The Government of Sierra Leone

NATIONAL REFERRAL PROTOCOL ON SEXUAL AND GENDER-BASED VIOLENCE (SGBV)

Pathways to Service Provision for Survivors of Gender-Based Violence

July 2022

CONTENTS

Available separately

ACRONYMS

BoDs	Board of Directors
BoGs	Board of Governors
CBOs	Community-Based Organisations
CP-IMS	Child Protection Information Management System
CRA	Child Rights Act
CRPD	Convention on the Rights of Persons with Disabilities
CSOs	Civil Society organisations
CWCs	Child Welfare Committees
DECSEC	Decentralisation Secretariat
FBOs	Faith-Based organisations
FSU	Family Support Unit
GBV	Gender-Based Violence
GBV-IMS	Gender-Based Violence Information Management System
GoSL	Government of Sierra Leone
HRC-SL	Human Rights Commission of Sierra Leone
IASC	Inter-agency Standing Committee
MBSSE	Ministry of Basic and Senior Secondary Education
MDAs	Ministries, Departments and Agencies
MIA	Ministry of Internal Affairs
MLGRD	Ministry of Local Government and Rural Development
MODEP	Ministry of Development and Economic Planning
MoF	Ministry of Finance
MoGCA	Ministry of Gender and Children's Affairs
MoHS	Ministry of Health and Sanitation
MSW	Ministry of Social Welfare
NaC-GBV	National Committee on Gender Based Violence
NGOs	Non-Governmental Organisations
OSC	One Stop Centre
PHU	Peripheral Health Unit
PRS	Poverty Reduction Strategy
PSDO	Principal Social Development Officer

PSS	Psycho-Social Support
SEAH	Sexual exploitation, abuse and harassment
SV	Sexual Violence
SLANGO	Sierra Leone Association of Non-Governmental Organisations
SLP	Sierra Leone Police
SOA	Sexual Offences Act
SOP	Standard Operating Procedure
SOMC	Sexual Offences Model Court
SPCs	Strategic Partnership Committees
SRGBV	School Related Gender-Based Violence
SSC	School Safety Committee
TBA	Traditional Birth Attendant
TCoC	Teacher Code of Conduct
TSC	Teaching Service Commission
VAWC	Violence Against Women and children

OBJECTIVES OF THE NATIONAL REFERRAL PROTOCOL

For a system to respond effectively and deliver survivor-centred services to sexual and gender-based violence (SGBV) survivors, a wide range of actors and service providers must coordinate with confidentiality, must collaborate effectively and must each fulfil their roles and commitments fully. The 2022 National Referral Protocol (NRP) sets out the objectives and the terms of coordination and collaboration between the key governmental and non-governmental entities that support the process of reporting and responding to cases of SGBV and outlines these entities' roles and responsibilities to do so in a way that puts the survivor at the centre of the response (survivor-centred).

Delivering a survivor-centred response to SGBV is complex for multiple reasons: (1), survivors face multiple levels of exclusion and marginalisation; (2) survivors have a wide range of needs; (3) individual survivors have differing needs as no two women or girls are the same; (4) survivors often face many barriers to accessing support to address their needs; and (5) SGBV stems from discriminatory social and gender norms and power dynamics, and efforts to tackle this often faces deep-seated challenges.

In response to high rates of SGBV in Sierra Leone and recognising the complexity of delivering survivor-centred responses, the Government of Sierra Leone produced the 2012 Gender-Based Violence National Referral Protocol (GBV NRP, 2012). The GBV NRP 2012 was a technical guidance document developed to ensure that survivors of SGBV, including children, receive free, prompt and coordinated responses from service providers including free medical care, legal advocacy and advice, and psychosocial support from the point at which the report is made to beyond the time when the legal case is completed.

Significant changes in the legal, political, policy and cultural environment in Sierra Leone have taken place since 2012, most notably the launch of the National Strategy for Response to Sexual and Gender Based Violence (SGBV) (Annex 1) in December 2021. This reinforces the importance of delivering SGBV response in a way that prioritises the dignity, needs, and wishes of the survivor. There is now a need to revise the NRP to ensure it is more survivor-centred and that services are effective, coordinated, child-friendly, gender-sensitive, and disability-inclusive.

THE NRP REVIEW PROCESS

This NRP revision follows consultations conducted by the Ministry of Basic and Senior Secondary Education (MBSSE) and Ministry of Gender and Children's Affairs (MoGCA) through Strategic Partnership Committees (SPC) across the country from January 5-11, 2021. SPCs are district-level committees set up by MBSSE in every district headquarter for the protection of adolescent girls during the COVID-19 outbreak. These committees are chaired by the Deputy Directors (DDs) of MBSSE in every district. Members include all partners working on the prevention and response to SGBV, including traditional leaders. This revision also incorporates feedback on the SGBV reporting pathway from a workshop with SGBV responders in December 2021. Two consultative meetings were held in Freetown with various stakeholders from UNICEF, UNFPA and relevant NGOs, persons with disabilities (PWD), Children's Forum Network, school authorities, line Ministries, and Family Support Unit (FSU). The purpose of the consultation was to validate the draft Protocol and incorporate gaps identified by participants. The NRP also reflects the diverse views and experiences of PWDs and SGBV (child and adult) survivors countrywide on the proposed pathways, following consultative meetings held on the 12th and 13th of April 2022 respectively.

Views and experiences of selected PWDs

The PWDs, including survivors, highlighted that they experience negative and discriminatory attitudes from service providers when they access services, particularly at the FSU, and government hospitals. They reported to face stigmatisation, challenges with physical access, and communication barriers while accessing SGBV services. There are limited sign language interpreters in police stations and hospitals as well as no wheelchair access in many public buildings. Persons with hearing impairment cannot directly call the 116 hotlines for SGBV services. They recommended the deployment of trained and qualified personnel on disability issues in care centres to ensure that their needs are integrated, and they are treated with dignity, respect and records are treated with confidentiality. Survivors with hearing/ speech impairment would like access to inclusive reporting services that are on par with the 116 hotlines. They suggested the establishment of PWD desks in all MDAs, increased psychosocial services to build self-confidence, free legal services, accessibility to public spaces, and networking among PWD institutions.

The 2022 NRP incorporates the **National Guidelines linking four key hotlines:** 116 SGBV VAC Hotline, 112 police and ambulance services and 117 health (Annex 2). The 2022 NRP also reflects changes within the Ministry Departments and Agencies (MDAs), such as the recently created ministries and institutions which have a stake in GBV prevention, reporting, response and service provision in Sierra Leone.

The 2022 NRP is updated to **reflect developments in child protection and education policy frameworks** that strengthen SGBV prevention and response at all levels. The updated NRP also ensures disability mainstreaming, which is essential to adhere to best practices and to enable the collection and management of disability-related data by age, gender and type of disability, in accordance with the questions set out by the Washington Group on Disability Statistics and supported by the evaluation of the Child and Adult Functioning Models.

Views and experiences of selected survivors of SGBV

Participants who engaged in consultations comprised of survivors who have accessed SGBV services from the One Stop Centre (OSC), Rainbo Initiative, Medecins Sans Frontier (MSF), 116 hotline as well as those living in locations without any of these facilities. Survivors identified delays in police investigations, court proceedings, absence of forensic lab, ill-equipped one-stop centres, unavailability of livelihood support, and weak or non-existent guidance and counselling departments in schools, to all affect the quality of SGBV services they received.

Child survivors reported stigmatisation at the police and medical centres while accessing services. They recommended increased government resources for SGBV services to fast track police investigations, court proceedings, and enforcement of SGBV laws particularly the Sexual Offences (Amendment) Act 2019.

They also asked for upgrading the One-Stop Centre services in current locations and extending country-wide, and to expand Rainbo centres, the establishment of safe homes across the country and a national forensic laboratory. They also recommended the provision of livelihood support to families or further educational support as part of re-integration services. They recommended receiving comprehensive sexuality education and the revitalisation of guidance and counselling departments in schools across the country.

The 2022 NRP establishes the **need for service providers to be trained on professional standards in caring for SGBV survivors**, particularly child survivors within or outside the school setting, training related to disability inclusion and caring for survivors with disabilities. With reference to the Interagency SGBV Case Management Guidelines (Annex 3) service providers also need orientation on consistent, confidential and professional SGBV case management. Under their agreed commitments to address SGBV within this protocol, MoGCA, MBSSE, MoHS, TSC amongst other relevant MDAs, will ensure that key stakeholders: girls, boys, the FSU, Social/ Case Workers from government and NGOs, Community Child Protection structures, school authorities and supporting structures are trained to support child survivors, to report all incidents of School Related Gender Based Violence (SRGBV) and SGBV confidentially in accordance with the law and relevant policies, and to explain the reporting mechanisms to others.

This revised 2022 NRP will **serve as a reference document to support and strengthen School Safety Systems**, that create pathways for all students to safely report and receive support and service linkages in response to cases of SRGBV, including psychological, physical, and sexual violence in schools and around schools.

The 2022 NRP is implemented in accordance with existing laws, policies and the guiding principles of respect for confidentiality, dignity and rights of survivors.

The 2022 National Referral Protocol addresses the National Strategy for Response to SGBV (2021 – 2023) goal: Provision of accessible and survivor-centred SGBV services in a holistic, coordinated and equitable manner.

The 2022 NRP will guide the coordination of MDAs and frontline service providers responding to SGBV by:

1. Outlying roles and responsibilities across a range of actors responsible for delivering survivor-centred and trauma-informed response services.

2. Reinforcing the importance of providing SGBV survivors with consistent, confidential and professional case management support throughout the process to enable them to make informed choices.

3. Defining coordination mechanisms and referral pathways to help all survivors of SGBV, including women and girls, men and boys, and persons living with disabilities to receive prompt, coordinated and effective services from the various agencies and service providers involved in their care.

4. Established standards of professional practice are prescribed and followed with regards to response services including case management and referrals, confidentiality, information sharing, recording of sensitive information and avoiding conflicts of interest. Mandatory reporting guidelines will be developed as annex to the NRP.

5. Presenting a framework for monitoring and evaluation of the protocol.

ROLES AND RESPONSIBILITIES OF MINISTRIES, DEPARTMENTS AND INSTITUTIONS/COMMISSIONS

This NRP 2022 constitutes an agreement of cooperation among the respective parties including the Government of Sierra Leone Ministries, Departments and Commissions – MoGCA, Ministry of Social Welfare (MSW), Ministry of Health and Sanitation (MoHS), Ministry of Basic and Senior Secondary Education (MBSSE), Teaching Service Commission (TSC), the Ministry of Finance (MoF), the Office of the Vice President through the SGBV Advisor, the Ministry of Internal Affairs (MIA) through The Sierra Leone Police Family Support Units (SLP FSUs), Ministry of Justice (MoJ) and The Judiciary, The Ministry of Local Government and Rural Development (MLGRD) through the Decentralisation Secretariat, the Human Rights Commission of Sierra Leone (HRCSL), and development partners including district level SGBV and SRGBV committees, district level child protection committees, Civil Society Organisations (CSOs), Non-governmental Organisations (NGOs), and Community Based Organisations (CBOs) (Annex 3).

At the normative level, Sierra Leone is a signatory to many International and Regional Instruments including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Beijing Declaration and Platform for Action (BDPfA), Convention on the Rights of the Child (CRC), African Charter on the Rights and Welfare of the Child (ACRWC), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (aka Maputo Protocol), Convention on the Rights of Persons with Disabilities (CRPD) – which recognises that women and girls with disabilities are often at greater risk of violence, abuse, neglect, or exploitation – and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, among others.

At the National level, the Government of Sierra Leone (GoSL) has legislated the Anti-Human Trafficking Act 2005; Domestic Violence Act 2007; Sexual Offences Act 2012; Legal Aid Board Act 2012; Sexual Offences (Amendment) Act 2019, Sierra Leone Persons with Disability Act 2011, all aimed at addressing gender-based violence especially that women and girls with disabilities experience higher rates of SGBV and face "double discrimination" or stigma on basis of their gender and their disabilities, more than women, girls, boys and men without disabilities. Protecting the human rights of women and girls with disabilities may require using human rights instruments for people with disabilities in conjunction with human rights instruments for women.[1]

[1] Human Rights Instruments for Women with Disabilities | Global Disability Rights Now!

Through this agreement, the listed agencies commit to ensuring an effective and inclusive response to and coordination of, survivor centred services for survivors of SGBV, including SRGBV. At all the different stages of the referral pathway, different actors and services have the responsibility to take all the necessary measures to ensure access and provision of survivor-centred services to the survivors of SGBV with a particular attention to child survivors and survivors with disabilities.

The listed agencies will play pivotal roles towards achieving sustained coordination in the implementation of the NRP on SGBV in Sierra Leone:

1	MoGCA represented by the Minister of Gender and Children's Affairs
2	Office of the Vice President represented by the SGBV Advisor
3	MBSSE represented by the Minister of Basic and Senior Secondary Education
4	TSC represented by the Chair of the Teaching Service Commission
5	MoHS represented by the Minister of Health and Sanitation
6	MSW represented by the Minister of Social Welfare
7	MoF represented by the Minister of Finance
8	MoJ represented by the Minister of Justice
9	Judiciary represented by the Hon. Chief Justice
10	MIA represented by the Minister of Internal Affairs
11	SLP – FSU represented by Head of Family Support Unit
12	MLGRD represented by the Minister of Local Government and Rural Development
13	HRCSL represented by the Chairperson of the Human Rights Commission of Sierra Leone
14	Legal Aid Board Sierra Leone

PREAMBLE

Whereas the Government of Sierra Leone and its Ministries and Agencies:

1	Are aware of and greatly concerned about the negative impact of SGBV on all survivors, particularly women, girls and persons living with disabilities.
2	Acknowledge that SRGBV must be integrated in national SGBV response mechanisms.
3	Commit to ensuring that national SGBV response mechanisms meet the needs of people with disabilities, particularly women and girls with disabilities, who are both at higher risk of SGBV and face higher barriers to accessing services.
4	Acknowledge that MoGCA in collaboration with its partners has established One Stop Centres (OSCs) in hospitals in 6 districts (King Harman Rd. Maternal and Child Health Hospital Freetown – Western Area Urban, Port Loko, Moyamba, Kailahun, Pujehun and Koinadugu) to provide survivor-centred SGBV case management, including psychosocial support, as well as medical, and legal services and referrals to safe housing, all in one location. The MoGCA intends to open additional OSCs in Bonthe, Karene, Falaba and Kambia districts.
5	Acknowledges that the Rainbo Initiative operates Rainbo Centres in 5 districts (Freetown Western Area Urban, Kono, Makeni, Bo, Bombali and Kenema) to provide survivor-cantered medical, including clinical management of rape, psychosocial and legal services, referrals to safe housing and case management to survivors of SGBV. There is a SGBV Centre at the Tonkolili Government Hospital supported by Médecins Sans Frontières (MSF).

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6	Take into consideration subsections (i and ii) of Section 39 of the Sexual Offences (Amendment) Act, 2019, which state that:

a. A survivor of SGBV shall be entitled to free medical treatment and a free medical report from any Government Hospital in Sierra Leone or from any other Health unit duly accredited by the MoHS for the provision of medical treatment for sexual offenses and related Health Care Services.

b. Medical treatment shall include counselling, psychosocial support and mental health services.

c. Recognise that many rape cases continue to be thrown out of court for lack of adequate evidence. Out of the 12,052[2] cases recorded by the SLP in 2018, only 1,334 went to court and only 226 convictions were reached (reflecting a conviction rate of less than 2%).

d. Acknowledge discrepancies in the evidence against perpetrators of SGBV which are due to lapses in the exhibits and reports.

Based on the above, each of the key Ministries, agencies and partners named herein commit to faithfully and to the best of their abilities undertaking the roles and responsibilities assigned to them and detailed herein and in their respective Standard Operating Procedures.

[2] Sierra Leone Police Annual General Crime Statistics Report 2018

PRINCIPLES GUIDING ACTIONS TAKEN UNDER THE 2022 NRP

The 2022 NRP is guided by the principles set out in the National Strategy for Response to SGBV:

1	Survivor-centred: All responses should be underpinned by respect, compassion, and human dignity, and prioritise the rights, needs, wishes, and choices of the survivor while upholding confidentiality
2	Inclusion: Support should be provided to all survivors without discrimination based on gender, poverty, class, ethnicity, tribe language, religion, age, ableness, sexual orientation and gender identity
3	Social transformation: Services should be gender-responsive and transformative to reduce inequality and gender-driven differences driving SGBV
4	It is also underpinned by a new principle of do no harm, through risk management and mitigation

These principles underpin a survivor-centred and trauma-informed approach for the 2022 NRP.

The survivor-centred approach is put in place through a set of principles that guide the work of all people—no matter what their role is—in all their interactions with people who have experienced SGBV.

1	**Right to safety:** 'Safety' refers to both physical safety and security, as well as to a sense of psychological and emotional safety for people who are highly distressed.
2	**Right to confidentiality:** Confidentiality refers to the right of a person to have any information about them treated with respect. It promotes safety, trust and empowerment.
3	**Right to dignity and self-determination:** SGBV is an assault on the dignity and rights of a person, and all those who come into contact with survivors have a role to play in restoring dignity and self-determination.
4	**Non-discrimination:** All people have the right to the best possible assistance without unfair discrimination on the basis of gender, age, disability, race, colour, language, religious or political beliefs, sexual orientation or social class.

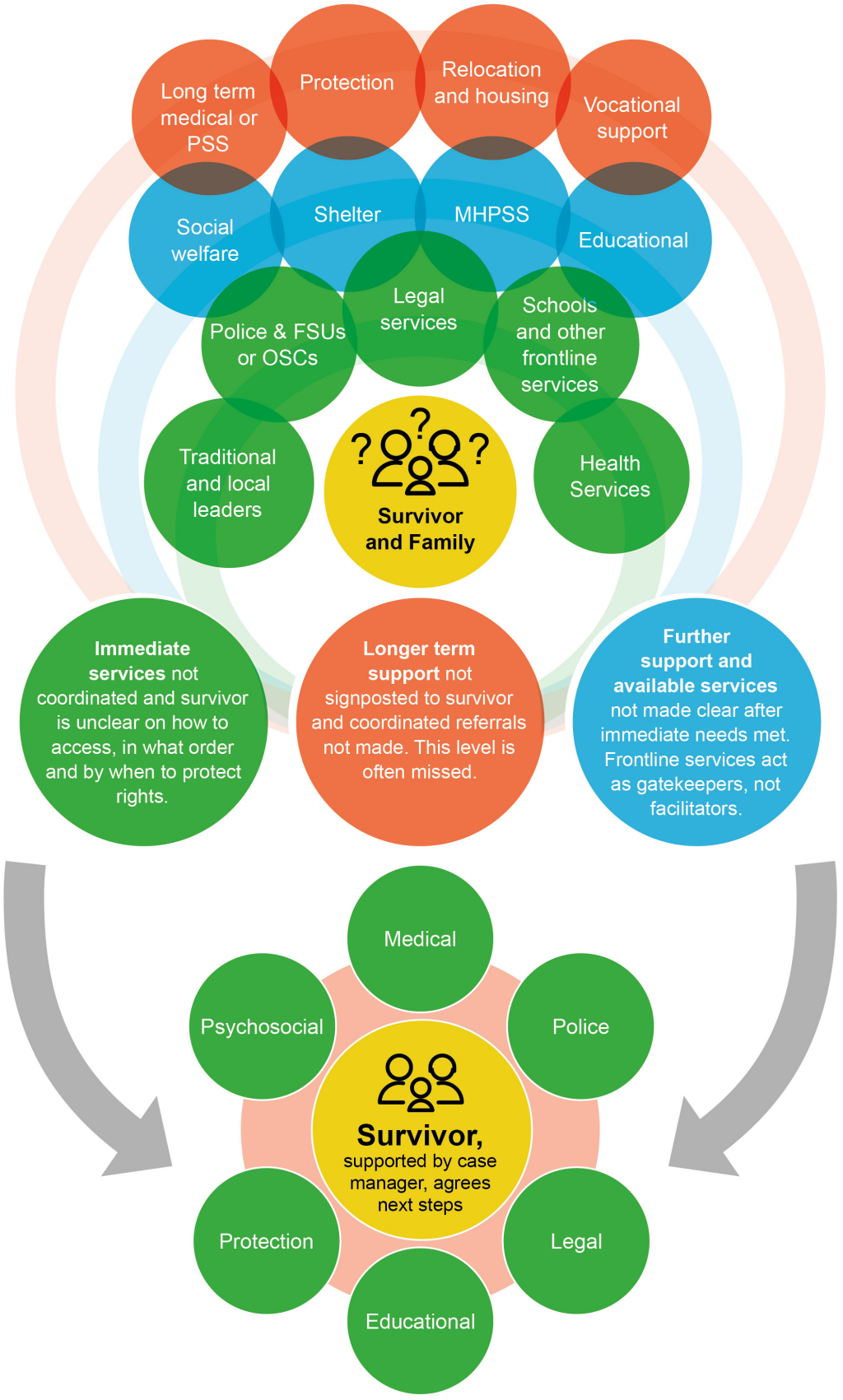
By working to enshrine these principles in actions undertaken under the 2022 NRP, service providers and agencies seek to ensure that they minimise a range of risks to the survivor as well as to others affected by the incident and the case; balance service delivery and legal and ethical obligations to achieve a fair process; and protect the survivor, anyone who reports a case, as well those who are accused and not yet convicted and those who may never come forward but are at risk of further harms.

As such, while a survivor- centred approach seeks to ensure the dignity, voice, and choice of the individual survivor, it does not obviate the commitments and obligations of service providers, agencies, and key actors to build a system that can deliver a fair process and protections to all affected and actively minimise any harms such a system might cause.

A critical feature of a survivor-centred and trauma-informed approach is that services collaborate and coordinate, and that effective case management supports a survivor to engage with and navigate the system. It also enables the system to work without harming the survivor, while building trust, respecting confidentiality, and ensuring non-discrimination.

This is demonstrated in Figure 1.

Figure 1: A demonstration of how services can be co-ordinated to support survivors



Case management is key to this approach as explained below:

SGBV case management is a structured method for providing help to a survivor. It involves one organisation, usually psychosocial support or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them and that issues and problems facing a survivor and her/his family are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process.

Case management evolved from the recognition that people seeking health and mental health care often have a range of other social service needs, and that a function was needed to coordinate these often fragmented services. Thus, the 'case management' function became a specialised role within health and social services, providing information and coordination of care and services to individuals and families, while advocating for the quality of care and services.

The digital SGBV Information Management System, Primero, will be made available for formalising and harmonising the existing case management system. Efforts will be made to align the primero system and procedures with the 2022 NRP where necessary to ensure effective signposting and formal referrals. NGOs, MDAs (including FSUs), CSOs and other interested parties would ideally partner with government as and when necessary in order to establish the structures needed to implement such a case management system.

Ministries, institutions and service providers working in the prevention and response of SGBV need to abide by agreed guidelines and ways of working that include:

Operating within the law: All professionals working with vulnerable people, which may include women and children and persons with disabilities, should be aware of and respect the relevant legislative framework. This includes the Child Rights Act 2007, Domestic Violence Act 2007, and SOA 2019 Amended, and the Convention on the Rights of Persons with Disabilities (CRPD) which recognise that women and girls with disabilities are often at greater risk of violence, abuse, neglect, or exploitation. It also includes the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa, which includes the Washington Group set of questions, and the Sierra Leone Persons with Disability Act 2011 and their own professional and institutional guidelines.

Managing conflicts of interest: In the event of a conflict of interest, e.g. when a family member or close associate of the professional is involved in a case, as victim or perpetrator or material witness, the professional should notify their line manager and request that the case is managed by a colleague.

Ensuring inclusion and non-discrimination: Professionals should ensure that when managing cases of SGBV affecting persons with disabilities, it is important to keep in mind that the survivor may have communication and physical barriers that prevent them from clearly explaining what has happened and what they wish to access in terms of services and support.[3]

Being child friendly: It is important to practice the best interest determination in cases of child survivors and to ensure protection from further abuse. Ensuring the best interest of the child would include considerations of whether or not to engage with a caregiver based on the child's safety. Their dependency on their caregiver may affect what they can disclose as well as what services they can access, especially if the caregiver controls what the survivor can do, including the choices they can make.

Protecting confidentiality: Professionals must ensure maximum confidentiality about the survivor's situation at all times bearing in mind that it can be difficult because the SGBV incident may have been reported by somebody else in the community, and not by the caregiver or the survivor.

Ensuring good communication: Information on the progress of the case of the survivor must be relayed in a timely and inclusive manner to the individual or to the parents/carers of the child survivor. Before taking any further steps, the professional must seek the informed consent of the survivor or parents/carers of the survivor, if a child.

[3] SOP SGBV Prevention & Response

Adhering to national SGBV Standard Operating Procedures (SOPs): SGBV service provision in Sierra Leone will be guided by the Sierra Leone SGBV SOPs to ensure a collaborative and coordinated process that adheres to the principles and guidelines outlined in the 2022 NRP. It is also important for individual organisations to develop internal SOPs that guide service provision and outline policies, and protocols staff need to adhere to. Currently, the OSCs, Rainbo Centres and the FSU all have SOPs for SGBV response. Other agencies such as education actors, health actors, and the judiciary are encouraged to develop SOPs. New SOPs should be built on these existing best practices to help ensure harmonisation in line with this protocol.

Standard Operating Procedures for SGBV interventions (SGBV SOPs) are specific procedures and agreements among organisations in a particular context that outline the roles and responsibilities of each actor working to prevent or respond to SGBV.

SGBV SOPs are developed through a collaborative process that can include, government, UN agencies, non-governmental organisations, women-led organisations, community-based organisations, organisations led by persons of concern and representatives of the diverse parts of the community in which services are being provided.

SOPs will ensure activities, practices and procedures put in place for the care and protection of SGBV survivors (regardless of age, sex, or disability) are of acceptable standards and safety. They should include detailed information on how the principles of do no harm, risk management and mitigation as well as the survivor-centred approach will be implemented in practice, as well as how confidentiality will be respected, and information shared in a context where reporting is made mandatory.

Obtaining informed consent: Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent (age 18+). Consent must be given per action and referral, and does not endure indefinitely; consent to one action or referral by a service provider does not constitute consent for any other actions. Survivors have the right to revoke consent at any time. Consent should be written if possible; if it is not possible, survivors can give verbal consent, which is recorded by the service provider. To provide informed consent, the individual must have the capacity and maturity to understand the services being offered, be legally able to give their consent, and have the relevant information to understand the implications of the decision they make.

Informed assent is the expressed will of the child to participate in services. A child's "informed assent" should be sought with children who are too young (by definition younger than 18) to give informed consent, but old enough to understand and agree to participate in services.

This includes taking time to watch and listen, always talking directly to the survivor, paying attention to how the survivor wishes to communicate, and not putting pressure on the survivor to disclose or agree to anything.

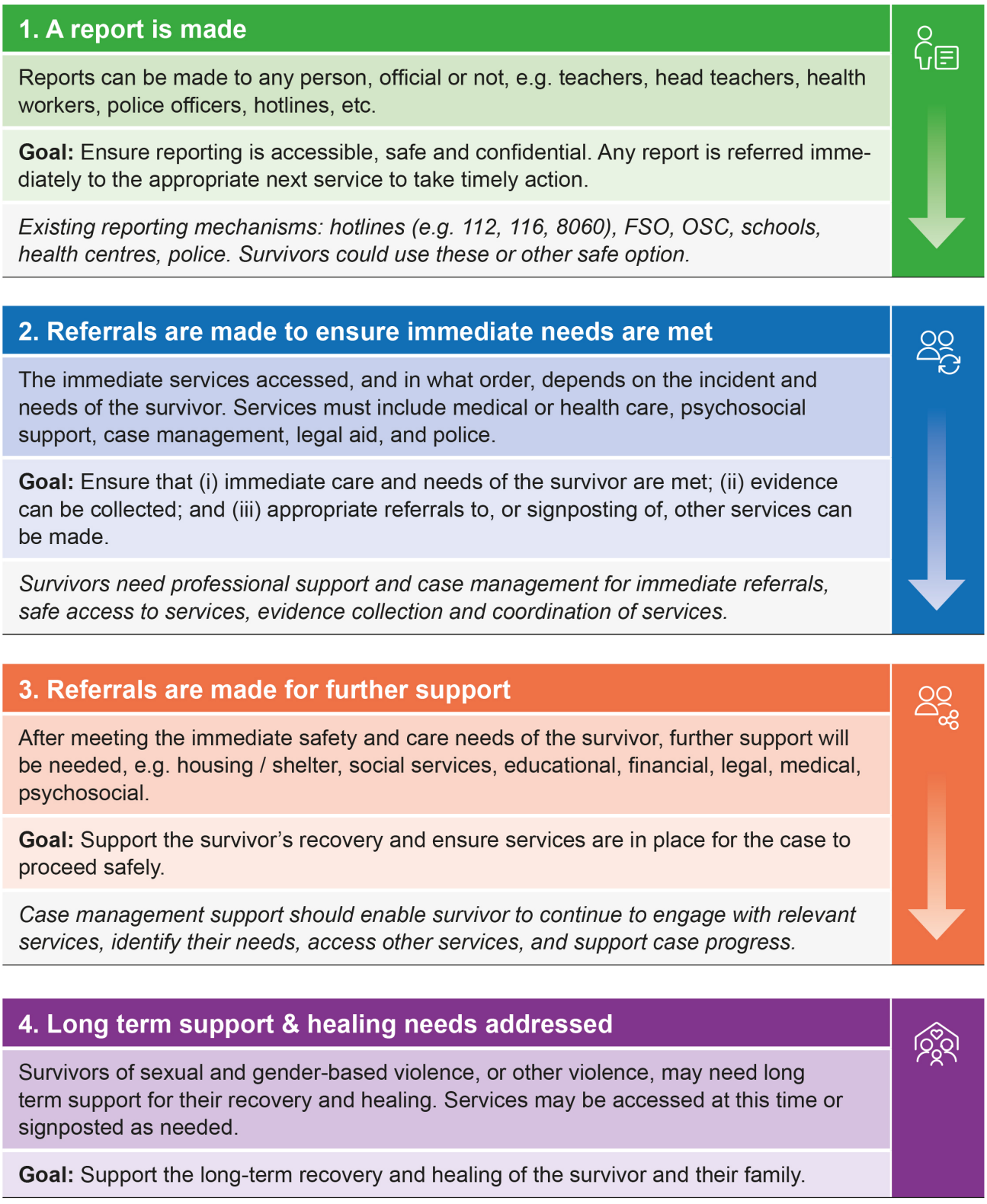
THE REFERRAL PATHWAY

There are four major phases of the Referral Pathway. In the first a report is made and referred; in the second, immediate and urgent care and support are received to address immediate physical and other harms and to collect evidence; in the third, referrals are made and other services are signposted so that the survivor can get care and support and so that a case can proceed; and finally, the long term impacts of the case and incident are addressed with further referrals and links to services.

The four phased of the referral pathway are shown in more detail in Figure 2.

The National Strategy for Response to SGBV lists many of the services available at each phase. It is critical for services to be mapped at the local, district and national levels and for key agencies, such as health, schools and the police, to be aware of local service providers and relevant referral pathways. A draft mapping by district is provided (Annex 4).

Figure 2: Four phases of the referral pathway



There will be specific considerations at each phase if the survivor is a person with a disability (PWD). (See Figure 3 for considerations at each of the four phases). The relevant agencies and partners will draw up particular protocols and guidelines for managing cases when the survivor or the perpetrator are PWDs. They will be harmonised with this protocol and other SOPs and will be introduced through training, targeting National Commission for Persons with Disabilities and Sierra Leone Union for Disabilities.

Similarly, particular considerations will be needed if the survivor is a child and/or if a case constitutes SRGBV. (See Figure 3 for considerations at each of the four phases).

In cases of SRGBV, the education sector, including key Ministries, TSC, agencies, partners and officials, will need to be consulted and involved throughout the process. Confidentiality should be maintained, and information shared on a need-to-know basis. Disciplinary actions against employees in the sector, such as teachers, will be part of the process as well as any legal proceedings. Education sector providers should communicate clearly to teachers, and it is advised that refresher trainings be organised for teachers. Teacher's knowledge on reporting procedures could be monitored and checked to ensure they understand what is expected of them and consequences when rules are flouted.

Additionally, the long-term impact of trauma or violence on a child will require specialised care and support for the child and for their family and possibly for peers who were affected.

Finally, it is important to note that referral pathways are not rigid or linear. Good coordination and collaboration, led by MoGCA, between service providers and information sharing throughout, including with the survivor and line with confidentiality protocol, will enable the process to progress effectively. As such, when agencies and partners assess the effective of the system, again led by MoGCA, they should include measures that assess quality of care, adherence to guiding principles, evidence of coordination and collaboration amongst key actors etc., as well as speed of resolution of cases or numbers of cases.

Figure 3: Considerations for PWDs and child survivors

1. A report is made		
Considerations for survivors and services	**Considerations for survivors with a disability**	**Considerations for child survivors**
Reports can be made to any person, e.g. teachers, head teachers, health worker, police officer, hotline, etc. **Relevant services:** Rainbo Centres, OSC, FSU, Police, Hotlines (e.g. 116, 8060)	May face challenges depending on the nature of their disability, particularly if they are children. They and their carers may be need support. **Additional services:** e.g. sign language or braille; trained disability specialists; additional support for carers	May face challenges with reporting depending on age. They and their carers may be need support. **Additional services:** e.g. child specialists; trained individuals; additional support for family or carers.
2. Referrals made to ensure immediate needs are understood and met by specialists		
Registration of survivor and case.		
Medical examination...	...with a disability specialist.	...with a child health specialist.
Survivor's statement taken by police...	...with support to enable communication.	...with support to enable communication.
Initial PSS support given to survivor and family...	...with disability specialist.	...with child specialist.
Paralegal assigned...	...who can communicate and work with survivor.	...who can communicate and work with child and carers.
Police Medical Form is endorsed.		
Case manager assigned...	...with disability training.	...with training to work with children.
3. Referrals for further support		
Referrals to services may include: e.g. further medical care; shelter; social protection; social welfare; psychosocial support; further legal services. Additional services and support are signposted as needed.		
Case manager assesses needs and risks with survivor and carer(s) as relevant.	...paying attention to ensure needs are fully understood and carer's role is assessed.	...paying attention to ensure needs are fully understood and carer's role is assessed.
4. Long term support & healing needs addressed		
Long-term needs assessed and further services signposted, or further referrals made. **Relevant services may include** legal aid, vocational and economic independence training, psychosocial support, medical, relocation and shelter, social welfare and protection support, etc.	Long-term challenges may be greater and more difficult to assess and meet for survivors with a disability and their carers. Additional case management support needed. **Relevant services may include** legal aid, vocational and economic independence trainings, psychosocial support, medical, relocation and shelter, social welfare and protection support.	Long-term impacts will be greater and more difficult to assess and meet for child survivors and their family. Additional case management support needed and links with schools and other key services maintained. **Relevant services may include** legal aid, vocational and economic independence training, psychosocial support, family support, medical, relocation and shelter, social welfare and protection support.

DATA COLLECTION, MANAGEMENT AND PROTECTION

COLLECTING SURVIVOR DATA SAFELY

Survivor data encompasses a) personal identifiable data about the survivor accessing services which are required to render quality SGBV response services; b) details about the SGBV incident (e.g. type of violence, location of incident etc.); and c) case management data which is information about the support provided and received by a survivor through the SGBV case management process. All types of survivor data should only be collected in the framework of service provision, and only when reported directly by the survivor i.e. not by a third party. Third party collection of SGBV data should only be done in instances where the age, maturity, level of cognitive development etc. of the survivor prevents a survivor from reporting themselves, in these instances the survivor's caregiver - in the presence of the survivor - can make the report if appropriate.

The data should allow disaggregated data by age, gender and disability, using the Washington Group set of questions and complemented by the Child and Adult Functioning Models. Such disaggregated data will help to better develop prevention and response activities and budgets.

DATA PROTECTION

Service providers and key stakeholders in the referral pathway will have access to sensitive protection data. Data should be recorded in an anonymous standardised reporting form to ensure safe data collection across all service providers in the country.

To ensure safety and confidentiality, all data will be anonymised when shared and will be treated with the highest standards of data protection at all times. Potentially identifying information on the survivor, her family, the perpetrator and in some cases the service providers will not be included or shared in any data report.

In keeping with the 'need to know' basis, no information about the survivors, perpetrators or other key players in any case will be shared without the informed consent of the survivor and this consent should be noted on the case file. Identifying case information (e.g. referral forms) will only be shared within the context of a referral and with the consent of the survivor. Survivor data will not be shared with anyone who is not authorised or does not have a reason to know this information. Full medical reports should only be shared between Health and the Family Support Units; full records of counselling sessions should not be disclosed to other agencies etc.

DATA MANAGEMENT

Currently, case files in the One Stop Centres and Rainbo canters are both paper and electronically based, while Police case files are mostly paper-based. All service providers should maintain a confidential file in both hard and soft copies on their work with each survivor.

All case files-whether paper or electronic- should use a coding system to ensure details of the staff providing SGBV case management service referrals or services, as well as information of the SGBV survivor are anonymised.

When it is fully operational, all data will be submitted and managed electronically through the Primero, an open-source software platform designed for managing protection-related data that facilitates SGBV case management including the provision of referrals between organisations using the web platform, as well as SGBV incident monitoring information management system – GBVIMS+.

PAPER FILE SECURITY

Paper documentation files should be structured, maintained in good order, and updated on a regular basis. The paper documentation especially the intake form and the consent form should be stored in two separate locked filing cabinets/rooms. One locked filing cabinet can be used to store the consent form and the survivor code only. No detail of the incident should be in this file. In the second locked filing cabinet, the intake form together with paper case management documentation (that contains NO identifiable information) can be stored. It is recommended to organise the files per month.

Paper documentation for each SGBV incident should be stored in its own individual file and labelled with its coded incident number. No identifying information, e.g. client names, should be on the outside of paper files. All paper case files should be stored in a locked cabinet, and only be made accessible to individuals specified at the organisation level. No one else should be given independent access to the paper files without permission.

ELECTRONIC DATA SECURITY

Computers containing data on survivors must have a secure password at all times. All soft copies of SGBV data are coded and stored in computers with passwords. Staff should be made aware that if digital information is being transferred that this be done by encrypted and password protected files and that at least two digital backups should exist per site level.

TRAINING OF DATA COLLECTORS

Service providers must be trained on data management and how to set up, use, monitor and protect survivor's data. Only trained caseworkers in government institutions and partners that are providing services to survivors will collect survivor data and will continuously ensure that the benefits of data collection outweigh the risk.

It is recommended that data collectors receive regular training. Training should include safeguarding and inclusive data collection. In addition to training, all service providers will submit a copy of their organisational safeguarding policies, including Child Safeguarding Policy, and Protecting Vulnerable Adults Policy to the National and District Child Welfare and NaC-SGBV to ensure that minimum standards are being followed with regard to confidentiality and safeguarding the dignity of survivors.

The Child Welfare Committee and NaC-GBV should also be made aware of specific confidentiality requirements contained in the Professional Codes of Conduct of Personnel of Service Provider (e.g. medical, school and nursing practitioners etc).

MEASURING PROGRESS ON THE NRP

All monitoring and evaluation activities will be coordinated through the District and National Child Welfare and NaC-GBV established by MoGCA. NRP shall be reviewed annually after the date of implementation by MoGCA and partners.

Each agency with a role in the NRP /SGBV response should develop standardised monitoring forms and indicators. These will show the quality, nature and quantity of services provided. They will be agreed by each agency or Ministry responsible and coordinated by MoGCA. They will be used to report effectiveness of their work in SGBV response. The purpose for the collection of this data should also be jointly defined.

The MoGCA, led by the Chief, will develop a set of indicators, agreed with the other signatories to this 2022 NRP, that measures the level and quality of collaboration, coordination, and communication between agencies and service providers and the quality of services provided. MoGCA will collaborate with partners to provide training on data collection, management and analysis for service providers.

COMMITMENTS AND SIGNATURES TO THE NRP

Minister of Gender & Children's Affairs	Date
Minister of Basic and Senior Secondary School	Date
Minister of Health and Sanitation	Date
Attorney General and Minister of Justice	Date
Minister of Finance	Date
Minister of Social Welfare	Date
Minister of Internal Affairs	Date
Minister of Local Government and Rural Development	Date
Hon. Chief Justice	Date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