker.

III.II.III. Case Referral

- Ability for a supervisor to review and approve or reject a referral.
- Ability for supervisor to refer a case with similar privileges to 2.1.1.8. "Referral."

III.II.IV. Case Closure

- Ability for a supervisor to review and approve or reject a case closure.

- Ability for supervisor to close a case with similar privileges to 2.1.1.9. “Case Closure.”
- Ability to re-open a case

III.II.V. Client Satisfaction Survey

- Ability of a supervisor to administer client satisfaction survey when clients consent for one.

III.II.VI. Performance Metrics

- Ability for a supervisor to see a snapshot of key performance indicators includingincluding case profiles for their direct reports
- Total number of new cases registered
- Total number of active case (active as in actively being worked on as opposed to pending which amounts to the unresolved cases)
- Number of caess open
- Number of cases closed
- Case/Case worker ratio
- Total number of successful referrals
- Total number of cases by violation/incident type
- Total number of cases by risk level
- Number of clients that require a safety plan
- Number of cases by time from case opening to case closure (less than one month, 1-3 months, 3-6 months, more than 6 months)
- Number of clients who received cash assistance through protection case management

III.III. User class 3: Coordinators

III.III.I. Review Complex Cases

- Search and view complex cases e.g., those involving multiple beneficiaries.
- Ability to provide guidance to supervisors and case workers on these complex cases.

III.III.II. Reporting and Data Analysis

- Ability to access a dashboard with Key performance indicators and case profiles to support decision making.
- Ability to generate organizational reports with aggregate information to facilitate information sharing.

- Ability to compile organizational aggregate reports.
- Ability to generate ad-hoc reports or statistics.

III.III.III. Access data export for further analysis

- Capacity to export data for further analysis to CSV or XLS formats, including stripping identifiers from the data (i.e., names)

III.III.IV. Access data export for quality control

- Access randomly selected case files as part of the case audit.
- Ability to access a dashboard with Key performance indicators to support quality control.

III.IV. User class 3: Information Management Officer

III.IV.I. Customization

- Review digital application against local form customization.
- Documenting request for change and sharing with TAs for approval.
- Ability to translate from in all relevant languages.
- Ability to generate ad-hoc reports or statistics.
- Ability to add users and assign them roles in the system.
- Ability to disable users in the system.

III.IV.II. Access data export for further analysis

- Capacity to export data for further analysis to CSV or XLS formats, including stripping identifiers from the data (i.e., names)

IV. Performance Requirements

IV.I. Promoting Accuracy

This system will utilize data assurance techniques, such as:

- Default configuration based on harmonized minimum data set.
- Drop down questions with standardized response options.
- Share database names between fields on multiple forms to reduce duplicative data entry.
- Skip logic to show specified data fields when relevant.
- Logic or validation warnings (e.g., a date of birth after the date of incident, issues an error notice)

IV.II. Timing

The system should be available for use 24/7 except during periods of system maintenance. Once data is synchronized or entered in real-time on the Internet, it will be available to those with authorized access. A hosting vendor should be carefully chosen for agile response times and ability to respond to data security concerns. The hosting vendor will ensure that system updates, software updates, and regular system maintenance are completed in a timely manner, ideally not during business hours unless in case of an emergency.

IV.III. Capacity Limits

The server hosting vendor will ensure that the server has the capacity to store the requested cases for a period of three years as well as associated storage capacity for retention of historical data and reporting.

IV.IV. Customization and flexibility

It is expected that the software product owner will be requested to continually update and improve the software. The software should also be flexible and customizable to suit organizational needs and inter-agency updates.

Annex 3.8
Data Protection Checklist

You can use this checklist to assess whether you have minimum standards in place when collecting, storing or sharing your client's data. If after going through this checklist you determine that you don't meet these standards you should contact your technical advisor or head of unit for support.

Data Protection Measures	Y/N
Is there a Staff Data Protection Agreement in place? (see Annex X) • Is it signed by staff interacting with protection case management data and stored as part of their HR files?	
Have staff been trained on confidentiality, data protection protocols and the process for seeking informed consent? • Has adherence to the data protection policies been included within staff contracts? • Are documents and accompanying training updated updated regularly (i.e. when contextual changes occur)?	
Are staff informed about and comfortable discussing applicable and functioning local mandatory reporting mechanisms? • Do staff know the applicable and functioning mandatory reporting requirements and how they are applied in the program (the process and outcomes)? • Have the risks to clients mandatory reporting been discussed in the program?	

Data Protection Measures	Y/N
Paper file security: are records/files stored in a safe location? • Are paper files being kept in a locked cabinet / drawer, accessible only to responsible individuals specified by the Managers? • Are all staff aware of the importance of being vigilant as to who is entering the room where they work and for what purpose? • No one else should be given independent access to the paper files without permission and there should be limited access to keys • Are electronic devices with client information locked in a safe location? (This includes laptops, external hard drives, USB/flash drives) • Is paper documentation for each case is stored in its own individual file, clearly labeled with the case number, not the name of the client? • Are the consent form and the identification and registration form in a separate folder to the rest of the client's case file?	
Is there a protocol for safe destruction of paper forms (shredding, burning and wetting)? • Are staff aware of appropriate times and places to do this? • Is there an emergency protocol in place for safe destruction/transfer of files in case of staff evacuation or imminent security threat?	
Is electronic data protected? • Do electronic case management systems meet minimum standards (see Annex X) • Are mobile devices appropriately protected with a strong pin, two-factor authentication? Are device operating systems and applications up to date? • Are laptops and computers protected by a strong, alpha-numeric password? Are device operating systems and softwares up to date? • Are staff aware of the sharing protocols, including that information should be transferred by encrypted and password-protected files whether this is by internet or USB/memory sticks? • Are all electronic devices set to screen lock after 3 minutes of inactivity?	

Data Protection Measures	Y/N
Are clients informed of their rights in terms of data collection, storage and sharing? • The right to request that their story, or any part of their story, not be documented on case forms. • The right to refuse to answer any question they prefer not to. • The right to tell the caseworker when they need to take a break or slow down. • The right to ask questions or ask for explanations at any time. • The right to request that a different caseworker of a different gender or organization be assigned to their case. • The right to refuse referrals, without affecting our willingness to continue working with them. • The right to access their personal information at any time.	
Is data access limited to ´need to know´ basis? • Are clients and caseworkers allocating a code based upon an agreed standard coding format? • Access to information on clients should be limited only to those who need to know it and to whomever the clients have agreed to know it through giving their informed content to store their data. • Information is not being passed to a third party without the informed consent of clients and/or their caregivers and following the data sharing protocols. • Agreed mandatory fields are shared with supervisors only, or when cases require and consent to referral.	
Are applicable data protection laws in the country of operation abided by • What are they? Has this been discussed in the program? Have required measures been implemented?	

Annex 3.9
Data Sharing Agreement Template

TEMPLATE DATA SHARING AGREEMENT

This Data Sharing Agreement (hereinafter "agreement") is designed to outline the process for the sharing of protection case management client data between *{Organization XX}* and *{Organization YY}* in *{location}* for the purposes of referral. It details the role and responsibilities, the protocols for data sharing, access and storage, as well as the required data protection measures.

1. TRUST STATEMENT

{Organization XX} and *{Organization YY}* recognize the benefits of sharing data in a responsible, safe, and purposeful manner to provide responsive and remedial support to a person at heightened risk of a rights violation through service provision.

The parties understand the risks of sharing and not sharing, and commit to sharing and receiving data and information according to the humanitarian principles and in line with protection and information management principles[1] and respective organisational policies on the same.

2. PURPOSE AND OBJECTIVES

The purpose of data sharing as part of this agreement is to facilitate Safe, accountable and timely referrals to connect client to essential basic, protection and specialised services. Information, including personally identifiably data on specific clients, with their informed

consent, is shared by *{Organization XX}* to *{Organization YY}* to:

- Facilitate **referrals** of clients and enable follow-up on these referrals.
- Facilitate **payment** by organization XX for specific services.
- Facilitate **analysis of aggregate outputs** and the development of lesson learnt documentation.

3. HUMAN AND TECHNICAL CAPACITY

{Organization XX}

Data consolidation, analysis and processing within *{Organization YY}* is governed by the following established policies {list relevant organizational policies and relevant HR structures to implement these policies and this DSA}.

{Organization YY}

Data consolidation, analysis and processing within *{Organization YY}* is governed by the following established policies *{list relevant organizational policies and relevant HR structures to implement these policies and this DSA}.*

Both organizations are committed to the PIM principles when collecting, analyzing and sharing data, including those of informed consent and do no harm.

{Organization XX} and *{Organization YY}* commit to ensuring that the designated focal points within the respective organizations can access the data shared. Authorized designated focal points are employee of the organizations in this agreement and access any data on a 'need to know' basis. Specifically, this will include *{roles to be modified as relevant}.*

- YY Referral focal point
- YY Protection supervisor
- YY Protection assistant
- XX Referral focal point
- XX Medical Team supervisor
- XX Medical assistant

Adding any additional staff as authorized persons will require written prior approval between the two parties.

4. CHARACTERISTICS DATA

This agreement governs the sharing of protection cases management client data between *{Organization XX}* to *{Organization YY}* including:

{Add list variables that will be shared. If this list exceeds 10 variables, provide a detailed list within an Annex. For each variable, clarify the specific purpose of sharing. Example list:

Variable:	**The purpose of sharing this data is to...**	**Sensitivity Classification**
Date of identification	*Enable case prioritisation and monitor follow up*	*Restricted*
Full name	*Schedule appointment with client*	*Strictly Confidential*
Phone number	*Schedule appointment with client*	*Strictly Confidential*
Address: governorate, district, sub-district, village/neighbourhood	*Offer services closest to clients location.*	*Strictly Confidential*
Preferred means of communication	*Ensure client can be reached using the most effective and preferred communication method*	*Restricted*
Details on individual's urgent needs and reasons for referral	*Provide a service tailored to the needs of the client. Avoid the client having to explain their situation multiple times.*	*Strictly Confidential*
Information related to the individual's situation in relation to the service eligibility criteria	*Ensure client can access available service*	*Strictly Confidential*
Any characteristics requiring accommodation from the receiving agency, such as disability status.}	*Ensure client can access available service, safely.*	*Strictly Confidential*

One or more variables within this dataset can be classified as "Strictly Confidential"[2], meaning that it contains formation or data that, if disclosed or accessed without proper authorization, are likely to cause severe harm or negative impacts d/or damage to clients and/or humanitarian actors and/or impede the conduct of the work of a response. These characteristics can only be shared if associated risks have been noted in the DRA as mitigatable.

5. PLANNED ACTIVITIES AND EXPECTED RESULTS

Prior to the referral, clients should be asked whether they consent to the referral and having their contact information and personal situation shared with the receiving organization for the purpose of referring them.

{Organization XX} will:

- Initiated by the designated focal point when (1) the person referred seems to meet the eligibility criteria and (2) gave their informed consent for their data to be shared with the receiving organization. The informed consent must be specific to the referral procedure and noted in the referral form.
- This referral form will be shared {detail sharing mechanism, e.g. e-mail, hard copy to designated focal point}. It includes an explanation of the services they are referred to as well as the data protection measures put in place.

{Organization YY} will

- The receiving agency should immediately inform the sending agency that the referral was received.
- Inform the sending agency about outcomes and follow up actions taken on all cases including whether the person referred was assessed, registered, whether the services were provided, what type of service and outcome. If the referral was not successful, the receiving agency will explain any challenges faced.
- In case of a data breach {Organization YY} will inform {Organization XX} within one working day.
- Client data will be destroyed after services has been provided or in line with organization policy.

6. OWNERSHIP OF THE DATA

The client retains full ownership of all data shared. As such, the client can request modification to already shared data, as well as the deletion of one or more types of data. {Organization YY} is to honor this request within 10 working days.

7. DATA USE AND SHARING WITH THIRD PARTIES

The data shared is considered confidential. The data can only be used in support of the objectives outlined in chapter 2 ¨Purpose and objectives¨.

The data is shared with {name of Department / Team within organization YY}. The data cannot be shared with other departments or teams unless previously approved by {Organization XX} in writing, and with informed consent of the client. The data cannot be shared with any other third party unless previously approved by {Organization XX} in writing, and with informed consent of the client.

8. EFFECTIVE DATE, DURATION, AMENDMENTS, AND TERMINATION

This Agreement may be modified, amended, or replaced with a new version if all Parties agree in writing. A Party may terminate this Agreement at any time but must provide at least one month's written notice to the other Party.

This Agreement becomes effective on the date of written confirmation of the Agreement by both parties and will remain in effect for (twelve (12) months).

9. USE OF DATA FOR REPORTING PURPOSES

Anonymized aggregated data can be used by both organization for overall service and caseload analysis. Any agreed use of anonymized data for statistical purposes will be created as per donor requirements.

Individual responses will never be published in full. If quotes are published, identifying details will be removed to protect the confidentiality.

10. DISPUTES

Should disputes arise out of this sharing agreement they will be resolved between the signatories. In case of problems not being resolved to the satisfaction of both parties the matter will be escalated to the responsible line managers.

Date:
For and on behalf of XX:
Signature:
Name:
Position:

Date:
For and on behalf of YY:
Signature:
Name:
Position:

Endnotes

1 http://pim.guide/essential/a-framework-for-data-sharing-in-practice/

2 See Information Sharing Protocol Sensitivity Classification IASC Operational Guidance Data Responsibility in Humanitarian Action 2023 https://docs.google.com/document/d/1lElv51jJCZoyf8Y8d4TRu3pNAusEknr3appKzSszaEc/edit

Annex 3.10
Common MEAL Terms and Definitions

MEAL	Monitoring, Evaluation, Accountability, and Learning (MEAL) is a way of assessing the impact and effectiveness of humanitarian interventions, and improving the quality and accountability of humanitarian action
Monitoring	Refers to the ongoing process of collecting and analyzing data on program activities and outputs, to ensure that they are implemented according to plan and to identify areas for improvement.
Evaluation	The periodic, user-focused, systematic assessment of the design, implementation and/or results of an ongoing or completed project.
Accountability	Ensures that clients' voices are heard and considered in program design and implementation. It allows organizations to solicit feedback from those they serve, making programs more responsive to the needs of the community
Learning	Having a culture and processes in place that enable intentional reflection. The aim of learning is to make smarter decisions
Outcome	Refers the tangible and measurable results or changes that occur as a result of providing protection services and support to individuals or communities facing various forms of vulnerability, risk, or human rights violations
Output	Refers to the immediate and direct results or products of a protection case management intervention or program. These outputs are typically the activities and services provided to individuals or communities facing various forms of vulnerability, risk, or human rights violations.

Data analysis	Refers to the process of systematically examining and interpreting data and information related to protection cases and the services provided to individuals or communities facing various forms of vulnerability, risk, or human rights violations. This analysis is a critical component of protection case management and aims to inform decision-making, improve program effectiveness, and ensure that the needs of beneficiaries are adequately addressed.
Activity	Are the specific actions, interventions, and services that professionals or organizations provide to individuals or communities facing various forms of vulnerability, risk, or human rights violations. These activities aim to address the unique needs and circumstances of each case, with the ultimate goal of improving the well-being, safety, and protection of the affected individuals.
Reporting	The process of documenting and communicating information about the status, progress, and outcomes of protection cases and the services provided to individuals or communities facing vulnerability, risk, or human rights violations
Data interpretation	The process of analyzing and making sense of the data collected while managing protection cases. This interpretation is a critical step in understanding the outcome of protection interventions, identifying trends and patterns, and informing decision-making for ongoing and future cases.
Information management system	Refers to a software or digital platform designed to support and streamline the processes and tasks involved in case management. Case management IMS systems are commonly used in various fields, including healthcare, social services, legal, and protection, to enhance the efficiency, organization, and documentation of case-related information
Client	An individual who is enrolled in protection case management services

Intake	The activity during which a possible client is identified, based on the context specific eligibility criteria. The total number of intakes exceeds the number of cases, as some people will not receive protection case management, but will instead be referred to a different service or activity.
Open case	A case that is active at the time of measurement.
Closed case	A case that has been closed, as part of the last step of protection case management, for instance when a client's needs have been met to the extent possible within the context, or if case worker has not been able to reach the client for predetermined period of time.
Total cases	Total number of cases open and closed.
Protection risk	The potential or actual exposure of a population to coercion, violence, or deliberate deprivation.
Psychosocial wellbeing	Psycho-social wellbeing is a holistic measure of a clients' welfare. It captures both subjective wellbeing, the degree to which a client is 'feeling good', and psychological functioning, whether a client is 'functioning well' in their daily life. Psycho-social wellbeing should increase as a result of case management support.
Psychological distress	Psychological distress focusses on a client's mental health. Someone with moderate or high levels of severe distress is experiencing a compromised state of mental health that interferes with their ability to function in their daily life. Disabling distress should decrease as a result of case management support.

Annex 3.11

Measuring the Protection Case Management Theory of Change

What we are aiming for

Impact: In humanitarian crises, people at risk are able to realize their rights and live in safety and with dignity.

Pathway: Protection risks are mitigated, and people at risk recover from experiences of harm, including discrimination, violence, reduced access to services, and threats to their integrity, safety, and life.

Category	Statement	Indicator(s)
Protection Outcomes (Level II)	2. People at risk achieve improved psychosocial wellbeing through protection case management support	• **PO-01:** % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support
Protection Outcomes (Level I)	1.1 People at risk are less impacted by protection risks through protection case management support.	• **PO-02:** % of clients who report being less impacted by protection risks after receiving protection case management support • **PO-04:** % of PCM clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support
Protection Outcomes (Level I)	1.2. People at risk with mental health needs demonstrate a reduction in symptoms of severe distress through protection case management support.	• **PO-03:** % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support

Category	Statement	Indicator(s)
Process & Quality Pathway:	People at risk have access to quality, and client-centered protection case management services when they need it.	
Process & Quality	1.1 People at risk are eligible for and receive to PCM services.	• **PQ-01:** % of intakes eligible for PCM • **PQ-02:** # total protection case management clients • **PQ-03:** # of new cases registered for protection case management (originally CP-09) • **PQ-04:** % of cases closed due to meeting objectives of the action plan • **PQ-05:** % of clients who received cash assistance through protection case management
Process & Quality	1.2 PCM services are sufficiently staffed and resourced.	• **PQ-06:** Average # of clients per case worker per month
Process & Quality	1.3 Case workers possess the skills, knowledge, and willingness necessary to support clients through PCM services.	• **PQ-07:** % of caseworkers whose knowledge assessment score is at least 70% • **PQ-08:** % of caseworkers whose attitudes score is at least 80% • **PQ-10:** # of case workers trained on protection case management
Process & Quality	1.4 PCM services are delivered in a client-centered way that is accountable to clients, inclusive, and in line with their needs and preferences	• **PQ-11:** % of clients that felt they were involved in decisions during their case management • **PQ-12:** % of clients that are satisfied with the case management services

Category	Statement	Indicator(s)
Process & Quality	1.5 PCM services are delivered in line with quality standards and protocols (as articulated in the protection case management guidance)	• **PQ-09:** % of case files reviewed that meet 80% of criteria of a case file checklist
Process & Quality	1.6 Case workers establish strong relationships with clients based on a foundation of empathy, inclusion, support and trust.	• **PQ-11:** % of clients that felt they were involved in decisions during their case management • **PQ-12:** % of clients that are satisfied with the case management services
Process & Quality	1.7 PCM clients are successfully referred to relevant services (including specialized mental health services, legal support, and health and education services).	• **PQ-13:** % of successful referrals
Case Characteristics: *Who are the people at risk?*	• % of cases by protection risk • % of cases by risk level • % of cases by duration • % of clients that have a disability • % of clients with a finalized safety plan • % of clients reporting symptoms of moderate to severe distress in the 14 days prior to survey completion *Disaggregation by gender, age group, and disability are industry-standard and should be used along with any other contextually-relevant vulnerabilities.*	

Annex 3.12
Client Feedback Modalities

When deciding on the most appropriate feedback channels, take into account the clients' preferred format and modalities, as well as any resource constraints and client literacy levels. The client should be provided with multiple options to provide feedback: it is recommended to establish at least one proactive feedback channel, such as a survey with clients, and one reactive feedback channel.

Reactive channels: Through reactive feedback mechanisms, such as toll-free hotlines, suggestion boxes and social media outlets, clients can provide feedback in a format and at the time they choose. This type of information complements insights collected through proactive channels. These channels are specific to PCM services or are, more commonly, part of a programme wide feedback mechanism system, that clients can access to provide feedback on any type of intervention received from a specific organization or sector. Ensure accessibility to these channels through targeted information dissemination.

Proactive channels: As part of protection case management, a survey with the client is the most common proactive feedback mechanism. It is the key instrument to measure client's level of satisfaction with the services. The following table details the advantages and disadvantages of the different modalities that can be used to administer such surveys:

	Modality	Advantages	Disadvantages
Recommended	A feedback survey is self-administered by the client[1]. The survey is kept anonymous.	The anonymous nature of a self-administrated survey can result in more open and honest feedback.	• Low literacy levels impede access. • As the survey is anonymous, it is not possible to follow up on client specific issues identified.

Recommended	A feedback survey is administered by a supervisor, case worker (other than the case worker assigned to the case) or another trusted member of the PCM team.	• A conversation with a trusted case worker can provided more detailed and feedback than a self-administered survey can. • Allows for immediate follow up to client specific issues identified. • Accessible to those with lower levels of literacy.	• Clients can consciously or subconsciously be motivated to respond in a positive way. • Additional workload on the team.
Alternative	A staff member external to the PCM team conducts the feedback survey, for instance a member of the MEAL team.	• Reduced workload on the PCM team. • Allows for immediate follow up to client specific issues identified. • Surveyor can be seen as more neutral and trusted. • Accessible to those with lower levels of literacy.	• High level of expertise of PCM required to understand the sensitive nature of case management and go beyond generic questions. • Possible confidentiality concerns around high-risk cases.

Timing

Clients are encouraged to provide feedback at any point during the case management service, by using reactive channel or during conversations with their case managers. The Client Feedback Survey can be completed at the end of the case management process, or after the case action plan has been (partly) implemented with the client. Administering the form at the end of the process, ensures that the full service is taken into consideration, while administering the form while the process is on-going allows for any issue to be immediately addressed.

Endnotes

1 Such a survey can be handed out at a service delivery point and/or shared by e-mail, WhatsApp or other digital platforms.

Annex 3.13
Outcome Monitoring Guidance

Part I: Introduction to PCM Outcome Monitoring

Since 2020, IRC has been working with partners in the humanitarian community to develop an approach for using case management to respond to protection risks in crisis situations. The approach is described in 'Your Guide to Protection Case Management', a global tool that provides guidance and support to practitioners delivering protection case management (PCM) services. This guidance note was developed to complement the PCM guide, and, in particular, to support PCM teams to **gather evidence on the outcomes of protection case management for individual clients.**

Outcome monitoring is only one part of the broader monitoring, evaluation, accountability and learning approach for PCM. The 'Monitoring, Evaluation, Accountability, and Learning (MEAL) Guidelines for Protection Case Management (PCM)' is a comprehensive resource designed to support PCM teams to implement MEAL activities. The MEAL Guidelines provide guidance, tools and resources for monitoring the outcomes of PCM, the process and quality of PCM work, and the profiles of the clients and cases accessing PCM services.

Why measure outcomes of PCM?

Historically, monitoring and evaluation of case management services has focussed on monitoring the outputs of case management (e.g. the number of clients reached, the number of cases closed) or the outputs of interventions intended to strengthen the quality of the case management services (e.g. the number of case managers trained). Outcome monitoring goes a step further – it seeks to measure the **impact of PCM services** on individual clients' lives, or the **change** that results from PCM work.

Outcome data about PCM interventions can be used to:

- Understand the results of PCM services for individual clients, including how these vary across different populations of clients and protection risks;
- Inform changes to strengthen PCM approaches and more effectively meet clients' needs[1];
- Generate evidence for best practice in PCM service delivery;
- Report on the results of PCM to key stakeholders, including clients, communities, donors, and partners.

Ultimately, this will support our primary goal: improving service provision for clients.

Outcome monitoring is also a useful tool for case workers: it can support case workers to track a client's progress and inform the case management response itself.

What are the PCM outcomes we are seeking to measure?

This guidance addresses three different protection case management outcome areas.2

1. **Psychosocial wellbeing**

Psychosocial wellbeing is a holistic measure of a clients' welfare. It captures both subjective wellbeing, the degree to which a client is 'feeling good', and psychological functioning, whether a client is 'functioning well' in their daily life. Psychosocial wellbeing should increase as a result of case management support.

2. **Psychological distress**

Psychological distress focusses on a client's mental health and well-being. Psychological distress can be defined as painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. Individuals with moderate or high levels of psychological distress may experience a compromised state of mental health, impacting their well-being, functioning, or quality of life. Psychological distress can be a precursor to a mental illness. However, experiencing psychological distress does not always indicate the presence of a mental health disorder. Symptoms of psychological distress should decrease as a result of case management support.

3. **Protection risk reduction**

This outcome aims to capture whether the PCM response has contributed to reducing the impact of a protection risk on a client. While case management may not be able to eliminate an external threat or undo harm that has already been experienced, it can reduce a clients' vulnerability to that threat and increase their capacity to cope with harm. The impact of a protection risk on a client should decrease as a result of case management support.

PCM outcomes and corresponding indicators

Outcome area	PCM Outcome	Outcome Indicator
Psychosocial wellbeing	People at risk achieve improved psychosocial wellbeing through protection case management support	• **PO-01:** % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support
Psychological distress	People at risk achieve reduced psychological distress through protection case management support	• **PO-03:** % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support
Protection risk reduction	People at risk are less impacted by protection risks through protection case management support	• **PO-02:** % of clients who report being less impacted by protection risks after receiving protection case management support • **PO-04:** % of clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support

Do I need to measure all PCM outcome indicators?

It is not necessary to monitor all three PCM outcome areas. As set out in the MEAL Guidelines, during the initial planning process, PCM teams select and customise the indicators that are relevant to their context, donor specifications, and learning objectives.

It is recommended to measure both the psychosocial wellbeing outcome and the protection risk reduction outcome if possible. These two outcomes are complementary: while psychosocial wellbeing captures the eventual outcome of PCM for the client, protection risk reduction captures a more direct outcome of PCM support – the degree to which the relevant protection risk affecting each client has been addressed (from the client's perspective). Risk reduction outcomes can enrich teams' understanding of why psychosocial wellbeing has or hasn't improved and how that relates to the PCM response.

Measuring the psychological distress outcome is optional. As will be described in greater detail in Section III, 'Compiling and Analysing Results', this outcome was developed to capture the degree to which PCM leads to improved mental health outcomes for the population of PCM clients with more serious mental health needs. PCM teams can determine whether this is relevant / a priority area for them.

If it is only possible to monitor one outcome, it is recommended to monitor the psychosocial wellbeing outcome. However please note that the protection risk reduction outcome doesn't require additional data collection, and draws on information gathered in the protection risk assessment and case closure forms (see section II below).

Part II: Gathering data on PCM outcomes

Tools for gathering data on PCM outcomes have been incorporated into the broader PCM toolkit, and data for outcome monitoring can be gathered by the case workers as part of the PCM process. The case worker is likely in the best position to collect data because he or she will have the strongest and most trusting relationship with the client.

It is important to keep in mind that outcome monitoring is NOT intended to assess the performance of an individual case worker. There are a number of factors that influence outcomes for an individual client, and many of these are not in the case worker's control (see section on interpreting results below).

Data gathering tools – an overview

The diagram below shows all the tools that are used as part of the PCM process and indicates which tools will be used to gather data on each of the three PCM outcomes. Data for each outcome area will be collected at least twice in the PCM process – once at the beginning of the PCM response and once at the end. Comparing the result at the beginning to the result at the end makes it possible to measure change for each individual client.

- Intake form and informed consent
- Protection risk assessment - *Includes questions for gathering data on **protection risk reduction outcome** ('baseline')*
- Psychosocial wellbeing scale - *Data gathering tool for the **psychosocial wellbeing outcome** ('baseline')*
- Basic MHPSS assessment - *Data gathering tool for the **psychological distress outcome** ('baseline')*
- Action Plan
- Psychosocial wellbeing scale - *Data gathering tool for the **psychosocial wellbeing outcome** ('endline')*
- Basic MHPSS assessment - *Data gathering tool for the **psychological distress outcome** ('endline')*
- Case closure - *Includes questions for gathering data on **protection risk reduction outcome** ('endline')*

The baseline psychosocial wellbeing scale (WEMWBS) and basic MHPSS assessment may be completed at the same session as the protection risk assessment. They may also be completed during a separate session if the case worker feels it is too much to fit all three activities into one session (e.g. because the client is tired or due to concerns about time). It is recommended to complete both scales in a single section, ideally before the action plan is developed, so the results can inform the action plan. Similarly, for establishing the endline, the tools can be used during the case closure or as a separate session. This is a decision for the caseworker and can be made on a case-by-case basis.

Reminders:

- **Confidentiality:** Before leading the client through the data gathering tools, it is good practice to remind the client about the principles in the confidentiality agreement, particularly that the case worker will keep their information confidential at all times and any exceptions to this.
- **Informed consent:** As set out in the scripts below, the case worker must always ensure they have informed consent from the client **before completing** either the psychosocial wellbeing scale or the basic MHPSS assessment. It is also good practice to get informed consent to use data from the surveys for MEAL purposes, reminding the client that data will be completely anonymised and with no identifiable information included, and will be combined with data from other clients in the analysis. For instance, after you have introduced the tool to the client, you might say something like:

"In order to make sure that the case management services we provide are truly supporting clients like you, it's important to us to regularly review our case management services and programming. With your permission, I would like to use some of the information you share with us today in order to learn about whether and how case management is helping our clients. All data will be anonymised – this means we will never include any information that would allow you to be personally identified. In fact, the data will be combined with data from other clients and analysed together in number form, so there is no way your personal responses could be connected to you. Learning about the outcomes of case management for clients can help us improve our services in the future. Do I have your permission to include your responses in our review? Please know that your response does not impact your ability to receive services in any way."

Gathering data on the psychosocial wellbeing outcome

The psychosocial wellbeing scale is a questionnaire with 14 statements about feelings and thoughts.3 For each statement the client will select a response which best describes their own experience over the past two weeks. The client will select from the following five options: (1) none of the time, (2) rarely, (3) some of the time, (4) often, or (5) all of the time.

Begin by **explaining the tool to the client and asking for their consent to participate in this activity.** You might say something like the following:

"As part of our meeting today, I want to ask if you would be willing to take part in an activity to help us both better understand how you are doing in different aspects of your life. First, I will ask you some questions about your thoughts, feelings, day to day life and relationships. Then, we will work together to develop an action plan to address some of the problems that are concerning you. If you are willing to do so, we can return to these questions in the future to see if things have improved. Is it okay with you if we complete this activity together?"

If the client agrees, **lead the client through the tool**. You might say something like the following:

"I am going to read out a statement about feelings and thoughts. I want you to think about your own experiences over the past two weeks and then choose the response that best describes your experience. For each statement you will choose a response from these five options: (1) none of the time, (2) rarely, (3) some of the time, (4) often, or (5) all of the time. There are no right or wrong, or good or bad answers to any of the questions – just choose the answer that feels the most right to you. If you decide you do not want to go any further or you want to skip any question, that's always okay, you are welcome to stop at any time. Do you have any questions for me before we begin?"

- Go through the statements one by one with the client;
- If the client is struggling to choose a response, feel free to prompt or guide them – but try not to influence their response;
- Remind the client that if they wish to stop at any time that is fine – they just need to let you know;
- Try your best to cover all 14 statements, unless the client declines to answer;
- Once the client has finished, thank them for sharing their answers with you.

Action point! The psychosocial wellbeing scale uses a tool called the 'Warwick Edinburgh Mental Wellbeing Scale' (WEMWBS) developed by academics at Warwick University and Edinburgh University. The tool is available to use freely for public sector organisations (including social services, NGOs and charities), but because the tool is protected by copyright, it is necessary to register with Warwick University before using the tool. IRC has

registered for a license. If you are from another organisation and are planning to use the psychosocial wellbeing scale (WEMWBS) it is necessary to register before doing so. The registration process is very short and straightforward. You can complete your registration here: https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/using/non-commercial-licence-registration/

Gathering data on the psychological distress outcome

The basic mental health and psychosocial support (MHPSS) assessment[4] is a questionnaire with 9 statements about experiences, feelings and thoughts. For each statement the client will select a response which best describes how often the statement was true over the past two weeks. The client will select from the following four options: (0) not at all, (1) several days, (2) more than half the days, or (3) nearly every day.

Begin by **explaining the tool to the client and asking for their consent to participate in this activity**.[5] You might say something like the following:

"*Today, I'll be asking you some additional questions so that we can understand more about how you are feeling and how your feelings, thoughts and emotions are impacting your life. The information you share will help us work together to create a plan to provide you with the best possible support services. If you decide you do not want to go any further or do not want to answer a question, that's always okay, you are welcome to stop at any time."*

During previous sessions together, we've talked about the confidentiality and how the information you share with me will be kept confidential.

There is an important exception to confidentiality, for your safety and the safety of others, that I want to share with you. In situations where there is a serious threat to your safety or the safety of others (for example you are at risk of being hurt or hurting yourself or others) it may be necessary for me to share some information about the safety risk with specific colleagues or specialized service providers so that you (or the person at risk) can be protected from harm. The goal is to keep you safe. In cases where I need to break confidentiality, I will always inform you first and consult with my supervisor. Do you have any questions for me before we continue?"

If the client agrees, **lead the client through the tool.** You might say something like the following:

"I am going to read to you a statement about experiences, feelings and thoughts. I want you to think about the past two weeks and choose the response that best describes how often the statement has been true for you. For each statement you will choose a response from these four options: (0) not at all, (1) several days, (2) more than half the days, or (3) nearly every day. Remember, there are no right or wrong, or good or bad answers to any of the questions – just be as honest as you can and choose the answer that feels the most right to you. You can stop me to ask questions or clarification at any time. And if you decide you do not want to go any further, you can stop at any time. is it okay with you if we complete this activity together? Do you have any questions before we begin? "

- Go through the statements one by one with the client;
- If the client is struggling to choose a response, feel free to prompt or guide them, but try not to influence their response;
- Remind the client that if they wish to stop at any time that is fine – they just need to let you know;
- Try your best to cover all 9 statements, unless the client declines to answer;
- Once the client has finished, thank them for sharing their answers with you.

Gathering data on the protection risk reduction outcome

Questions designed to gather data for the protection risk reduction outcome have been integrated into the protection risk assessment form and the case closure form. You can gather this information from the client as part of these processes. The relevant questions are set out below.

From: 'Protection risk assessment, Part G: Summary for Client'

"From what we have discussed, what do you feel is the thing which is worrying you most?"

"You mention (...) as the main problem(s) you worry about. How much would you say the problem(s) we discussed are affecting you and your life right now?"

Not at all; Some; A moderate amount; A lot; Severely

"How would you rate your ability to address this problem? "

No ability; Low ability; Moderate; High; Very high

When asking about the 'main problem', refer back to the problem (or problems) the client highlighted in the original question. If the client struggles to understand the question or rank the impact of the problem you can provide some explanation or guidance. For example, you might illustrate the way the problem is affecting the clients life, by adding the phrase: "For example, by impacting your safety and security, your health, your mood and stress levels, your ability to do daily tasks, your ability to access what you need, your family life, your personal dignity, etc."

Case closure form (question 3)

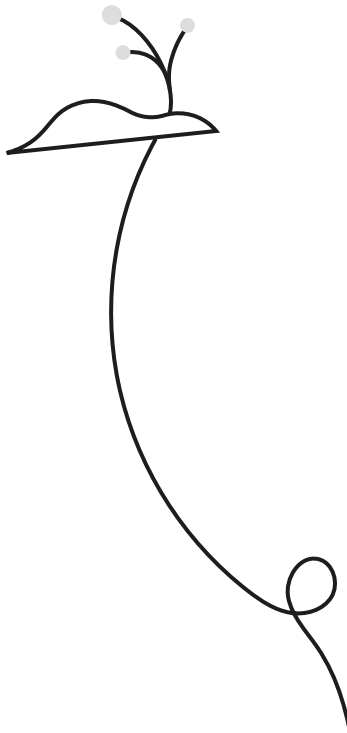
"When we first discussed your case, you mentioned (...) as the main problem(s) you worried about. How much would you say this problem is (these problems are) affecting you and your life right now? "

Not at all; Some; A moderate amount; A lot; Severely

"Now that we are closing the case, how would you rate your ability to address this problem? "

No ability; Low ability; Moderate; High; Very high

Again, provide some guidance to the client if needed.



Gathering qualitative data on protection outcomes

Qualitative data can help us understand and interpret quantitative results by providing important context and explanation: the **'why'** and *'how'* behind the client's response to a standardised question. For this reason, we have added a number of open-ended questions to the case closure form. The responses to these questions will not be used to calculate indicators or measure outcomes.

Qualitative questions included in the case closure form:

- What about the PCM support you received was most valuable to you personally? Why?

- Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could PCM have supported you better?
- What were the most important changes that you experienced in your life as a result of your participation in PCM?
- Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could PCM have supported you better?

A note on contextualisation

Both the psychosocial wellbeing scale and the basic MHPSS assessment are based on tools that have been validated in a range of diverse contexts. Given this, we would recommend using the tools as they are without making significant changes. This is particularly the case for the psychosocial wellbeing scale. The statements in the scale refer to concepts that are abstract, and likely to be broadly relevant across contexts. Furthermore, as part of its licensing agreement the University of Warwick asks users to agree not to: "adapt, alter or modify the content of the WEMWBS or the resources in any way."

That said, it is important to ensure that the statements in the scales are meaningful and appropriate in the context where they are being used. For instance, when piloting the use of the Basic MHPSS Assessment with PCM teams, case workers gave feedback that not all statements were relevant to clients' lives. For example, the assessment asks respondents if they have had "trouble concentrating on things, such as reading, listening to the radio or watching television". In a context where television isn't available or accessible this question may need to be adapted – for instance by replacing 'watching television' with another, more relevant activity that requires concentration.

As part of the initial planning process, it is important to review the statements in the psychosocial wellbeing scale and Basic MHPSS Assessment to ensure that they are clear, relevant and meaningful in the context where you are working. In particular, it may be helpful to consider:

- Whether local terminology could be used to communicate concepts more clearly and meaningfully;
- Whether examples are contextually relevant.

This will help ensure that tools are valid and results are meaningful.

For additional information on contextualization of MHPSS MEAL materials and beyond, please refer to the MHPSS Minimum Service Package (MSP) key considerations, relevant guidelines, standards and tools on contextualization and/or reach out to the MHPSS MSP HelpDesk. The MHPSS MSP builds on existing MHPSS standards and tools to create a single, easy-to-follow intersectoral package inclusive of core activities, an orientiation guide, costing tool, gap analysis tool, and seminal guidelines. For additional support in MHPSS M&E, please reach out to the MHPSS M&E HelpDesk. The IASC MHPSS Reference Group introduced the MHPSS M&E Helpdesk in 2021 to support uptake and use of the IASC Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings: With means of verification (Version 2.0).

Part III: Compiling and Analyzing Results

Psychosocial Wellbeing

Scoring the psychosocial wellbeing scale

Each of the 14 items on the psychosocial wellbeing scale has a scoring range of 1 – 5, with the following values:

- None of the time (1)
- Rarely (2)
- Some of the time (3)
- Often (4)
- All of the time (5)

To calculate the total score for each individual client, simply add up the scores across all 5 items. Total scores will range from 14 – 70.

A note on missing values:
If you are using a digital system for scoring: do not calculate a score for a client with **more than two** missing values – these responses should not be included when the indicator is calculated. For clients missing **one or two** values, calculate the 'average' response to each statement (total score / number of statements with a response), and fill in the missing value with the average.

If you are scoring the surveys manually: do not calculate a score for a client with **any** missing values.

Data from incomplete surveys can be entered into your database for further analysis, indicating missing values, but the score should not be used when calculating the psychosocial wellbeing indicator (see below).

Interpreting scores[6]

The following thresholds can provide some guidance on how to interpret clients' psychosocial wellbeing scores. Please note that these thresholds are based on analysis of data from UK populations – while we assume these are also relevant and appropriate for clients using PCM services, contextual differences should be taken into account.

14-40	**Very low psychosocial wellbeing:** The client's score is in the very low range, indicating that they are facing significant difficulties and would likely benefit from MHPSS services and may also require additional support from a specialized mental health professional. It is likely useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referals for specialized MHPSS services.
41-44	**Low psychosocial wellbeing:** The client's score is in the low range, indicating that they would likely benefit from receiving MHPSS services to support their mental health and psychosocial wellbeing. It may be useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for non-specialized and specialized MHPSS services.
45-59	**Moderate psychosocial wellbeing:** The client's score is in the moderate range, indicating that they are doing ok. But they could still benefit from MHPSS services to support their mental health and psychosocial wellbeing. Activities centred around improving resilience and addressing or reducing risk factors, may be beneficial to prioritize activities that support coping strategies.
60-70	**High psychosocial wellbeing:** The client's score is in the high range, suggesting they are doing well. It is still important to incorporate MHPSS services in PCM activities for the client to take steps to improve resilience and develop coping strategies in order to maintain high wellbeing, particular in light of emerging risks, threats and challenges.

If case management is effective in supporting clients to address protection risks, recover from harm and access their rights and entitlements you can expect wellbeing scores to rise. **For each PCM client it is useful to record the following data: the client's psychosocial wellbeing score at intake, the client's psychosocial wellbeing score at case closure and the change in the client's score (see below).**

Interpreting change over time for an individual client

In order to measure change in a client's psychosocial wellbeing, you need to have at least two scores for the client over time (meaning they need to have completed the psychosocial wellbeing survey at least twice during the PCM process).

Subtract the baseline score from the endline score to calculate the level of change. If the clients' score has decreased the level of change may be a negative number.

[Endline score] – [Baselinet score] = change in psychosocial wellbeing

An increase (or decrease) of three or more constitutes a significant change in psychosocial wellbeing.7 This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual improvement (or decline) in psychosocial wellbeing.**

A change in psychosocial wellbeing may result from the case management intervention and it may also result from a change in external factors that affect an individual's psychosocial wellbeing.

- Qualitative data provided by clients on the case closure form can also help you understand the reasons behind changes for individual clients;
- Contextual information, such as information contained in protection analyses, can help you identify external factors that may have influenced psychosocial wellbeing;
- Finally, by analysing data across many clients, you can begin to identify trends in how PCM interventions affect psychosocial wellbeing.

Interpreting change across many clients: calculating the psychosocial wellbeing indicator

The psychosocial wellbeing indicator was developed to capture whether protection case management contributes to improved psychosocial wellbeing for clients. The indicator and its two parts are set out below.

> **Psychosocial wellbeing indicator:** % of PCM clients who demonstrate improved psychosocial wellbeing after receiving PCM support.
>
> **Numerator:** # of clients surveyed whose psychosocial wellbeing scores improve by at least 3.
>
> **Denominator:** # of clients who participate in the psychosocial wellbeing survey at both baseline and endline.

In order to calculate the indicator you need to:

Step 1: Calculate the total number of clients who participated in both baseline and endline of the Psychosocial Wellbeing Assessment during the designated time period;

Step 2: Calculate the number of PCM clients whose psychosocial wellbeing scores improved by at least 3 between baseline and endline;

Step 3: Divide the second number (Step 2) by the first number (Step 1) and multiply the result by 100: this is your indicator value.

In addition to calculating the proportion of clients with improved psychosocial wellbeing, it may be useful to calculate:

- The average psychosocial wellbeing score across all clients at intake and case closure;
- The distribution of psychosocial wellbeing scores across clients at intake (how many clients fell into the very low, low, moderate, and high categories), and characteristics of clients within these categories.
- The distribution of psychosocial wellbeing scores across clients at case closure (how many clients fell into the very low, low, moderate, and high categories);
- The average change in psychosocial wellbeing score across all clients;

- The distribution of the change in psychosocial wellbeing scores across all clients.8

It can be useful to disaggregate these results by other relevant variables in order to understand and explain them. You may consider the following questions:

- How do psychosocial wellbeing outcomes differ according to the client's gender, age, disability status, displacement status, risk level and/or type of protection risk?
- How do psychosocial wellbeing outcomes differ between different geographic areas? What are the possible explanations for these differences (e.g. availability of referral services, external risks and conditions, etc)?
- Do outcomes differ in relation to how the case management service was implemented, or the quality or process of PCM (consider process and quality indicators for relevant variables)?
- How have psychosocial wellbeing outcomes changed since the previous review period? What might explain this (e.g. differences in practice, capacity, availability of referral services, external risks and conditions, etc)?

More information about how to analyse and interpret results can be found in the Monitoring, Evaluation, Accountability and Learning (MEAL) Guidelines for Protection Case Management.

Psychological Distress

Scoring the Basic MHPSS Assessment

Each of the nine (9) core questions on the Basic MHPSS Assessment has a scoring range of 0 – 3, with the following values:

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

To calculate the total score for each individual client, add up the score for each of the nine (9) items. Total scores will range from 0 – 27. A tenth question on the Basic MHPSS Assessment asks about the extent to which the previously mentioned symptoms make functioning in daily life difficult. The response to the tenth question is not factored into the final

score; however, case workers may use the response to help gauge the impact of the reported symptoms on their daily life.

A note on missing values:
If you are using a digital system for scoring: do not calculate a score for a client with **more than two** missing values – these responses should not be included when the indicator is calculated. For clients missing **one or two** values, calculate the 'average' response to each statement (total score / number of statements with a response), and fill in the missing value with the average.

If you are scoring the surveys manually: do not calculate a score for a client with **any** missing values.

Data from incomplete surveys can be entered into your database for further analysis, indicating missing values, but the score should not be used when calculating the psychosocial wellbeing indicator (see below).

Interpreting Basic MHPSS Assessment scores

In order to understand what the client's score tells us about a client's psychological distress and depression levels, determine which category the score falls into:

0-04	**Minimal:** Individuals in this category experience few or no symptoms. They may occasionally feel down, but these feelings are infrequent and fleeting. Daily functioning is generally unaffected. They continue to perform well in their work, social interactions, and other daily activities without significant issues. They might not require any specific treatment but should maintain healthy lifestyle habits to prevent escalation
5-9	**Mild:** Experience more frequent feelings of sadness or lack of interest, but these symptoms are still manageable. There is a minor impact on daily life. Tasks may feel a bit more challenging, and there might be a slight drop in productivity or social engagement. It might be beneficial to incorporate lifestyle changes such as exercise, better sleep to address these mild symptoms.

10-14	**Moderate:** Symptoms are more pronounced and persistent, such as frequent sadness, significant loss of interest in activities and, fatigue Daily functioning is moderately affected. Work performance, relationships, and social activities may suffer. Individuals might struggle with maintaining their usual level of productivity and could benefit from a structured support plan
15-19	**Moderately** severe: Individuals experience symptoms, such as intense sadness, persistent fatigue, and feelings of worthlessness or excessive guilt. There is a considerable impact on daily functioning. Individuals may find it hard to perform at work, maintain relationships, or take care of daily responsibilities. Focused intervention is typically necessary at this stage.
20-27	**Severe:** Symptoms are severe and debilitating. Individuals may experience extreme sadness, hopelessness, lack of energy, and thoughts of death or suicide. It becomes difficult to carry out even simple daily tasks, and there is a high risk of self-harm or suicide. Referrals to focused specialized MHPSS assistance is necessary.

As set out in the Basic MHPSS Assessment Guidance document, if a client falls into the 'severe' category (score of 20-27), they should be referred to a specialised MHPSS service provider. If they are classified as 'moderately severe', the caseworker should discuss available support services with the client and get input from a supervisor and client on how they can best support the client.

Interpreting change over time for an individual client

Undertaking the Basic MHPSS Assessment once, at the start of the process, can provide useful information on the specialised services the clients requires as part of the case management process. However, this form can only be used to measure protection outcomes if it is used at least twice during the PCM process: in order to measure change in a client's level of psychological distress, you need to have at least two scores for the client over time.

Subtract the baseline from the endline score to calculate the level of change. If the clients' score has decreased (*which we would expect to see!*) the level of change will be a negative number.

[Endline score] – [Baseline score] = change in psychological distress

A change of five or more constitutes a significant improvement (or decline) in levels of psychological distress.9

This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual reduction (or increase) in psychological distress.**

Interpreting change across many clients will help you calculate the psychological distress indicator

The reduced psychological distress indicator was developed to capture whether protection case management contributes to reduced psychological distress for clients with more serious mental health needs. The indicator and its two parts are set out below.

Psychological distress indicator: % of PCM clients with mental health needs who demonstrate a reduction in symptoms of psychological distress over the course of the PCM process.

Numerator: # of clients with an initial score of 15 or higher (indicating moderately severe or severe levels of disabling distress) whose final score was 5 or more points **lower** than the initial score.

Denominator: # of clients who completed the Basic MHPSS Assessment at both baseline and endline and scored 15 or higher at intake.

In order to calculate the indicator you need to:

Step 1: Of the PCM clients who completed the MHPSS Basic at both baseline and endline, determine the number of PCM clients who scored 15 or higher on their initial score;

Step 2: Of these, count the number whose final score on the Basic MHPSS Assessment was 5 or more points lower than the initial score;

Step 3: Divide the second number (Step 2) by the first number (Step 1) and multiply the result by 100: this is your indicator value!

In addition to calculating the proportion of clients with improved psychosocial wellbeing, it may be useful to calculate:

- The average psychological distress score across all clients at intake and case closure;
- The distribution of psychological distress scores across clients at intake (how many clients fell into the minimal, mild, moderate, moderately severe and severe categories);
- The distribution of psychological distress scores across clients at case closure (how many clients fell into the minimal, mild, moderate, moderately severe and severe categories);
- The average change in psychological distress scores across all clients.
- The distribution of levels of change in psychological distress scores across all clients.

It can be useful to disaggregate these results by other relevant variables in order to understand and explain them. You may consider the following questions:

- How do psychological distress outcomes differ according to the client's gender, age, disability status, displacement status, risk level and/or type of protection risk?
- How do psychological distress outcomes vary between clients who received an MHPSS referral (and subsequent services) and those who did not?
- Do outcomes differ in relation to how the case management service was implemented, or the quality or process of PCM (consider process and quality indicators for relevant variables)?
- How have psychosocial wellbeing outcomes changed since the previous review period? What might explain this (e.g. differences in practice, capacity, availability of referral services, external risks and conditions, etc)?

More information about how to analyse and interpret results can be found in the Monitoring, Evaluation, Accountability and Learning (MEAL) Guidelines for Protection Case Management.

Protection Risk Reduction

Interpreting protection risk reduction results

In order to understand how effective the case management response has been in responding to clients' protection concerns, we have asked

clients to rank how much they are impacted by their priority protection risks at the beginning and end of the case management process.

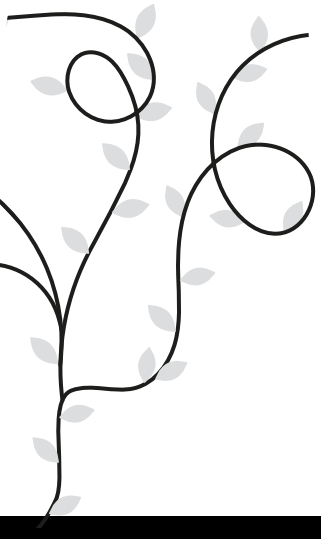
Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4).

- Not at all (4)
- Some (3)
- A moderate amount (2)
- A lot (1)
- Severely (0)

We also request them to rank their ability to address this problem. Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4).

- Very high (4)
- High (3)
- Moderate (2)
- Low ability (1)
- No ability (0)

By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of the severity of their protection risk, and their ability to address this problem, has changed. We hope to see an improvement in both scores, which means they are less affected by the problem and have increased ability to manage it. This change may reflect external factors, such as an increase or decrease in the protection risk of concern. But it may also reflect a reduction in the clients' vulnerability to the risk and/or an increase in their ability to cope with the risk, as a result of the case management response.



Again, a change in the impact of a protection risk on a client may result from the case management intervention and it may also result from a change in external factors – particularly, the nature of the protection threat that creates the risk for the client.

- Qualitative data provided by clients on the case closure form can also help you understand the reasons behind changes for individual clients;
- Contextual information, such as information contained in protection analyses, can help you identify external factors that may have influenced protection risk;

- Finally, by analysing data across many clients, you can begin to identify trends in how PCM interventions affect protection risk.

Interpreting change across many clients: calculating the protection risk reduction indicator

The protection risk reduction indicator was developed to capture whether protection case management support reduces clients' vulnerability to protection risks and increases their ability to cope with protection risks, thereby reducing the impact of these risks on the client. The indicator and its two parts are set out below.

Protection risk reduction indicator: % of PCM clients who report to be less impacted by protection risks after receiving case management support.
Numerator: # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the risk assessment stage
Denominator: # of clients who shared how much a protection risk is impacting their life at both the risk assessment and case closure stage.
Protection risk reduction indicator: % of PCM clients who report that they are better equipped to reduce or mitigate the protection risk after receiving PCM support.
Numerator: # of clients who report to be better able to address the problem at case closure than they did at the risk assessment stage
Denominator: # of clients who shared their ability to cope at both the risk assessment and case closure stage.

Using results

The MEAL guidelines provide a comprehensive overview of how data on PCM outcomes (and other PCM data) can be used to report to donors and support funding requests, to inform context analysis and strategic planning, and to support external evaluation.

Endnotes

1 Outcomes data can provide helpful insight into how PCM services can be delivered effectively when analysed together with monitoring data on PCM process and quality.

2 The PCM Theory of Change, included in 'Your Guide to Protection Case Management', sets out how the PCM response is expected to contribute to each outcome area.

3 The psychosocial wellbeing scale is based on a validated tool called the Warwick Edinburgh Mental Wellbeing Scale designed to measure psychosocial wellbeing.

4 The basic MHPSS assessment draws on a mental health assessment tool called the PHQ9.

5 See the basic MHPSS assessment Guidance for more detail

6 Thresholds were taken from the 'User Guide to the Warwick-Edinburgh Mental Wellbeing Scales (WEMWBS and SWEMWBS)', version 4, June 2020.

7 This change threshold is recommended by Warwick Medical School based on statistical analysis of existing data. For more detail, see: https://hqlo.biomedcentral.com/counter/pdf/10.1186/1477-7525-10-156.pdf

8 When interpreting data keep in mind that three is the threshold for a significant change in WEMWBS.

9 A 5-point change on the Patient Health Questionnaire (which the Basic MHPSS Assessment is based on) is considered to be the threshold for clinically significant change.

Annex 3.14
Indicator Interpretation

PROTECTION OUTCOME INDICATORS

PO-01: % of clients who demonstrate improved psychosocial wellbeing after receiving protection case management support

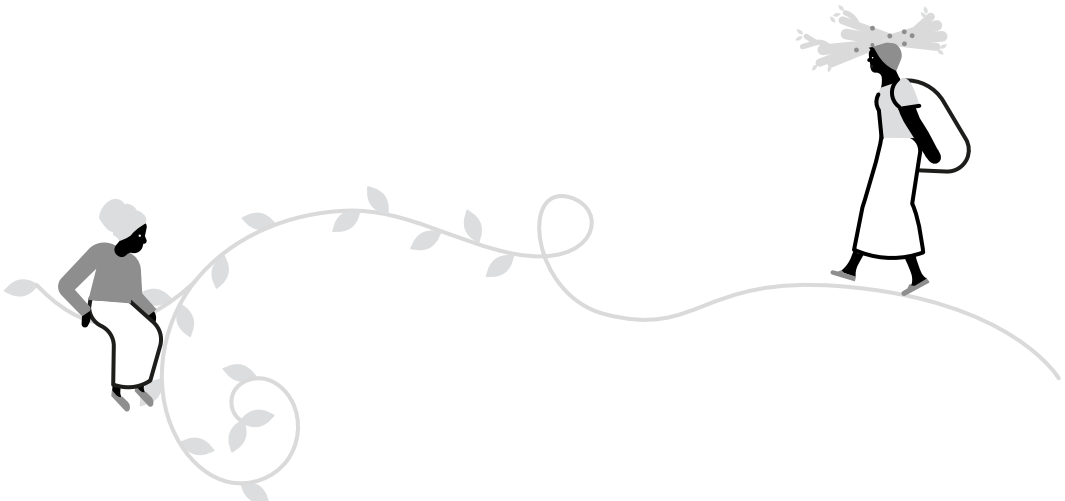
Indicator ID	**PO-01**
Category	Protection Outcome
Objective(s)	To measure the impact of case management on individual clients' lives
Calculating the score for individual clients	Each of the 14 items on the psychosocial wellbeing scale has a scoring range of 1 – 5, with the following values: • None of the time (1) • Rarely (2) • Some of the time (3) • Often (4) • All of the time (5) To calculate the total score for each individual client, add up the scores across all 5 items. Total scores will range from 14 – 70.
Interpreting the score for individual clients	**Score: 14-40** Very low psychosocial wellbeing: The client's score is in the very low range, indicating that they are facing significant difficulties and would likely benefit from MHPSS services and may also require additional support from specialised mental health professionals. It is likely useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for specialized MHPSS services. **Score 41-44** Low psychosocial wellbeing: The client's score is in the low range, indicating that they would likely benefit from receiving MHPSS services to support their mental health and psychosocial wellbeing. It may be useful to administer the basic MHPSS assessment for clients that score in this range to further inform the PCM response, including potential referrals for non-specialized and specialized MHPSS services.

	Score 45-59 Moderate psychosocial wellbeing: The client's score is in the moderate range, indicating that they are doing ok. But they could still benefit from MHPSS services to support their mental health and psychosocial wellbeing. Activities centered around improving resilience and addressing or reducing risk factors, may be beneficial to prioritize activities that support coping strategies. **Score 60-70** High psychosocial wellbeing: The client's score is in the high range, suggesting they are doing well. It is still important to incorporate MHPSS services in PCM activities for the client to take steps to improve resilience and develop coping strategies in order to maintain high wellbeing, particular in light of emerging risks, threats and challenges.
Calculating and interpreting change over time for individual clients and across many clients	In order to measure change in a client's psychosocial wellbeing, you need to have at least two scores for the client over time (meaning they need to have completed the psychosocial wellbeing survey at least twice during the PCM process). Subtract the baseline score from the endline score to calculate the level of change. If the clients' score has decreased the level of change may be a negative number. *[Endline score] – [Baseline score] = change in psychosocial wellbeing* **An increase of three or more constitutes a significant improvement in psychosocial wellbeing.** This means that the change reflects more than random differences in the way the client answered the questions: it reflects an actual improvement in psychosocial wellbeing. **Calculating change across many clients:** **Numerator:** # of clients surveyed whose psychosocial wellbeing scores improved by at least 3. **Denominator:** # of clients who participate in both stages of the psychosocial wellbeing survey at both baseline and endline.

What could this mean?	• **Data quality:** If all surveyed clients are reporting high (or low) distress, or there are many questions without a response, the assessment may not be understood by the client/case worker, or they may not be comfortable using the assessment **A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced risks or threats to clients' wellbeing or reduced clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which have further undermined clients' wellbeing.
What else do we need to know to strengthen interpretation?	• Other information provided by client: response to protection risk reduction questions on protection risk assessment and case closure forms; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-02: % of clients who report being less impacted by protection risks after receiving protection case management support

Indicator ID	**PO-02**
Category	Protection Outcome
Calculating and interpreting change over time for individual clients and across many clients	Calculating and interpreting change over time for individual clients and across many clients Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4). • Not at all (4) • Some (3) • A moderate amount (2) • A lot (1) • Severely (0) By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of the severity of their protection risk has changed. We hope to see the value of the clients' response value increase over the course of the case management process, as this indicates that they are less impacted by the protection risk. **Calculating change across many clients** **Numerator:** # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the start of the process. **Denominator:** # of clients who shared how much a protection risk is impacting their life at the start of the process and case closure stage.
Objective(s)	To measure the impact of case management on individual clients' lives



What could this mean?	**A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which has increased the impact of the problem(s) of concern (protection risk(s)) on clients or clients' vulnerability to these.
What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-03: % of clients with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving protection case management support

Indicator ID	**PO-03**
Category	Protection Outcome
Objective(s)	To measure the impact of case management on individual clients' lives
Calculating the score for individual clients	To understand what the client's score tells us about a client's psychological distress and depression levels, determine which category the score falls into: • 0-4: Minimal • 5-9: Mild • 10-14: Moderate • 15-19: Moderately • 20-27: Severe
Interpreting the score for individual clients	As set out in the Basic MHPSS Assessment Guidance document, if a client falls into the 'severe' category (score of 20-27), they should be referred to a specialised MHPSS service provider. If they are classified as 'moderately severe', the caseworker should discuss available support services with the client and get input from a supervisor and client on how they can best support the client.
Calculating and interpreting change over time for individual clients and across many clients	In order to measure change in a client's level of psychological distress, you need to have at least two scores for the client over time (meaning they need to have completed the Basic MHPSS Assessment at least twice during the PCM process). Subtract the baseline from the endline score to calculate the level of change. If the clients' score has decreased (which we would expect to see!) the level of change will be a negative number. *[Endline score] – [Baseline score] = change in psychological distress* **A decrease of five or more constitutes a significant improvement** in levels of psychological distress. This means that the change reflects more than random differences in the way the client answered the questions: it reflects an **actual reduction in psychological distress.** **Calculating change across many clients:** **Numerator:** # of clients with an initial score of 15 or higher whose final score was 5 or more points **lower** than the initial score. **Denominator:** # of clients who completed the assessment at both baseline and endlineand scored 15 or higher at intake.

What could this mean?	• **Data quality:** If all surveyed clients are reporting high (or low) distress, or there are many questions without a response, the Basic MHPSS Assessment may not be understood by the client or the case worker or the caseworker may not be comfortable using the assessment **A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • Caseworker(s) have strong knowledge of and skills in MHPSS service delivery; • PCM support is delivered in line with quality standards and protocols; • MHPSS problems are prioritized in the case management action plan; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible, particularly specialized MHPSS services; • There is a change in external or contextual factors which have reduced risks or threats to clients' wellbeing or reduced clients' vulnerability to these. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible, particularly specialized MHPSS services; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • Case worker(s) lack the confidence or skills to address clients' MHPSS concerns; • MHPSS problems have not been identified, or sufficiently addressed in the action plan; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors (e.g. an increase in risks or threats or the emergence of new risks or threats) which have further undermined the clients' mental health and psychosocial wellbeing.

What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; response to protection risk reduction questions on protection risk assessment and case closure forms; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PO-04: % of clients who report that they are better equipped to reduce or mitigate the protection risk after receiving protection case management support

Indicator ID	**PO-04**
Category	Protection Outcome
Objective(s)	Clients respond by selecting from the five options set out below, with their corresponding values (0 – 4). • Very high (4) • High (3) • Moderate (2) • Low ability (1) • No ability (0) By comparing a client's response at the risk assessment stage to their response at case closure, we can understand how their perception of their ability to cope with a protection risk has changed. We hope to see the value of the clients' response value increase over the course of the case management process, as this indicates that they are better equipped. **Calculating change across many clients** **Numerator:** # of clients who report to be less impacted by the protection risk of concern at case closure than they did at the start of the process. **Denominator:** # of clients who shared how much a protection risk is impacting their life at the start of the process and case closure stage.
Objective(s)	To measure the impact of case management on individual clients' lives

What could this mean?	**A HIGH proportion of clients could mean:** • Caseworker(s) possess the capacity, knowledge and skills to deliver effective and client-centered PCM services; • PCM support is delivered in line with quality standards and protocols; • Case worker(s) establish strong, supportive and trusting relationships with clients; • Relevant referral services are available and accessible; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' ability to cope. **A LOW proportion of clients could mean:** • Critical referral services are unavailable or not accessible; • There are gaps in case worker(s) or supervisor capacity, knowledge, and skills; • A strong, trusting and supportive relationship between the client and caseworker has not been achieved; • There is a change in external or contextual factors which have reduced the impact of the problem(s) of concern (protection risk(s)) on clients or clients' ability to cope.
What else do we need to know to strengthen interpretation?	• Other information provided by client: wellbeing score; responses to qualitative questions on case closure form; client feedback and satisfaction surveys. • Measurement of quality and process indicators – analysis of how wellbeing outcomes differ in relation to indicators on the quality and process of PCM. • Relevant contextual information on threats, shocks and risks affecting clients, including information contained in protection analyses.

PROCESS & QUALITY INDICATORS

PQ-01: % of intakes eligible for PCM

Indicator ID	**PQ-01**
Category	Process and Quality
Objective(s)	Measure outreach and quality of intake
What could this mean?	**A HIGH proportion of intakes could mean:** • Strong understanding of case management among community in catchment areas • Strong understanding of case management within the humanitarian system. • Contextually relevant eligibility criteria. • High quality protection analysis. • Case management/Intake team understand case management criteria and process. **A LOW proportion of intakes could mean:** • Limited understanding of protection case management among (potential) clients and humanitarian actors. • Gaps in training/coaching • Low quality protection analysis. • Eligibility criteria are inappropriate. • PCM is not a priority within the context.
What else do we need to know to strengthen interpretation?	• What are the needs of those arriving who are not eligible for PCM? • What are the gaps in outreach and dissemination?

PQ-02: # of total protection case management clients

Indicator ID	**PQ-02**
Category	Process and Quality
Objective(s)	To understand total caseload, overall project reach and resource requirements.
What could this mean?	**An HIGH in the number of cases could mean:** • Ability access to case management • Increased trust in programming or service provision • There is awareness of how to accessPCM and what PCM is • High concentration of protection risks covered by protection case management. • Other actors providing PCM have reduced or closed services. • Strong referral to case management system • Strong staff capacity • Population movement into the catchment area. • An increase in cases can have implications for the case workers, such as a decrease in quality due to increased load and a high workload of case workers. **A Low in the number of cases could mean:** • Barriers to access case management • Limited trust in programming or service provision • Presence of other actors providing similar services • Limited concerns covered by protection case management. • Insufficient staffing of case workers • Gaps in referral to case management system • Population movement away from the catchment area.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

PQ-03: # of new cases registered for protection case management

Indicator ID	**PQ-03**
Category	Process and Quality
Objective(s)	To understand current caseload and resource requirements.
What could this mean?	**An INCREASE in the number of new cases could mean:** • Increased access to case management process • Increased trust in programming or service provision • Increases awareness of the case management process. • Increase in concerns covered by protection case management. • Other actors providing PCM have reduced or closed services. • Improved referral to case management system • Increased staff capacity • Population movement into the catchment area. • An increase in cases can have implications for the case workers, such as a decrease in quality due to increased load and a high workload of case workers. **A REDUCTION in the number of new cases could mean:** • Reduced access to the case management process • Decreased trust in programming or service provision • Presence of other actors providing similar services • Decrease in concerns covered by protection case management. • Gaps in referral to case management system • High workload case workers, unable to serve additional clients. • Population movement away from the catchment area.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

PQ-04: % of cases closed due to meeting objectives of the action plan

Indicator ID	**PQ-04**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Measure appropriateness of the goals
What could this mean?	**A HIGH proportion of case plans closed could mean:** • Goals in case action plan are SMART[1] • Goals are not sufficiently ambitious • Required services are available and accessible. • Client has trust in the process and action plan. • High case worker(s) capacity, knowledge, and skills **A LOW proportion of case plans closed could mean:** • Case plan goals are not SMART, for instance when the goals set are unrealistic. • Several key services are unavailable or not accessible. • Outdated service mapping. • Gaps in case worker(s) or supervisor capacity, knowledge, and skills • High staff turnover • sudden change in operational context, for instance displacement of a number of clients.
What else do we need to know to strengthen interpretation?	• Duration of cases (CC-03) • Client satisfaction (PQ-11) • Case worker knowledge assessment (PQ-07) • Contextual analysis of shocks

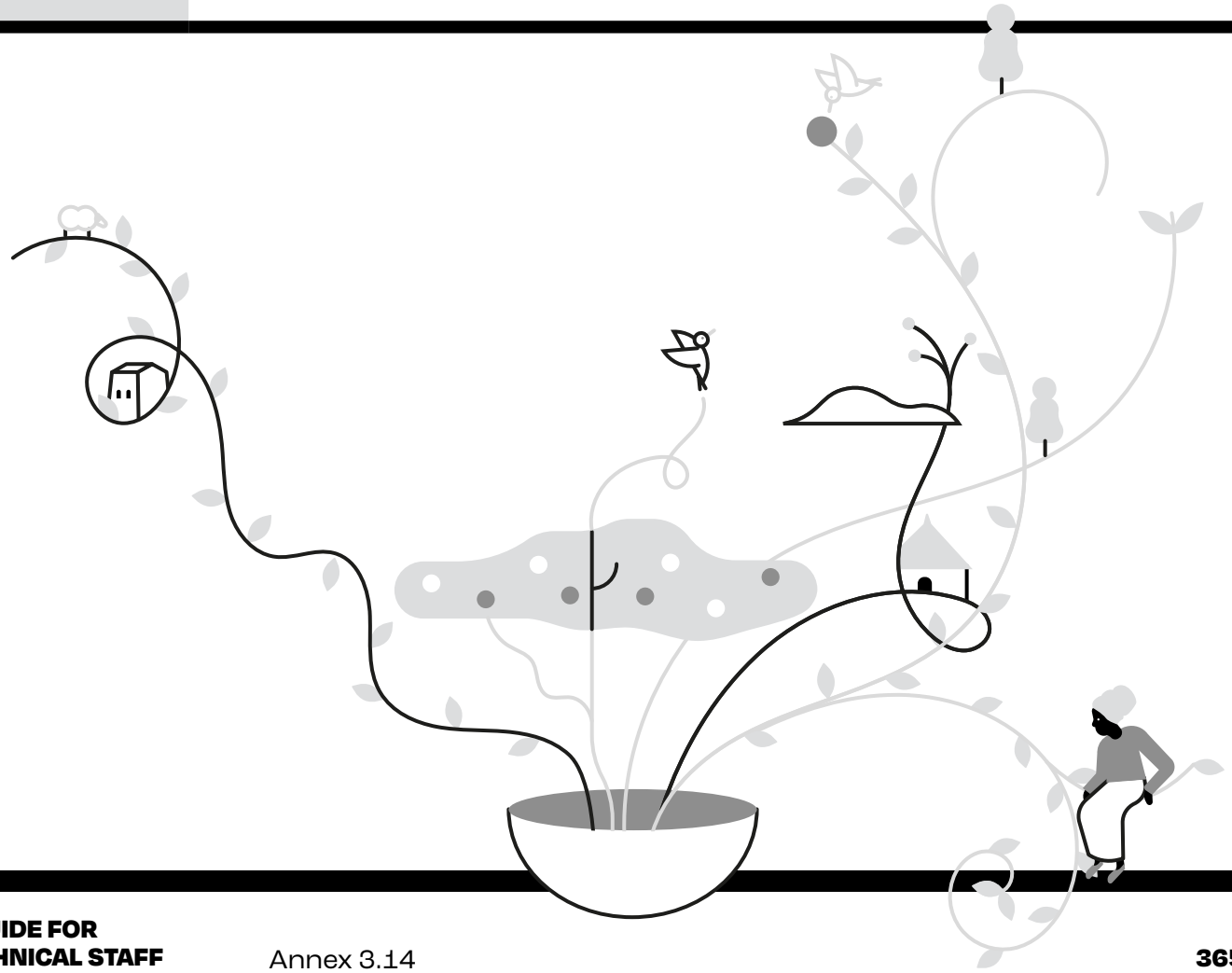
1 SMART objectives are articulated in a way that is Specific, Measurable, Achievable, Realistic, and Time-based

PQ-05: % of clients who received cash assistance through protection case management

Indicator ID	**PQ-05**
Category	Process and Quality
Objective(s)	Understand who has received cash assistance
What could this mean?	**A very LOW proportion cases receive cash assistance** • Cash might not be an appropriate for the types of protection risks addressed by case management • Case workers are unaware of how to provide cash or the process is burdensome and challenging for the case worker **Cash could be creating additional protection risks** • A very HIGH proportion of that receive cash assistance • Case workers could be providing cash assistance based on basic needs rather than addressing a protection risk • A high number of complex cases
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic and type of risk

PQ-06: Average # of cases per case worker per month

Indicator ID	**PQ-06**
Category	Process and Quality
Objective(s)	Understand caseworker workload
What could this mean?	**A HIGH number of cases per caseworker could mean:** • High workload caseworker • High ratio of complex cases to caseworkers • High number of inactive vs active case • Case workers do not use case closure procedures, or these are unclear. **A LOW number of cases per caseworker could mean:** • Capacity is available to take on additional cases.
What else do we need to know to strengthen interpretation?	• # of high-risk cases by case worker, to reduce concentration of high-risk cases. • Duration of cases (CC-03)



PQ-07: % of case workers whose knowledge assessment score is at least 70%

Indicator ID	**PQ-07**
Category	Process and Quality
Objective(s)	Identify gaps case worker knowledge
What could this mean?	**A HIGH proportion of caseworkers could mean:** • High quality training • Strong supervision structures • Low staff turnover. • High case worker(s) capacity and knowledge • Knowledge assessment has been successfully contextualized. • Data limitations: if the proportion is too high, this might indicate a limitation in how the survey is administered. **A LOW proportion of caseworkers could mean:** • Deficiencies in the training • Weak supervision structures • High staff turnover. • Difficulties in recruiting the right profile. • Low case worker(s) capacity and knowledge • Lack of contextualized tools and guidance. • Data limitations: deficiencies in how the survey is administered.
What else do we need to know to strengthen interpretation?	• Starting date case workers • Caseworker attitude score (PQ-08) • Caseworker learning path, e.g. number of training sessions, coaching opportunities, pre-post tests etc.

PQ-08: % of case workers whose attitudes score is at least 80%

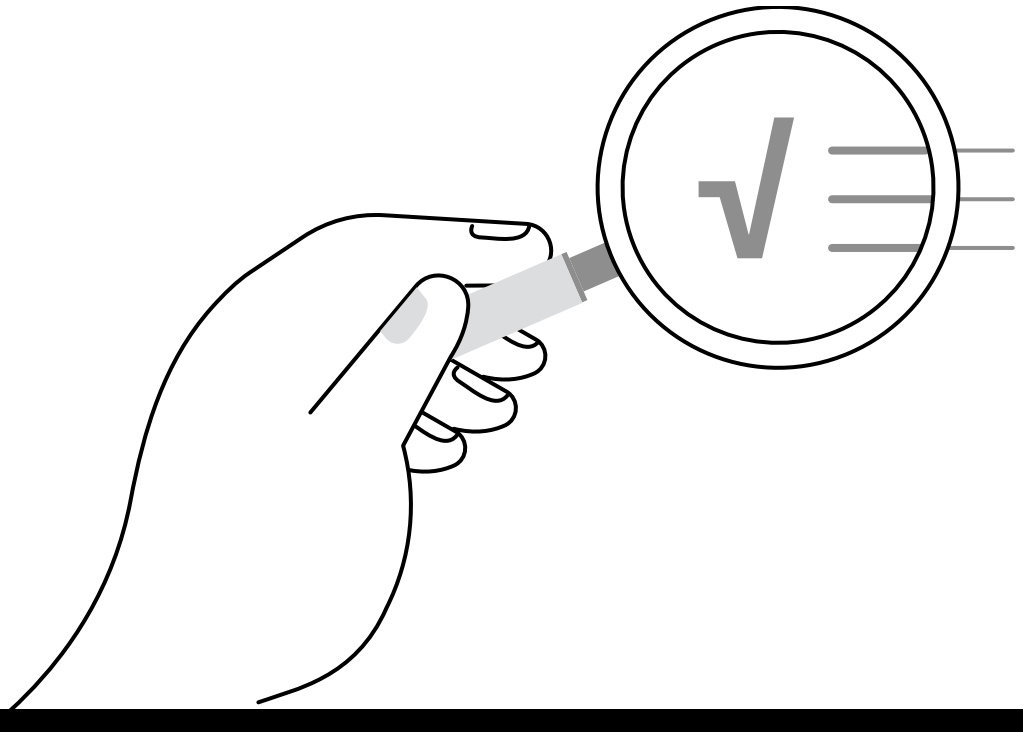
Indicator ID	**PQ-08**
Category	Process and Quality
Objective(s)	Measure case worker attitudes towards clients
What could this mean?	**A HIGH proportion of caseworkers could mean:** • High quality training related to caseworker attitude • Strong supervision structures • Low staff turnover. • High case worker(s) capacity and knowledge • Knowledge and attitude assessment has been successfully contextualized. • Data limitations: if the proportion is too high, this might indicate a limitation in how the survey is administered. **A LOW proportion of caseworkers could mean:** • Safe space for case manager to express limitations. • Deficiencies in the training • Weak supervision structures • Difficulties in recruiting the right profile. • Biases and stereotypes engrained in PCM process. • Data limitations: deficiencies in how the survey is administered.
What else do we need to know to strengthen interpretation?	• Case worker experience • Caseworker knowledge score (PQ-07)

PQ-09: % of case files reviewed that meet 80% of criteria of a case file checklist

Indicator ID	**PQ-09**
Category	Process and Quality
Objective(s)	Measure quality of documentation and identify priority gaps.
What could this mean?	**A HIGH proportion of casefiles could mean:** • High quality training • Strong supervision structures • High case worker(s) capacity and knowledge • Forms are appropriate for and endorsed by case workers. • Strong information management system • Guidance and tools adapted to context. **A LOW proportion of casefiles could mean:** • Gaps in case worker(s) capacity and knowledge • Weak supervision structures • Information management system is unsuitable for the context.
What else do we need to know to strengthen interpretation?	• Which components score high or low? What is the proportion of cases with: Informed consent/assent to collect, store and share information. A risk assessment carried out within 1 week of the identification. A developed case plan?

PQ-10: # of case workers trained on protection case management

Indicator ID	**PQ-10**
Category	Process and Quality
Objective(s)	Understand caseworker capacity
What could this mean?	**A HIGH number caseworkers trained could mean:** • Case workers have a basic understanding of protection case management • Low turn over of case workers and effective supervision **A LOW number of case workers trained could mean:** • Lack of capacity of case workers that have not been trained on protection case management • A high turnover of case workers • Lack of a structured supervision
What else do we need to know to strengthen interpretation?	• % of case files reviewed that meet 80% of criteria of a case file checklist (PQ-09)



PQ-11: % of clients that felt they were involved in decisions during their case management

Indicator ID	**PQ-11**
Category	Process and Quality
Objective(s)	Measure client centered nature of process
What could this mean?	**A HIGH proportion of clients could mean:** • Service provision is client-centered • Use of reasonable adaptations when needed to ensure the accessibility of language and information (in response to barriers) • High quality training • High caseworker(s) capacity and knowledge **A LOW proportion of clients could mean:** • Gaps in case worker(s) capacity, attitudes, and knowledge. • Lack of explanation of case management to client. • Existing communication barriers are not addressed, making it difficult for the client to engage. • Cultural or individual barriers to participation in decision making, including power dynamics between client and case manager.
What else do we need to know to strengthen interpretation?	• Client feedback for specific supervisors • Was the action plan signed off? • Were strengths identified and used to develop the action plan? • Did the action plan include barriers identification and in response reasonable adaptations for persons with disabilities? • Case worker attitude score (PQ-08)

PQ-12: % of clients that are satisfied with the case management services

Indicator ID	**PQ-12**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Measure client satisfaction with the process
What could this mean?	**A HIGH proportion of clients satisfied could mean:** • The case management process is effective. • Client has trust in the process and case worker capacity. • The process is client centered approach and reasonable adaptations are implemented as required. • High caseworker(s) capacity, knowledge, and skills • Data quality: If all surveyed clients are satisfied with the process, the measurement instrument might be biased, or clients do not feel safe reporting concerns. **A LOW proportion of clients satisfied could mean:** • Unrealistic expectations of case management process • Lack of a client centered approach • Lack of identification of barriers or measures to address barriers. • Required services are not available or accessible.
What else do we need to know to strengthen interpretation?	• Average number of cases per case worker per month (PQ-06) • Success of referrals (PQ-13) • Analysis of barriers/accessibility audit per case (particularly for those identified with a disabilities)

PQ-13: % of successful referrals

Indicator ID	**PQ-13**
Category	Process and Quality
Objective(s)	• Measure quality of overall case management process • Identify gaps in service delivery
What could this mean?	**A HIGH proportion of successful referrals could mean:** • Up-to-date and quality service mapping • Required services are available and accessible. • Client trusts the service provider and is able/willing to follow up. • High caseworker(s) capacity, knowledge, and skills • Data limitations: The measurement of ¨successful¨ does not capture all barriers and as such underreports existing constraints to access. **A LOW proportion of successful referrals could mean:** • Outdated service mapping. • Client unwilling or unable • Several key services are unavailable, overwhelmed or not accessible. • Lack of (implementation of) clear SOPs with service providers.
What else do we need to know to strengthen interpretation?	• What are the barriers to access, are there physical access issues, information gaps or language/attitude constraints? • Has there been accompaniment from the case worker or supervisor during referral? If yes, what has been their experience? (by type of service)

CASE CHARACTERISTICS INDICATORS

CC-01: % of cases by protection risk

Indicator ID	**CC-01**
Category	Case characteristics
Objective(s)	Measure characteristics of cases and relevant changes over time.
What could this mean?	**The breakdown by type of cases increases understanding of:** • Protection risks not covered by the case management process, due to a lack of trust, outreach, or prevalence of the concern. • The key concerns faced by clients. • Appropriateness of the eligibility criteria. • Specific barriers for certain groups facing specific protection risks (people with disabilities, older people… etc.) **A change in time of in protection concerns can reflect a change in:** • Overall context • Barriers to access for clients with a specific profile. • Outreach activities and related understanding of case management among the community.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risks)

CC-02: % of cases by risk level

Indicator ID	**CC-02**
Category	Case characteristics
Objective(s)	Measure characteristics of cases and relevant changes over time.
What could this mean?	In a well-functioning case management system, the majority of cases will be at medium risk, with a small number identified as high risk. **A low or high % of cases identified as high risk can mean:** • Gaps in understanding of the risks levels and how to apply these. • Lack of outreach to high-risk cases. **A change over time in risk levels among clients can reflect a change in:** • Understanding of risk levels by case managers. • Changes in the overall context • Barriers to access for clients with a specific profile. • Outreach activities and related understanding of case management among the community.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by risks (e.g., are certain profiles more represented among certain risk levels)

CC-03: % of cases by duration

Indicator ID	**CC-03**
Category	Case characteristics
Objective(s)	Measure the quality of the process and understand the team's ability to close cases.
What could this mean?	**A HIGH proportion of cases with a specific protection risk showing delays could mean:** • Case closure process is unclear or not used. • Gaps in case worker(s) capacity and knowledge • Specific protection risks are difficult to address within the operational context. • Gaps in service provision (accessibility or availability) • Barriers remain unidentified or not addressed. **A LOW proportion of cases with a specific protection risk showing delays could mean:** • Strong case worker capacity • Eligibility criteria are up to date in the context. • Complex cases are excluded from the process. • Goals are not sufficiently ambitious. • Key services required are available and accessible.
What else do we need to know to strengthen interpretation?	• Are the goals within the action plans SMART? • Are the eligibility criteria appropriate within the context? • Is the service map up to date?

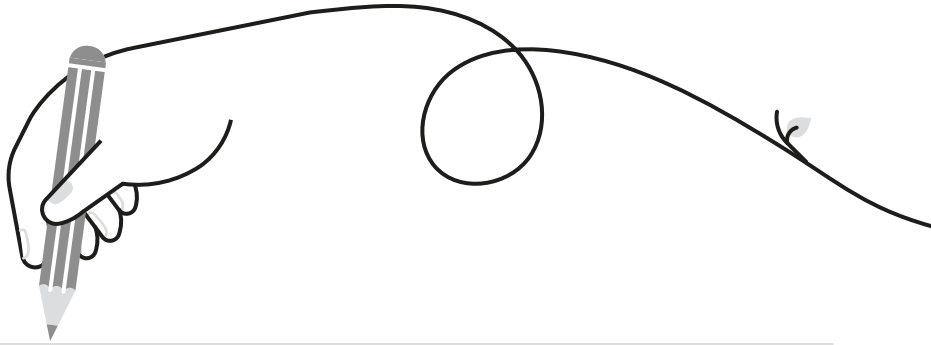
CC-04: % of clients that have a disability

Indicator ID	**CC-04**
Category	Case characteristics
Objective(s)	To determine the profile of clients and any barriers to accessing PCM specifically affecting those with a disability.
What could this mean?	**A HIGH proportion of clients with a disability** • A high proportion of the population has a disability • Specific context crisis results in increase risks/violence for people with disabilities (requiring immediate case management response) • Protection case management is perceived as a useful service for those with a disability. • Effective identification and reduction of access barriers. • Case workers are comfortable with working with people with disabilities (extensive inclusion training/coaching or extensive experience) • Data quality concern: Misuse or misinterpretation of the module administered to measure disability among clients (Washington Short Group of Questions) **A LOW proportion of clients with a disability** • Gaps in inclusion training/coaching resulting in knowledge gaps for the case workers • Negative attitudes of case workers toward persons with disabilities • Lack of barriers identification for accessibility leading to proper outreach for persons with disabilities • Outreach process not prioritizing persons with disabilities • Key services are unavailable or inaccessible • Data quality concern: Misuse or misinterpretation of WGSS
What else do we need to know to strengthen interpretation?	• Feedback case managers on use WGSS • Case workers attitudes on inclusion and inclusive practices in case management • Contextual analysis related to barriers identification for persons with disabilities (physical, attitudes, information/communication barriers) • Main barriers identified as part of the PCM process (seeing, hearing, walking, remembering, self-care and communicating)

CC-05: % of cases with a finalized safety plan

Indicator ID	**CC-05**
Category	Case characteristics
Objective(s)	Understand profile of cases managed
What could this mean?	**A very LOW proportion of safety plans can indicate:** • Misunderstanding among case workers on the value and use of safety plan. • Safety plan format and process is not considered appropriate within the context. • Clients do not share safety concerns, for instance due to a lack of trust. • Lack of outreach to high-risk cases. **A very HIGH proportion of safety plans can indicate:** • Overuse of the safety plan, including for clients who do not face immediate threats to their safety and security. • Case workers are comfortable with safety planning.
What else do we need to know to strengthen interpretation?	• Clients by diversity characteristic by safety plan (e.g., are certain profiles more represented among those with a safety plan)

Form 1
Intake



Initial informed consent to undertake intake

I _____ (client/service user name), hereby give permission to the (name service provider) to collect information in order to determine whether the provision of case management services may be of benefit to me.

I understand that my information will be treated with confidentiality and respect and that I have the right to:

- Decide what information I share with the caseworker. They will not pressure me to share information.
- Request for my information not to be documented or written down.
- Refuse to answer any questions that I don't want to and ask for the caseworker to stop or slow down at any time.
- Ask questions at any time to the caseworker; if I feel that I could work better and talk more easily to someone else than the assigned caseworker or work with another organization I can request this.

The caseworker will keep my information confidential. The only exceptions to this are;

1. The caseworker may seek guidance from a supervisor in relation to my case. The caseworker would only share information as needed to support me.
2. If I express thoughts or plans that involve causing physical harm to myself or others, the caseworker will take action to protect my safety and the safety of those around me, without seeking my consent, although they would do their best to inform me of actions taken.

By signing this form, I give permission to the (name service provider) to collect my personal information for the specific purpose of determining whether the (name service provider) is in a position to support me and whether the provision of case management services may be of benefit to me.

If we agree that case management services are of benefit, the caseworker will explain in more detail how information is used and shared throughout the case management process. At that point, I can adjust or review my permission to collect information, before continuing with case management services.

_____	_____	_____
Signature of client (or caregiver)	Caseworker code	Date

Part A | Preliminary intake information

Complete these details before your intake with the client. The client should have provided permission for an interpreter or anyone else to be present.

Date intake*

Client code*

Case code

Caseworker code*

Geographic location intake*

Interpreter code

Has the client provided consent for this intake?

- ☐ Yes
- ☐ No (Do not continue until the client has provided consent)

Who referred/identified the person?

- ☐ Family, friend, neighbour or community member
- ☐ Internal referral
- ☐ Referral from other organisation
- ☐ Self-referral
- ☐ Government
- ☐ Other (specify):

Does the client need any support to take part in this intake?

- ☐ No
- ☐ Yes. Note down what support has been put in place:

Part B | Intake

Sex assigned at birth	• Female • Male • Intersex • Prefer not to say • I do not understand the question
Gender*	• Woman • Man • Non-binary • Prefer not to say • I use another term – please specify: _____ _____
Age or date of birth?*	
Is the client already receiving case management from another organisation or actor, or have they in the past?	☐ Yes ☐ No If yes: from whom?

Part C | Protection Case Management eligibility

Main protection risk or problem shared by client, and impact on the client's well-being and safety	
Social support network (e.g. family and community support)	
Protection risks (match with Form 0)* Select all that apply	• (Forced) family separation • Abduction, kidnapping or enforced disappearance • Arbitrary or unlawful arrest and/or detention • Death or injury through deliberate or non-deliberate attack by armed groups • Extortion • Forced labour or slavery • Forced recruitment into armed forces/groups • Maiming or mutilation • Physical assault or abuse (not related to sexual and gender-based violence) • Psychological/emotional abuse • Torture or inhuman, cruel or degrading treatment • Trafficking in persons • Other, please specify:
Risk Level*	• HIGH (Serious and imminent risk requiring immediate action in max 48 hours) • MEDIUM (Probability of a serious risk, requiring intervention within a week) • LOW (Low probability of a serious risk)

Based on the client's responses, what are the next steps? Select all that apply	• A. Continue with Protection Case Management Protection Risk Assessment • B. Do not proceed with case and refer to GBV Case Management • C. Do not proceed with case and refer to Child Protection Case Management • D. Referral to Legal Aid • E. Referral required, Protection Case Management is not necessary
Urgent follow-up actions based on intake:	
Case manager observations:	

Client code: _____

Form 1a

Interpreter Non-Disclosure Agreement

Date*

Name of interpreter*

Phone number / email of interpreter*

Organisation(s)

Language*

- ☐ Language 1
- ☐ Language 2
- ☐ Language 3
- ☐ Sign language

Gender of interpreter

- Woman
- Man
- Non-binary
- Prefer not to say
- I use another term – please specify:_____

NON-DISCLOSURE

I _____(interpreter name) understand that the sole purpose of my presence is for translation. I am not here to judge or reformulate the client's statements and should translate as close as possible to the original language used by the client. I understand that everything that will be said during that interview will be kept confidential and that I am not authorised to share information. I understand that by signing that statement I am making myself contractually reliable to the _____(organisation name) in the way that _____(organisation name) could engage legal proceedings against me if I am breaching the confidentiality principle.

_____ _____

Signature of client. *Please sign or mark to show understanding.* Date

Form 2
Informed Consent

Part A | Consent

Explain informed consent and the Protection Case Management process, see Module 4, page 156

INFORMED CONSENT to release information

I_____ (client name), acknowledge that the _____ (service provider name) has clearly explained the case management process to me. I understand that I will guide the case management process to identify my needs and goals, and that the primary purpose of this service is to ensure my safety, dignity, and well-being.

I understand that my information will be treated with confidentiality and respect, and that through the case management process I have the right to:

- Decide what information I share with the caseworker without pressure to share information
- Request for my information not to be documented or written down
- Not to answer questions that I don't want to
- Ask for the caseworker to stop or slow down at any time or ask questions at any time to the caseworker
- Request another organisation or caseworker if it would make me feel more comfortable and/or easier to communicate
- Understand why the referral is taking place, how it will be done, what information will be shared.
- Ask for the caseworker to accompany me or refuse referrals to services if I don't want them
- Stop the case management process at any time
- Request to see my case files or other documents, as well as asking for any changes to them

My caseworker will keep my information confidential, except in situations with the following exceptions:

1. When a caseworker may seek guidance from a supervisor or from other case managers in relation to my case. My caseworker would only share information as needed to support me and it will not include information that could identify me.
2. If I express thoughts or plans of committing physical harm to myself, or others, my caseworker will take action to protect my safety and the safety of those around me. If there is a risk of immediate danger, my caseworker would not need to seek my consent in such cases but would do their best to inform me of actions taken.

3. If there are situations where non-identifiable information may be used for purposes of humanitarian reporting and analysis only.

By signing this form, I authorise this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

Signature/thumbprint of client

Caseworker code

Date

Part B | Contact information & other identifying information

To be kept separate from the rest of the Protection Case Management forms

What is your preferred mode of communication?*

Select all that apply

- ☐ Phone
- ☐ Whatsapp
- ☐ Email
- ☐ In-person at home
- ☐ In-person at other agreed to location
- ☐ Through community focal point
- ☐ Another designated individual
- ☐ Other

Explain:

If preferred contact is by phone, who owns the phone? *Check whether it is safe for you to contact and get authorisation to identify yourself to the contact provided*	☐ Owned by client ☐ Borrowed/shared
Preferred time and day to be contacted	
Contact number	
Email address	
UNHCR registration number	
Physical address	
If preferred contact is through a community focal point, what are the name contact details of the community focal point?	
Preferred meeting location	☐ In person at home ☐ In person at our community space ☐ In person in a different location ☐ Other: please specify

Part C | Client consent to engage an interpreter

INFORMED CONSENT to engage an interpreter

I_____ (client name), acknowledge that the_____ (interpreter name) will be present during the case management process/session for the sole purpose of translation to facilitate understanding and communication. To the best of their abilities, they will not change the meaning of my words. I understand that they will keep my information during the case management process/session confidential and that they are not authorised to share any of my information. I understand I can request for them to stop attending at any time.

By signing this form, I authorise the presence of the interpreter during case management sessions.

_____

Signature/thumbprint of client

_____ _____

Caseworker code Date

Form 3

Protection Risk Assessment Form

Part A | Preliminary information

To be kept separate from the rest of the Protection Case Management forms

Date assessment *

Client code*

Case code

Caseworker code*

Interpreter code

Has the client provided consent for the Protection Case Management process?*	☐ Yes ☐ No (Do not continue until the client has provided consent)
Does the client need any support to take part in this meeting?	☐ No ☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Clients bio-data

Civil/marital status	☐ Single ☐ Married/co-habitating ☐ Divorced/separated ☐ Widowed
Displacement status	☐ IDP ☐ Returnees ☐ Local community ☐ Other
If displaced, where is the place of origin?	
Languages the client can communicate in	

Washington group set of questions
Read out loud: "The next questions ask about difficulties you may have doing certain activities."

1. Do you have difficulty seeing, even if wearing glasses?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
2. Do you have difficulty hearing, even if using a hearing aid?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know

3. Do you have difficulty walking or climbing steps?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
4. Do you have difficulty remembering or concentrating?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
5. Do you have difficulty with self-care, such as washing your whole body or getting dressed?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
6. Using your usual customary language, do you have difficulty communicating, for example understanding or being understood?	☐ No, No Difficulty ☐ Yes, Some Difficulty ☐ Yes, A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Don't know
Disability Status (case worker only): Yes / No *(Yes = one or more questions where the client has responded with yes to "a lot of difficulty/cannot do at all")*	☐ No ☐ Yes

Client code: _____

Part C | For people who require a caregiver

A caregiver is a person who provides direct care for an adult. This can be a parent, or any adult person who by law or custom is responsible for doing so.

Is there a caregiver?

☐ No
☐ Yes

If yes, what is the name of the caregiver/s?

If there is a caregiver, what is the relationship between the client and the caregiver?

Client's living environment

Describe your client's housing/ shelter situation

How many people are you living with? For each, note down their age and gender.

Number	Age	Gender

Who is the client living with and what are the relationships between the household members?

Client code: _____

Specific risk(s) to safety	
Describe your client's safety concerns and resulting needs	☐ No ☐ Yes
Is a safety plan needed for this case? *If yes, close this form and fill out the safety plan with the client.*	

Basic needs, services and legal status	
Describe your client's access to basic needs, services, and government assistance.Note any related gaps.	
Describe the client's physical and mental health and needs	
Describe the client's access to education and vocational training. Note any related gaps.	
Describe any documentation and legal challenges	
Does your client have legal status within the country?	☐ Yes ☐ No ☐ Do not know

Client code: _____

Part E | Exploring strengths

Summarise what the client is already doing to address any issues identified, or planning to do in the future (protective factors/coping capacities).

Part G | Summary for client

From what we have discussed, what do you feel are things which are worrying you most?

If you think about the problems that worry you most right now, how much would you say they are affecting you and your life?

- Not at all (0))
- Some (1)
- A lot (2)
- Severely (3)
- Do not understand the question
- Do not want to respond

How would you rate your ability to address noted problems?

- No ability (0)
- Low ability (1)
- High (2)
- Very high (3)
- Do not understand the question
- Do not want to respond

What do you see as the way forward?

Thank the client and finalise the form

Client code: _____

Part H | Summary for caseworker

Protection risks (match with Form 0)*
Select all that apply

- (Forced) family separation
- Abduction, kidnapping or enforced disappearance
- Arbitrary or unlawful arrest and/or detention
- Death or injury through deliberate or non-deliberate attack by armed groups
- Extortion
- Forced labour or slavery
- Forced recruitment into armed forces/ groups
- Maiming or mutilation
- Physical assault or abuse (not related to sexual and gender-based violence)
- Psychological/emotional abuse
- Torture or inhuman, cruel or degrading treatment
- Trafficking in persons
- Other, please specify:

Did the client self-report identifying as being part of the diverse SOGIESC community?
Do not ask the client directly

- ☐ Yes
- ☐ No
- ☐ Do not know

Are there characteristics which may increase the client's exposure or affect their ability to cope?
Select all that apply

- Chronic Illness
- Older person
- Person with a disability
- Legal status
- Lack of documentation
- Religious or ethnic minority
- Minority language speaker
- Other, please specify:

Any additional comments or observations about your client, and their appearance or behaviour, which could indicate their level of distress and mental health and psychosocial wellbeing? (e.g., a client appears distracted, distant or confused, is crying or angry and cannot calm down, and is acting differently from previous interactions.)	
Review the risk Level	• HIGH (Serious and imminent risk requiring immediate action in max 48 hours) • MEDIUM (Probability of a serious risk, requiring intervention within a week) • LOW (Low probability of a serious risk)
Urgent follow-up actions based on risk assessment	
Caseworker observations	

Client code: _____

Form 4

Psychosocial Wellbeing Assessment Tool[1]

Date*

Client code*

Case code

Caseworker code*

Interpreter code

Does the client need any support to take part in this meeting?

- ☐ No
- ☐ Yes: Note down what support has been put in place:

I am going to read you some statements about feelings and thoughts. Think about the last two weeks and please tell me how often the statement has been true for you in your life. Tell me if the statement has described your experience:

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

1. I've been feeling optimistic about the future

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

2. I've been feeling useful

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

3. I've been feeling relaxed

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

4. I've been feeling interested in other people

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

5. I've had energy to spare

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

6. I've been dealing with problems well

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

7. I've been thinking clearly

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

8. I've been feeling good about myself

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

9. I've been feeling close to other people

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

10. I've been feeling confident

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

11. I've been able to make up my own mind about things

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

12. I've been feeling loved

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

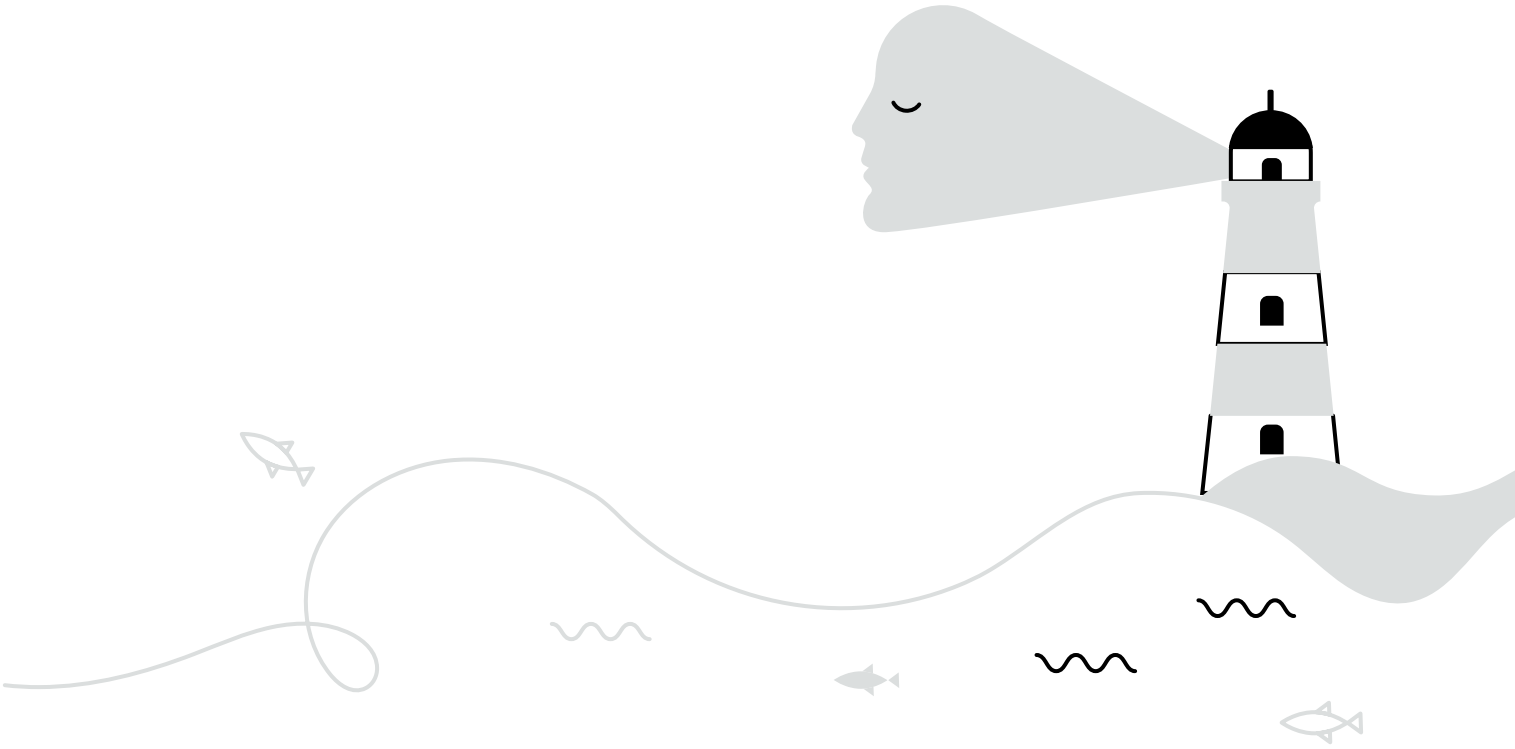
13. I've been interested in new things

- ☐ None of the time (1)
- ☐ Rarely (2)
- ☐ Some of the time (3)
- ☐ Often (4)
- ☐ All of the time (5)

14. I've been feeling cheerful	☐ None of the time (1) ☐ Rarely (2) ☐ Some of the time (3) ☐ Often (4) ☐ All of the time (5)
Total combined score (14-70)	

Endnotes

1 This tool applies an (adapted) version of the Warwick-Edinburgh Mental Wellbeing Scales



Client code: _____

Form 5

Basic Mental Health and Psychosocial Support (MHPSS) Assessment

Date*

Client code*

Case code

Caseworker code*

Interpreter code

Does the client need any support to take part in this meeting?

- ☐ No
- ☐ Yes: Note down what support has been put in place:

Over the past two weeks, how often have you been bothered by any of the following problems...

1. Little interest or pleasure in doing things?*

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

2. Feeling down, depressed or hopeless?*

- ☐ Not at all (0)
- ☐ Several days (1)
- ☐ More than half the days (2)
- ☐ Nearly every day (3)

3. Trouble falling or staying asleep? Or the opposite – sleeping too much?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
4. Feeling tired or having little energy?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
5. Poor appetite and not wanting to eat, even when food was available? Or the opposite –overeating?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
6. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
7. Trouble concentrating on things, such as reading or watching television?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
8. Moving or speaking so slowly that other people notice? Or the opposite, such as being fidgety or restless and moving around a lot more than usual?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)
9. Had thoughts that you would be better off dead, or thoughts of hurting yourself in some way?*	☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

If you are experiencing any of these problems, how difficult have these problems made it for you to take care of yourself, manage things at home, do your work, and/or get along with other people?*

☐ Not difficult ☐ Difficult ☐ Very difficult ☐ Impossible

Suicidal ideation assessment

To be used if a client has had any suicidal thoughts (answered in question 9)

A. In the past month, have you had serious thoughts or plans to end your own life?

If the client responded 'no' to Question A, thank them for answering your questions and you can end this section of the assessment.

☐ Yes
☐ No

B. If yes to question A: What plans have you made or actions have you taken to end your life?

Write response here:

C. Do you have plans to end your life in the next two weeks?

If 'yes' or 'unsure', ask the client to describe their plan to you.

☐ Yes
☐ No
☐ Unsure

Write response here:

Referrals:

If the client responds 'no', and declines to complete the suicidal ideation assessment, complete a referral to MHPSS services for further assessment and MHPSS service provision. Without more information from the client at this time, the client should be categorised as a high-risk client and should receive a referral.

If the client answers 'yes' to question C, they have a plan to end their life in the near future and you must contact your supervisor immediately. Stay with the person while you do this. If you are unsure whether the client will end their life in the near future, tell them you would like to contact your supervisor to ask them follow-up questions.

For the caseworker:

Total combined score (0-27), to be filled after the assessment

***Include any additional comments or observations about your client, and their appearance or behaviour, which could indicate their level of distress and mental health and psychosocial wellbeing*.**

Client code: _____

Form 6
Case Action Plan

Part A | Preliminary intake information
Complete these details before your meeting with the client. The client should have provided permission for an interpreter or anyone else to be present.

Date*

Client code*

Case code

Caseworker code*

Date of last meeting*

Is a safety plan required?

☐ No
☐ Yes

Does the client need any support to take part in this meeting?

☐ No
☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Action plan

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

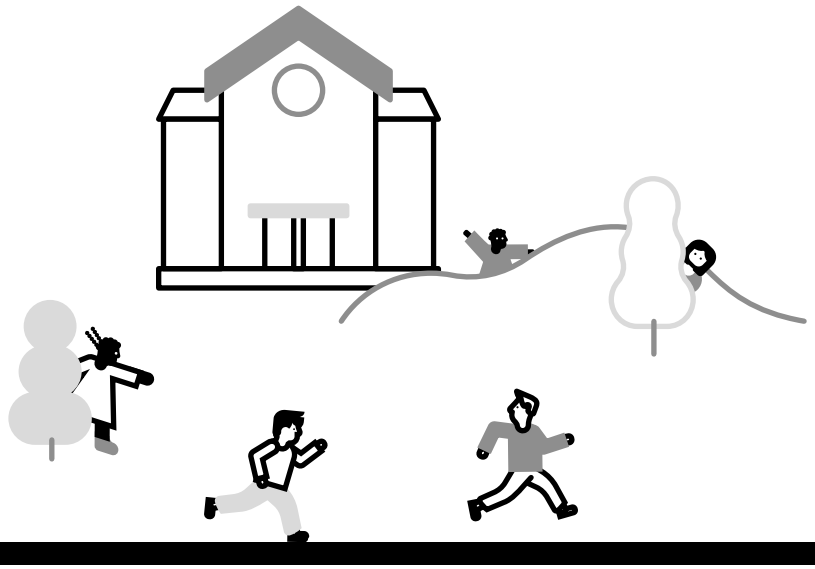
Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*

Specific risk: **Goal (s):**

Actions	By who	When	Status
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*
			☐ *Met (insert date)* ☐ *In Progress* ☐ *Unmet (insert date)*



Client code: _____

Referrals made
Select all that apply

- ☐ Psychosocial support
- ☐ Legal Aid services
- ☐ Livelihoods
- ☐ Family reunification
- ☐ Education
- ☐ NFI
- ☐ Health
- ☐ Cash
- ☐ Registration
- ☐ Water/sanitation
- ☐ Food services
- ☐ Shelter (including rehabilitation)
- ☐ Transport
- ☐ Documentation
- ☐ Safehouse
- ☐ Other, specify:

Are there any referrals that the client requires but are not available? If yes, which ones?
Select all that apply

- ☐ Psychosocial support
- ☐ Legal Aid services
- ☐ Livelihoods
- ☐ Family reunification
- ☐ Education
- ☐ NFI
- ☐ Health
- ☐ Cash
- ☐ Registration
- ☐ Water/sanitation
- ☐ Food services
- ☐ Shelter (including rehabilitation)
- ☐ Transport
- ☐ Documentation
- ☐ Safehouse
- ☐ Other, specify:

Is cash provided as part of an action plan? ☐ Yes ☐ No

If yes, How much?

Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date
Client signature	Caseworker code
Date	Date

Form 7
Referral Form

Priority*	Date of identification*	Referral date*
Indicate the priority of the case so the receiving agency knows the timeframe to respond. Consider if there are indications of immediate risk to personal safety.		
☐ High risk (48 hours) ☐ Medium risk (1-7 days) ☐ Low risk		

Referred by*	Referred to*
Insert the contact information of referring agency	***Insert the contact information of receiving agency***
Sector: Agency: Location: Focal point name: Email: Phone:	Sector: Agency: Location: Focal point name: Email: Phone:

Client code: _____

Client information* (only include if consent has been obtained)

Insert the person's individual bio data and contact. Check your service mapping to see whether additional information requirements are needed to access the service. Only include the identifying information required for the receiving agency to provide the service.

Name:
Address:
Phone:
Phone belongs to whom:
Preferred method of contact:
Preferred date/time for contact:

UNHCR registration # (if applicable)
Age:
Sex:
Disability status *(based on the outcome of your Washington group questions in the identification & intake form)*: Y/N

Caregiver information

Name:
Affiliation/organisation:
Relationship to the client:
Address:
Phone:
Caregiver informed of referral: Y/N
Explain if no:

Referral for which specific service and assistance*

Indicate the service(s) you are referring for. Please refer to the service mapping to ensure the service is available and the case meets the eligibility requirements for the service. Update explanations of services available in your context. See examples for CP, GBV, and MHPSS.

- ☐ **Child protection:** *This can include children at risk of exploitation, violence and abuse, children engaged in the worst forms of child labour, unaccompanied and separated children*
- ☐ **Gender-based violence:** *Women-at-risk of gender-based violence who can benefit from prevention and response services, including case management, safe spaces, early marriage cases*
- ☐ **Health**
- ☐ **Mental health and psychosocial support (MHPSS) services:** *This can include service providers in health, protection, and beyond; depending on the referral needs of the client and available MHPSS services providers in the area.*
- ☐ **Legal:**
- ☐ **Basic needs (food, nutrition)**
- ☐ **Shelter**
- ☐ **Water, sanitation and hygiene**
- ☐ **Education**
- ☐ **Livelihood**
- ☐ **Other**

Case narrative*

Describe the minimum information required for the receiving agency to respond. For example, problem description, whether the client receives other assistance, number in the household. Also include what accessibility/reasonable accommodation measures should be in place/put in place by the receiving organisation to support access to the service. For example, a temporary ramp or an interpreter. Remember for referrals to SGBV, CP and legal case management services do not provide details of the incident or case.

Consent *to release information**

Read the disclosure with the individual. Inform the individual how the service provider will use their data and answer any questions they might have before they sign the disclosure. For children under 18 years where the caregiver may be implicated in the abuse, informed assent should be sought instead.

Explain to the individual that they have the right to request that their information not be documented and can request retrieval of the information at any time. They have the right to refuse to answer any questions they prefer not to and the right to ask questions or for explanations about the referral process at any time.

I _____ (clients name), acknowledge that the service provider, _____ (service provider name) has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. I understand that my information will be treated with confidentiality and respect, and will only be shared as needed to provide assistance. I understand the information may be used for humanitarian analysis. By signing this form, I authorise this exchange of information to the specified service provider/s for the specific purpose of providing assistance.

_____ _____

Signature of client Date

Form 8
Safety Plan

Part A | Preliminary intake information

Complete these details before your meeting with the client. The client should have provided permission for an interpreter or anyone else to be present.

Client code*

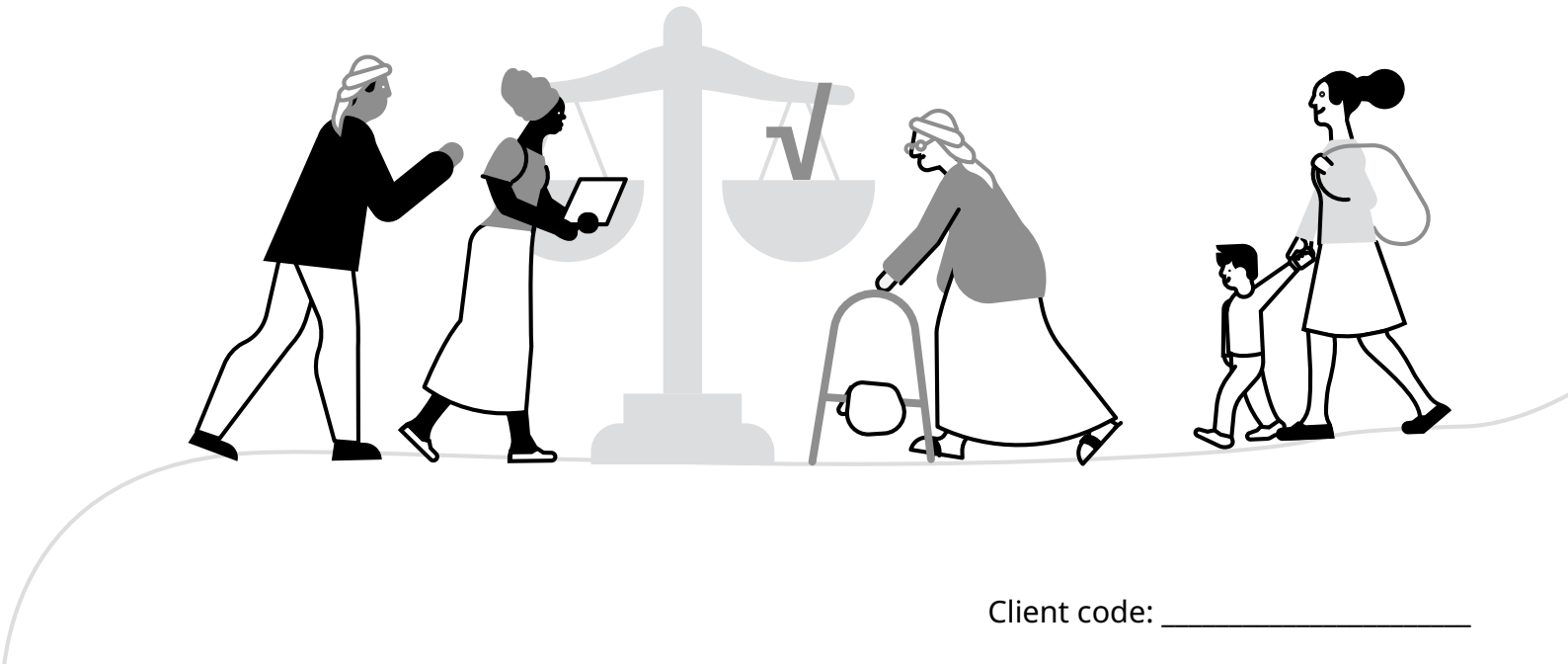
Case code

Caseworker code*

Date*

Does the client need any support to take part in this meeting?

☐ No
☐ Yes: Note down what support has been put in place:



Client code: _____

Part B | Safety

Risk or event that the client is planning for*

Current plans

What is the client's plan to protect themselves? *

Explore potential safety strategies

Whom do they trust? Is there anyone who can intervene or influence the perpetrator? What local authorities or prominent members of the community might they involve? what circumstances would they involve them?

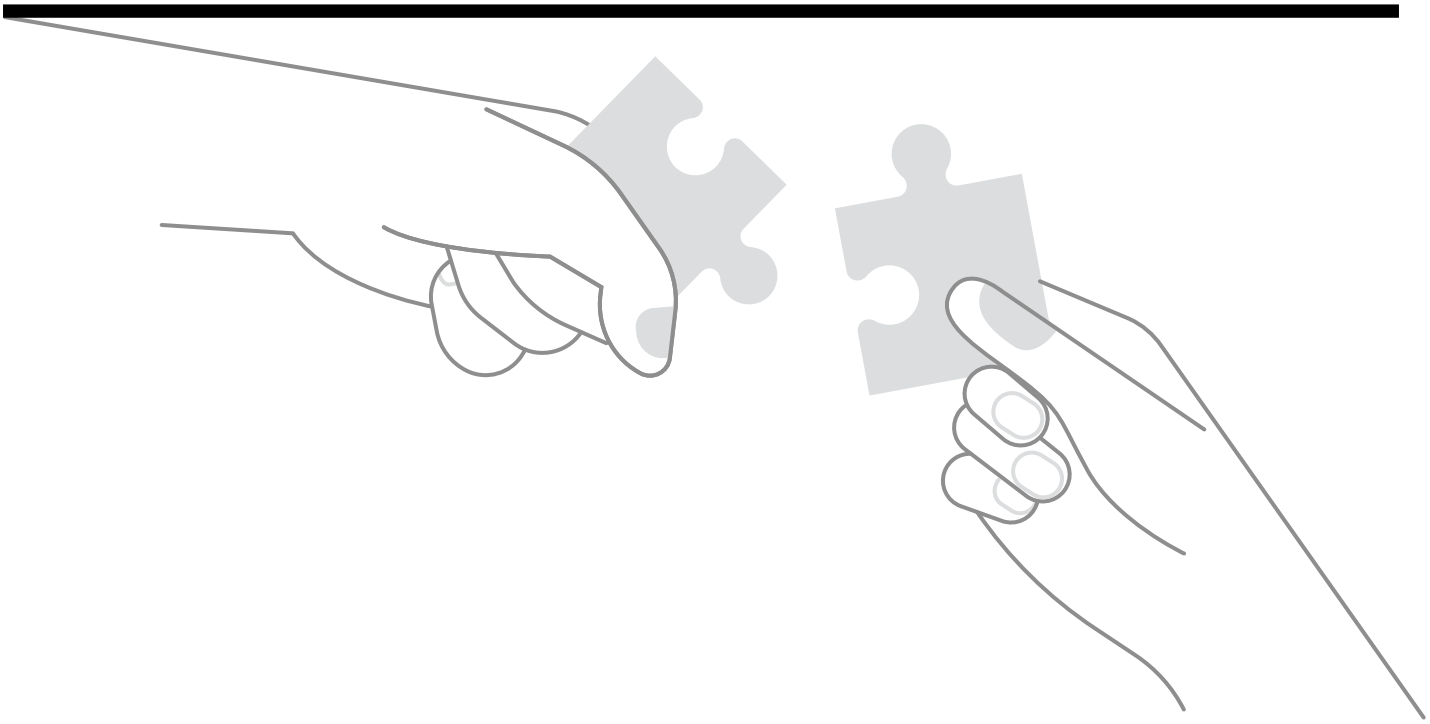
If the client has to leave, where could the client go, what financial resources do they have and/or what materials resources do they have?

If the client has to leave, or if the risk/ incident occurs, what will happen to their family or other responsibilities that they normally have? Who else might be in danger? Have they been made aware of this danger?

What will they bring, for themselves and their families? What financial and material resources and documents do they have?

Client code: _____

Preparatory action to be taken by the client	Preparatory action to be taken by the caseworker



Client code: _____

Form 9
Follow-up & Monitoring

Part A | Preliminary information

Date*	
Client code*	
Case code	
Caseworker code*	
Risk-level at intake*	☐ High ☐ Medium ☐ Low
Risk-level* *Update the risk-level based on progress of the case action plan*	☐ High ☐ Medium ☐ Low
Does the client need any support to take part in this meeting?	☐ No ☐ Yes: Note down what support has been put in place:

Client code: _____

Part B | Re-assess safety and mental health and psychosocial wellbeing

Part C | Progress made towards goals

These goals are linked to the goals laid out in the action plan. You will need to update them accordingly and insert any needed details about actions to achieve them.

1. ***Update the client on developments you have with regards to their action plan since the last time you met.***
2. ***Where appropriate, also ask the client to update you on developments regarding their action plan.***
3. ***Agree on how you are progressing towards goals including any challenges.***
4. ***Agree on changes you need to make to the action plan and next step.***

Goal 1*	Progress towards goal:
Goal 2	Progress towards goal:
Goal 3	Progress towards goal:

Client code: _____

Part D | Progress made towards goals

Consult the case action plan to see the referrals made. Discuss with the client the successfulness of the referrals. Have the referral(s) been successful? If not, why?

Agree on any revisions you need to make to the case action plan.
Update the case action plan with the client. Note down any justification for changes made to the Case Plan

Part E | Follow-up

Agree on the need for the next follow-up visit, including the location, time and day.
Check whether you need to make any adjustments to ensure the clients full participation in the next meeting. (i.e. organising for interpretation, meeting in a more accessible place)

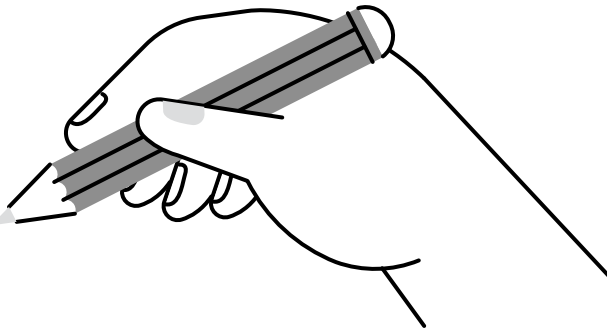
Follow-up meeting:
☐ Yes
☐ No

Location:
Date:
Time:
Adjustments for full participation needed:

Agree on what you each want to achieve by the next visit
On your next visit you can start by checking in with each other on whether you met these goals

Client code: _____

Form 10
Casefile Notes



Date*

Client code*

Caseworker code*

Select the action(s) taken by the caseworker

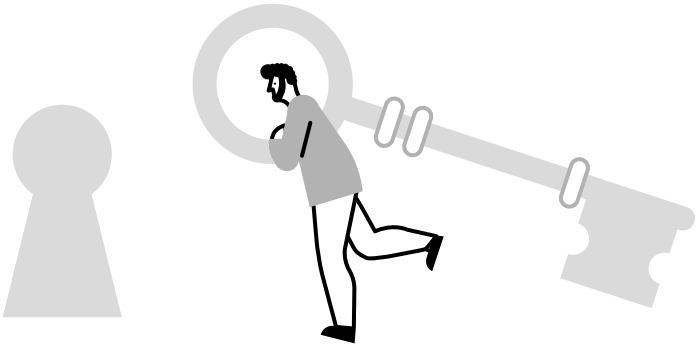
- ☐ Home visit
- ☐ Meeting/contact/phone cal
- ☐ Referral made
- ☐ Changes to case plan
- ☐ Update any new information received
- ☐ Other (explain)

Briefly describe any actions taken and updates regarding the beneficiary and her/his situation

Recommendations/actions required (if relevant):

Client code: _____

Form 11
Case Closure



Date*

Client code*

Case code

Caseworker code*

Case Closure	
Were the goals of the action plan met?* Summarise *progress towards goals in the action plan*	☐ Completely ☐ Mostly ☐ Few elements ☐ No
Explain the reasons for closing the case.*	☐ Client's needs have been met to the extent possible ☐ No contact with the client for more than _____ ☐ Client requested to close the case ☐ Client left the area ☐ Case Transfer ☐ Death of client ☐ Other

Client code: _____

If there was a case transfer, what are the reasons for transferring the case?	☐ Another organisation is better placed to manage the case due to specialised services required by the beneficiary ☐ Client moving to a new location; the case will be transferred to another case management organisation in that location ☐ There are organisational reasons for transferring this beneficiary's case ☐ The Client has requested a different organisation to provide PCM services ☐ Other
Impact of the service provided	
When we first discussed your case, you mentioned (...) as the main problem(s) you worried about. How much would you say this problem is (these problems are) affecting you and your life right now?	☐ Not at all (0)) ☐ Some (1) ☐ A lot (2) ☐ Severely (3) ☐ Do not understand the question ☐ Do not want to respond
How would you rate your ability to address this problem?	☐ No ability (0) ☐ Low ability (1) ☐ High (2) ☐ Very high (3) ☐ Do not understand the question ☐ Do not want to respond
What about the Protection Case Management support you received was most valuable to you personally? Why?	
Were there any changes you were hoping PCM could help you to achieve that didn't happen in practice? How could Protection Case Management have supported you better?	

Client code: _____

Closure checklist for caseworker	
If the client requires future services, the client has been informed of information on available services, how to access them, and how to contact your organisation, other agencies or community support structures.*	☐ Yes ☐ No
The client is actively involved in decisions regarding case closure or transfer, and, whenever possible, has given their informed consent for the case to be closed or transferred.*	☐ Yes ☐ No If no, explain:
The client has given consent to participate in the client feedback survey.*	☐ Yes ☐ No

Signature of client _____ Date _____

Signature of caseworker _____ Date _____

Signature of supervisor _____ Date _____

Form 12
Service User Feedback Survey

Instructions

This form should be completed at the end of the Protection Case Management process, or after the case action plan has been (partly) implemented with the client. Allow for the client to self-administer the form where possible. If this is not possible, the survey should be administered by someone who is not the assigned caseworker to the case. Either, another caseworker, the supervisor, MEAL staff, or others appropriately trained in protection principles, psychological first aid, and data protection principles.

Step by step:

1. Identify who on your team is going to administer the feedback form. In case of self-administration by the client, adjust the questions to ensure the client fully understands what is being asked, contextualise the questions where required, and translate the form to the local language(s).
2. Ask for informed consent following these steps:
   - Explain the purpose of the survey. Inform the client that you will ask them some questions but will not write their name on the form, and that the survey will remain anonymous.
   - Remind the client that you will not ask them any questions about their actual case, but are just interested in the services they received throughout the Protection Case Management process.
   - Ask for their permission to proceed. **The client consent section** aloud to the person, as noted below. If the client declines, tell the person that it is ok and if they change their minds, they can contact you.

To be read to the client:

We would like to know how you feel about the Protection Case Management and counselling services you received or are receiving. In order to understand your experience, we would like to ask you a few questions about your experiences. This survey is voluntary. Its purpose is to collect information about the services that have been provided to you, assisting us to make improvements in the quality of care that our clients receive in this community. Please let us know whether you require any support to participate in the survey. For example, whether it is easier for me to read the questions to you, whether you understand me well, or if you require an interpreter.

These questions are only to help us improve our services and in no way are related to your actual case. ***Your name and responses will remain anonymous and will not affect your services or support in any way.***

Do you agree to provide us with feedback through this questionnaire?

☐ Yes ☐ No

If consent is given, continue on to the survey.

_____

Date survey conducted

Survey administered by	
Gender	☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say ☐ I use another term – please specify:
Age	
Displacement status	☐ IDP ☐ Returnee ☐ Local community ☐ Other
Preferred spoken language	[Context-specific list]
Has your case been closed?	☐ Yes ☐ No ☐ Do not know
How did you find out about our service(s)?	☐ Family, friend, neighbour, or community member ☐ Referral from another organisation ☐ Community discussion ☐ Flyer or pamphlet you saw or received ☐ Government referral ☐ Other (specify):

Disability status-WG-SS: The next questions will ask if you have difficulties doing certain activities

1. Do you have difficulty seeing, even if wearing glasses?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
2. Do you have difficulty hearing, even if using a hearing aid?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
3. Do you have difficulty walking or climbing steps?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
4. Do you have difficulty remembering or concentrating?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know
5. Do you have difficulty (with self-care such as) washing all over or dressing?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know

6. Using your usual customary language, do you have difficulty communicating, for example understanding or being understood?	☐ No Difficulty ☐ Some Difficulty ☐ A lot of Difficulty ☐ Cannot do at all ☐ Refused ☐ Do not know

Access and safety	
How many times have you met with the caseworker since you started services with us? This includes meetings by phone that you have had with the caseworker to discuss your case in detail.	
Did you ever have any difficulties reaching, entering, circulating or using our services?	☐ Yes ☐ No
If yes, please Explain	
If yes, did you share this information with your caseworker?	☐ Yes ☐ No
If yes, was there any measure put in place to facilitate your access?	☐ Yes ☐ No
If yes, were any measures effective?	☐ Yes ☐ No If no, please explain why not:

How long did you have to travel (in minutes) to receive Protection Case Management services?	☐ Less than 15 minutes ☐ 16-30 minutes ☐ 31 minutes – 1 hour ☐ More than 1 hour ☐ No travel, phone-based services Please explain:
Did you pay for travel to cProtection Case Management services?	☐ Yes ☐ No
If yes, did it seem affordable?	☐ Yes ☐ No ☐ Not Applicable – did not pay for travel
If you have been referred to other services, did you feel safe accessing the Protection Case Management services?	☐ No, not at all ☐ Not really ☐ Somewhat /neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not	
Have you been referred to other services during the case management process?	☐ Yes ☐ No ☐ Do not know
If yes, did you ever have any difficulties reaching or using any services you were referred to?	☐ Yes ☐ No Please explain:

If yes, which services?	☐ Health ☐ Legal assistance ☐ Education ☐ MHPSS ☐ Cash/asic needs ☐ Shelter ☐ WASH ☐ Other (Pleases specify)
If yes, did you share this information with your caseworker?	☐ Yes ☐ No
If yes, did the caseworker support you to put any measure in place to facilitate your access?	☐ Yes ☐ No
If yes, were any measures effective?	☐ Yes ☐ No If no, please explain why not:
If you have been referred to other services, did you feel safe accessing the services?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not	

Respectful and dignified treatment	
Did you feel comfortable talking to the caseworker?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
Did you feel pressured at any time by your caseworker?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely

Voice and empowerment	
How satisfied were you with your social worker's communication skills?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
Do you feel the case manager has sufficiently involved you when decisions were made during the Protection Case Management process?	☐ No, not at all ☐ Not really ☐ Somewhat/neutral ☐ Mostly yes ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", please explain why not.	
Was there any issue in your caseworkers' attitude towards you that you would like to share?	

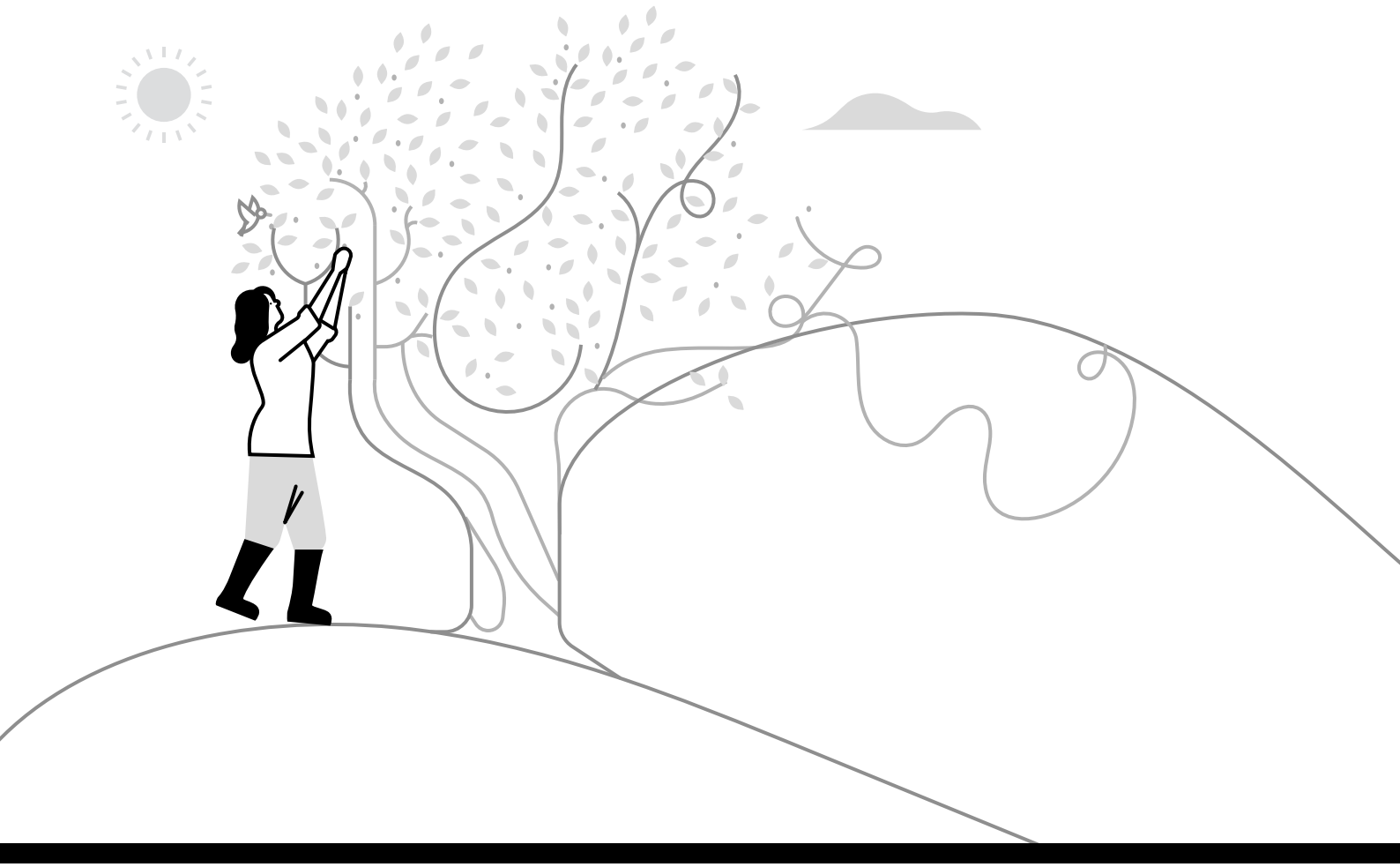
Accountability	
Did the caseworker explain to you how to provide a complaint or feedback if you wanted to?	☐ Yes ☐ No ☐ Do not know
Did the caseworker explain your rights at the beginning?	☐ Yes ☐ No ☐ Do not know

Relevance and satisfaction

Has your problem been addressed?	☐ No, not at all ☐ Not really ☐ Somewhat ☐ Mostly ☐ Yes, completely
If "no, not at all", "not really" or "somewhat/neutral", were there any changes you were hoping the Protection Case Management services could help you to achieve that didn't happen?	
Overall, how satisfied were you with the services that you received during your Protection Case Management	☐ Not at all satisfied ☐ Not really satisfied ☐ Somewhat/neutral ☐ Somewhat satisfied ☐ Completely satisfied Please explain:
What improvements could we make to our services for other clients?	

Would the client recommend a friend who has experienced something similar to come here for support?	☐ Yes ☐ No If no, please explain why not:

Thank the client for taking the time to take the survey.



***CC-06: % of clients reporting symptoms of moderate to severe distress or indicated suicidal ideation in the 14 days prior to Basic MHPSS Assessment at Protection Risk Assessment**

Indicator ID	**CC-06**
Category	Case characteristics
Objective(s)	• To determine the profile of clients and their level of distress • To identify clients requiring referrals for additional MHPSS services, inclusive of but not limited to specialized MHPSS services
What could this mean?	**A HIGH proportion of clients with moderate and severe disabling distress could mean:** • Limited accessible and quality MHPSS services and referrals • The context has deteriorated and/or the client has experienced complex or compounding risks • Limited family and/or community support structures • Limited individual self-regulation skills including the ability to understand, express and regulate emotions **A LOW proportion of clients with moderate and severe disabling distress could mean:** • Accessible and quality MHPSS services • The context is stable or has stabilized or the client has experienced minimal exposure to complex or compounding risks • Strong family and/or community support structures for clients • Strong individual self-regulation skills including the ability to understand, express and regulate emotions **Data quality:** If all surveyed clients are reporting high (or low) distress, the Basic MHPSS Assessment may not be understood by the client or the caseworker or the caseworker may not be comfortable using the assessment
What else do we need to know to strengthen interpretation?	• Caseworker has been trained on MHPSS service provision, including how to conduct the Basic MHPSS Assessment • Access to quality MHPSS services, including but not limited to specialized MHPSS services • Analysis of the context (e.g. to identify sudden changes such as increased generalized violence) • Assessment or knowledge on community and individual support structures