



Iraq Genocide Recovery and Persecution
Response - Learning and Pilots (GRPR L&P)

PERSPECTIVES FROM DEVELOPMENT PRACTITIONERS

Iraq GBV Case Management Technical Forum

INTRODUCTION

The Islamic State of Iraq and Syria (ISIS) occupied as much as one-third of Iraq between 2014 and 2017, during which time many from ethnic and religious minority groups experienced gender-based violence (GBV). In addition to militant violence perpetrated by ISIS and its affiliates, GBV was perpetrated by community members, family members, officials and strangers in the crisis context. ISIS targeted Yazidi groups for genocide while targeting other minority groups—such as Christians, Shabaks, and Turkmen—with rape, trafficking and other forms of GBV.

For some, GBV continued after liberation as a result of heightened household tension, the stigma of sexual assault, or social norms that permit and justify GBV. In the Ninewa Plains in the north of Iraq, the conservative norms of many communities limit the opportunities for survivors of GBV to talk about their trauma or to seek support. Furthermore, there is a shortage of trained mental health professionals and social workers in Iraq to provide such support, but competent case management could help make the most of the limited mental health services available and could be an important tool in helping GBV-affected populations return home after displacement and trauma and receive psychosocial support.

The U.S. Agency for International Development (USAID) Iraq Genocide Recovery and Persecution Response,

Learning and Pilots program aims to aid survivors of GBV in the Ninewa Plains. It is part of broader USAID efforts to help persecuted ethnic and religious minorities heal and restore their communities, support economic recovery, and prevent future atrocities.

The Learning and Pilots program facilitates periodic technical learning forums to enhance understanding and support for survivors of GBV. These forums bring together experts and practitioners to delve into challenging topics that service providers encounter when assisting fragile communities recovering from conflict and displacement. The forums provide a platform for sharing, questioning and learning, as well as an opportunity to network and build alliances for future coordination and collaboration.

A learning forum on GBV case management was held in Erbil on December 23, 2019. It included representatives from 10 organizations in Northern Iraq (Mosul, the Ninewa Plains, Dohuk, and Saladin) that provide GBV case management services to women and men, adolescent girls and boys, ethnic and religious minority communities, internally displaced persons and host communities, and non-camp populations.

The following organizations participated in the forum:

- Al-Mesalla
- Al-Afaq for Economic Development
- Alliance of Iraqi Minorities

DISCLAIMER

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- Heartland Alliance International
- Human Appeal
- International Organization for Migration
- INTERSOS
- Iraq Health Access Organization
- Iraqi Institution for Development
- Women's Empowerment Organization.

Learning forum participants discussed how organizations approach case management, the challenges they face and how to overcome them, and strategies to ensure quality referrals for beneficiaries. Participants also discussed case management best practices and informal standards for providing beneficiaries with relevant, quality services. The facilitated discussion covered questions such as:

- What is case management?
- How do organizations perform case management?
- How are case management roles defined within organizations and what kind of training is offered?
- How is case management introduced to beneficiary communities?
- How are referrals among organizations and government entities managed?
- How are challenges addressed?
- What quality assurance measures are taken?

The full set of questions that informed this discussion are given in the annex.

CASE MANAGERS' ROLES AND TRAINING

CHARACTERISTICS OF CASE MANAGEMENT

Learning forum participants described the many different configurations of how their organizations define and perform case management. Some organizations provide case management in clinic settings; others in community settings and homes.

Despite the differences, similarities and a loosely shared understanding emerged among participants. Case management staff perform beneficiary intake, explain available services to the beneficiary, provide referrals, and follow up on referrals made. Participants described an emphasis on assessing needs to determine the most relevant services

available and then providing some level of assurance that the beneficiary received the services.

Compliance structures were also similar. All organizations required completing paperwork tracking services provided, obtaining beneficiaries' consent, and following up on cases, especially those of adolescents and children.

Some organizations have more stringent requirements. For them, case management requires, in addition to connecting beneficiaries to services, a procedural emphasis on proper and improper ways of handling beneficiaries' information and consent and of providing referrals. Many learning forum participants said that they follow the organizational and procedural standards of the GBV cluster which is also referred to as a GBV working group at the provincial level.

ORGANIZATIONAL ROLES FOR CASE MANAGEMENT

Case management is performed by staff with varying levels of responsibility, training and certification and a range of titles and responsibilities.

Most organizations assign a social worker to tasks such as beneficiary intake and registration. Participants did not describe an educational or certification requirement for this role, but a general set of competencies and preferences for training. In many organizations, the social worker explains the case management process and confidentiality procedures to beneficiaries during the intake interview. Because case management is unfamiliar to most communities, some organizations focus on the role of the social worker as "someone to talk to." Technical terms are presented in simplified terms. One participant said social workers in their organization are also responsible for managing the women's center, which entails supervising staff.

In many organizations, a case manager oversees several social workers, makes referrals, follows up on referrals made, and contributes to team meetings to discuss complex cases.

Sometimes there is a team lead, who supervises the case managers, provides higher-level supervision, and assists with complex cases. A team lead is the organization's representative in the GBV subcluster, responsible for coordinating referral pathways. Team leads are also responsible for collecting data and reporting to the program manager.

Some participants said that their organization hires case workers for community engagement. A case worker

identifies potential cases in communities and encourages beneficiaries to visit the center and use its services.

CASE MANAGEMENT PROCESS

During an initial consultation, the social worker opens a case file. She assists the beneficiary in completing the necessary forms, including consent forms, assesses the beneficiary's needs, and discusses the services available.

Many participants emphasized the importance of ensuring that the beneficiary understands and signs the form before referrals are made. After the beneficiary signs the consent forms, the social worker or a case manager makes referrals for services available in the center or the area. A few organizations offer and refer clients for services such as yoga.

In many organizations, supervising case managers are responsible for auditing case files and performing follow-up on referrals. One participant said that after three months of follow-up, a case is closed.

TRAINING

Participants described what they thought should be required training in case management and GBV for all staff working for their organizations. One participant noted the importance of refresher training. Participants also characterized mentoring performed by case managers for social workers as training and described case managers' roles in ensuring case worker training and competency.

Although many organizations prefer social workers to have a bachelor's degree in psychology or sociology, many participants focused on the value of a person's skills and experience, in particular the ability to follow confidentiality procedures, to listen effectively, to be sympathetic but not empathetic, and to be precise communicators. Social workers must demonstrate these competencies in written tests, assessment interviews, and completing specialized training in GBV, case management, psychosocial support (PSS), and trauma response. Other relevant training covers GBV in emergencies, child protection, data protection systems, and preventing sexual exploitation and abuse. Working with adolescents and children requires further, specialized training, as well as more coordination among an organization's social workers and supervisors.

Organizations providing case management services in the Ninewa Plains approach training differently. Some align staff training to the specifics of a project. If a target community has specific needs or sensitivities, such as Yazidi

communities, training is tailored to meet those needs. Other organizations provide a baseline level of training for all staff on general protection and case management. Specialized training, such as intensive case management training for GBV social workers and case managers, is offered. The third level of training is through coaching or mentoring, to provide staff with on-the-job support and to fill capacity gaps. Some organizations have the capacity to provide training internally and can also offer training to partners and other community service providers, such as hospital workers or teachers. Some organizations out-source training to another organization.

Participants viewed training quality as important, saying that training should come from qualified trainers who are viewed as "certified" through participation in training delivered by trusted organizations that are experienced with case management. Participants described qualifications conferred by participation in train-the-trainer sessions and conveying technical information clearly and knowledgeably.

"Certified" training organizations are equated with organizations whose training is trusted, funded and adopted by donors and multilateral organizations such as Save the Children, International Rescue Committee, and World Child International. According to the participants, the measure of success for training-the-trainer sessions is the ability of newly trained trainers to transmit the core knowledge at the same level at which they were trained. Another way for a trainer to gain this level of proficiency, besides taking train-the-trainer courses, is by facilitating sessions led by a trainer and learning by example.

SUPERVISION

Social workers and case managers were considered able to work independently when they consistently showed competency in safety, confidentiality, and respecting a beneficiary's dignity. Social workers and case managers also must be able to complete forms and reports correctly, because these documents create the sequence of assessments, referrals, and services offered. Beneficiary reaction is also important for determining if a social worker or case manager is sufficiently prepared. For example, the fact that a woman returns to a service provider to continue receiving services suggests that she is satisfied with and benefits from the services.

Participants also pointed to the role of teams (e.g., case workers, program managers) in providing follow-up and assessing the social worker's performance.

One participant noted that social workers cannot be hesitant when performing duties or show uncertainty

about how to perform their job, including protecting confidentiality during case review with other practitioners in the center, and in making referrals. Another participant pointed to the use of tools to judge a social worker's or case manager's competencies.

Supervision can be structured through evaluation tools, team meetings, and case meetings. Many organizations use forms from the GBV Information Management System. Once a social worker or case manager refers a beneficiary for services, she or he then provides follow-up after the referrals.

Many participants noted that not only technical competence, but also the attitude of practitioners is crucial, especially when addressing GBV in communities with conservative norms. A practitioner who blames the beneficiary for their experiences of violence or has strong opinions about how the beneficiary ought to respond to violent experiences can be harmful for the beneficiary. One participant spoke about using attitude tests during interviews but emphasized that more work is needed to address attitudes among GBV case managers.

One organization noted the difference in supervision between cases that are managed in a center and case management and services delivered in homes or other places in the community. When services are not delivered in a center or during community engagement, social workers need to have skills in identifying and assessing beneficiary needs and may have a different structure for supervision and mentorship.

CENTER SERVICES

Participants noted the sensitivities surrounding GBV and therefore the importance of how GBV services are promoted to communities and beneficiaries. They identified the provision of multiple services as a best practice to moderate these sensitivities.

Participants explained that getting beneficiaries inside the center through activities such as workshops, vocational training, and sewing presents opportunities for coordination with GBV services. Once women and girls attend workshops or training at the center, they can access GBV services more easily. Participants also stressed that the services should be differentiated from GBV issues and not all should be thematically linked to GBV. One participant said that their organization has a multipurpose center providing access to complete health services. Another participant said that centers should provide core services in livelihoods and health.

PARTICIPANT RECOMMENDATIONS

1. Confidentiality and consent should be prioritized as critical aspects of case management that should be reinforced through training and case supervision.
2. Organizations should provide quality training and retraining for all staff, with targeted training for specialized staff.
3. Organizations should hire case management staff with academic degrees in psychology or sociology while also accepting that training and experience may be more important than a degree.
4. Attitude matters. More work is needed to change social workers' and case managers' attitudes toward GBV and beneficiaries with GBV experiences.
5. Organizations should coordinate with the GBV sub-cluster and use its forms if possible to follow a standard and create consistency in service provision.

COMMUNITY ENGAGEMENT

Organizations have different approaches to raising awareness about case management services. Some use training on livelihoods or PSS to attract beneficiaries to the center and then connect beneficiaries with case management services. When GBV issues arise in other services or workshops, social workers discuss confidentiality to address participants' concerns.

AWARENESS-RAISING APPROACHES

Community engagement includes using fliers and newspapers to provide general information about case management services and the types of services provided. More specialized services such as GBV are generally not included in printed materials and are discussed in person as needed.

Other organizations use mobile teams with expertise in GBV and case management for community engagement to reach beneficiaries, to offer psychological first aid, and to identify potential cases. Additional mobile teams provide services to beneficiaries who are not able to receive services at the center.

Another organization described combining community engagement with awareness-raising, using curricula such as Women Speak Out and the Turning Point Program. Through these programs, women and men are taught about gender equality and decision-making. Sex-segregated workshops and joint workshops are held, and the organization assesses the progress made.

RECRUITING

Participants had diverging views about whether it is better to recruit staff from within communities or whether outsiders are more effective in community engagement. Some found that GBV case management requires trusted community members. Others asserted that beneficiaries are wary about meeting with a social worker known to the community for the intake interview because of concerns that the social worker would breach confidentiality. Fear of gossip and judgment is strong; thus, outsiders are preferable for conducting GBV community engagement.

STIGMA

Stigma may be associated with the term “case management” when communities are familiar with the concept, particularly in GBV cases, and so other descriptions are preferred for community engagement purposes. Similarly, one participant recommended that during community engagement, using terms and concepts for GBV and case management that are familiar to the community puts potential beneficiaries at ease. Staff should therefore be trained on the relevant local terms and concepts.

Multiple participants said that during community engagement, information about all the services offered at a center should be provided, and community members should be encouraged to visit for more information about specific services. A participant described the risk of associating a center with mental health services, citing an example of a center in Ninewa that was associated with stigma because of how the center’s services were introduced to the target communities. As a result, the center encountered difficulties reaching beneficiaries and relies on other organizations for referrals.

ENGAGING LEADERS AND STAKEHOLDERS

Some communities were inaccessible, “locked” according to one participant, no matter what kind of community engagement takes place. To build trust, this organization prioritizes building relationships with community and religious leaders. For example, in Christian communities, the organization seeks to strengthen relationships with religious leaders. Some activities are held in church spaces, and some religious leaders share information about services during sermons. This helps to build trust and to overcome resistance from the community.

One participant noted that although working with community and religious leaders is important, this approach risks excluding minority groups not necessarily represented by these leaders. Instead, she recommended finding a community member who has the trust and affection

of the whole community—someone who may not be a leader but who is trusted and holds influence. She also recommended the GBV subcluster for shared advocacy and problem solving to overcome challenges in engaging communities.

LOCAL GOVERNMENT PRIORITIES

Service providers sometimes encounter resistance from local governments, when authorities claim a mismatch between the services offered and the investments that the local government prioritizes. Local governments often prefer international donors and NGOs to offer services besides PSS programs and resist issuing the necessary permits.

Participants agreed about the importance of coordinating services to avoid duplication, but also asserted that local governments often do not value PSS services or activities promoting change in social norms because they do not view them as community needs. This view highlights the importance of avoiding stand-alone GBV or PSS services, and of mainstreaming these services with other services. An example cited was the provision of hospital improvements and health services in the hospital that included GBV services.

Participants stated that psychosocial wellbeing is not a high priority for the Iraqi government. One participant suggested that more progress might be made training social workers and clinical workers in the Iraqi system on GBV issues. Another participant said, however, that their organization had conducted training to promote skills and build capacity among Iraqi government employees, but a larger-scale attitude change had not emerged.

PARTICIPANT RECOMMENDATIONS

1. Service providers should coordinate with local governments to learn their programming priorities and should advocate with government actors to recognize the importance of PSS services for conflict-affected populations.
2. Donors and implementing partners should improve coordination to avoid duplication of programs, which can overwhelm or frustrate local government.

REFERRALS

Before an organization establishes a case management platform, the services available to a community should be mapped, and a referral pathway coordinated with a ‘do no harm’ approach at the center. The key ‘do no harm’

approaches for making referrals include confidentiality, protection of the survivor, and consent procedures. After a referral is made, the case manager continues to follow up, track, and maintain contact with the referral organization to monitor progress.

REFERRALS BETWEEN ORGANIZATIONS

When organizations make referrals for services outside of their organization or partnership networks, many use established forms, such as from the GBV subcluster, that include an emphasis on ensuring that consent is secured from the beneficiary before a referral is made.

Participants said a main challenge is when an organization makes a referral but does not receive a response or the response is slow—a problem when the need for services is urgent. Another challenge is when the case is referred and services are provided, but no information is available about the extent of services provided.

Many organizations follow up when there is no response to a referral, such as after three days, or sooner if the case is urgent. Participants also spoke about the need for coordination among organizations to mitigate non-responsiveness and to communicate information about the case and its level of urgency. These comments imply a level of informal communication and networking among staff at different organizations rather than a formal structure. Yet, as one participant noted, the communication about coordination among organizations often happens at the level of team lead or other supervisory position and is not necessarily communicated to the case worker or manager who makes the referral.

One participant described their organization's service map, which is updated during team meetings. It includes the different points of contact about who manages different aspects of referrals. Referrals are made in a format that is agreed on by their organization and the other organizations in the service map. The case is discussed by phone or through protected email to ensure confidentiality.

Services for women are often unavailable. Some referral organizations do not take certain cases. For example, few organizations take legal cases regarding altercation between spouses, including divorce or alimony. These organizations may not have funding for adequate legal services and therefore will provide only consultation and mediation rather than a full range of services. This is also due to the length of time these cases take. Other referral organizations may offer very limited services. For example, some organizations provide medical diagnosis but do not prescribe medication or provide treatment.

GOVERNMENT REFERRALS

Participants spoke to the greater challenges referring to government agencies compared to other organizations. With organizations, participants can call to see why a referral has not received a response. It is much more difficult to follow up with local government institutions unless there is a personal connection between the case manager and someone in that government office.

The effectiveness of the referral is also based on the capacity and skills of the person in the government office who receives the referral. Some staff in the local governments do not take GBV-related issues seriously, which makes the connections between the case manager and the government employees even more important. In other cases, the government staff do not want to get involved in the complexity that can develop in cases such as harassment, and it is not considered a serious issue.

In some locations, there are community police units, and units for child and family protection in the police stations. But there is a shortage of staff, guidance and funding to meet the needs in these areas. These units often accept only intimate partner violence and sexual harassment cases, not other GBV-related cases.

QUALITY ASSURANCE OF REFERRALS

Participants described different methods of assuring the quality of referrals, but all participants expressed both the importance of quality assurance as well as the limitations they face in this endeavor. The GBV subcluster lists the services that each participating GBV service-providing organization offers, but these are only for organizations with a GBV program for the purposes of service mapping. The GBV subcluster does not conduct capacity assessments of service providers, but it does provide case management forms and guidance on how to use them and on how to provide case management services. Some participants said that referrals should be made only to organizations that are registered with the GBV subcluster.

Participants also spoke about performing occasional site checks to ensure that the services listed are provided. Other participants described their organization's safety audits, which include visiting the areas served, meeting community leaders, asking about the services available from the organizations, and the sustainability of the services. Another participant described her organization's service mapping of their contacts, who are also often members of the GBV Cluster. A rapid assessment is performed in a phone call about the services available. Another participant said that most organizations do some service mapping, but that this does not necessarily

address quality. The participant's organization conducts client satisfaction surveys that include questions about the quality of the referral, but this information is not necessarily shared across organizations.

One participant made a similar point about not having enough time to assess a referral organization in advance. Asking about the quality of an organization's services creates sensitivities because it indicates doubt about the organization. And the need to make referrals quickly reduces the time to research the quality of services. In practice, what happens is "assessing by doing," which means that feedback from beneficiaries about a referral organization affects the willingness to continue making referrals to the organization. In the end, the only way to evaluate the quality of services is to obtain feedback from women about their experiences.

Children and adolescents require procedures that are age and gender appropriate. One organization described agreements they have with child protection and GBV agencies for adolescent cases, because these differ from case management for adults. Adolescent cases can present complications that require team conferences to address, especially when the perpetrator is a parent, because adolescent cases require the involvement of a child's custodian. Referrals in these cases are carefully tracked with follow-up.

PARTICIPANT RECOMMENDATIONS

1. Use the options available within time constraints.
2. Maintain good relations with other service organizations to verify the quality of services offered by organizations to which referrals are made.
3. Leverage professional or personal relationships when making referrals to local governments to improve the likelihood of the government point of contact responding to the request.

KEY CHALLENGES

1. Negative attitudes of local government workers, social workers and case managers to GBV and those receiving GBV services.
2. The lack of time to assure the quality of service referrals and the suspicions raised when quality assurance questions are asked about referral organizations' services.
3. Effective coordination along referral pathways to ensure timely response to referrals, and appropriate follow-up between organizations.

4. Absence of sharing information with all relevant staff about plans to coordinate referrals among organizations.
5. Difficulties referring to local government offices, particularly in the absence of personal connections.
6. Absence of a culture conducive to maintaining confidentiality and the lack of professional standards or laws that hold professionals accountable for violating confidentiality.
7. Weak and inconsistent practices in record keeping and case file procedures across organizations.

CONCLUSION

Case management is an important function. It connects beneficiaries from communities in Northern Iraq suffering the impact of ISIS to services that they need. GBV is a sensitive issue and requires careful, knowledgeable engagement to protect beneficiaries' privacy and ensure consent before making service referrals or sharing information, avoiding deepening stigma, and avoiding retraumatizing beneficiaries. This brief draws on the experience of organizations that provide case management services in Northern Iraq. The information provided by the participating practitioners points to minimum standards for case management in that region.

The tiered structure of case management responsibilities in organizations, where social workers receive supervision from case managers or team leads, provides insight into how case management responsibilities are assigned within organizations, how oversight and supervision are structured, and how complex cases require multiple team members.

The responses also highlight the challenges in providing beneficiaries with quality services and addressing stigma associated with mental health and gender-based violence.

Four elements recurred in the aggregated responses:

- The value practitioners expressed in having a resource such as the GBV subcluster
- The importance of ensuring beneficiary consent and protecting privacy
- The importance of training for staff who contribute to case management
- The need to support social norm change to address stigma surrounding GBV and mental health.

Recruitment for and use of GBV, PSS, and mental health services are more effective when these services are

integrated into service packages that include less-sensitive components. These may be awareness-raising activities, livelihoods training, or recreational activities that bring women and girls to centers where they can access case management services more discreetly.

Although participants noted best practices and points of agreement, they also noted areas that require improvement: bias and stigma surrounding GBV in these communities and social norm change among local government workers and case managers. Furthermore, although participants found the GBV subcluster useful, they also

suggested that the group could take a more robust role in identifying and assessing services and training service providers.

Participants agreed that the quality of services, ensuring confidentiality, and providing staff with rigorous training were critical to meeting the needs of the communities in which they worked. A potential follow-up to this learning brief could be an assessment and map of communities' perceptions of case management and services available as the communities grow familiar with them.

ANNEX A. DISCUSSION QUESTIONS

INTRODUCTION TO CASE MANAGEMENT

1. How does case management look in your organization?
2. Who does the case management?
3. How do you prepare case managers?
4. What are the components of case management?
5. What does each component contribute?
6. Who decides to close a case and when?
7. What kind of support is provided to case managers to help them handle their own responses to the difficult information they are hearing (e.g., secondary trauma)?

CASE MANAGEMENT AND CONTEXT

1. Do you think the social context impacts the way you do case management? Do you use different approaches with different groups or in different locations?

EXPERIENCE AND TRAINING

1. What qualifications do case managers have?
2. Does your organization offer training for case managers?
3. Do case managers have training from outside of organizations, such as through education programs or professional training organizations?
4. What level of expertise do case managers have in organizations working in this area?
5. What is the indication that a case manager is sufficiently trained? (E.g., is there a period of supervision, or apprenticeship)
6. What groups or networks about case management does your organization participate in?

COMMUNITY ENGAGEMENT AND INTRODUCING CASE MANAGEMENT

1. How do you usually introduce case management to the community? What are the challenges?
2. How do you introduce confidentiality and privacy practices to community?
3. How do you invite women and girls to use case management services? How do women and girls become aware of services if they are not present when services are introduced?

4. What level of community acceptance of case management have you observed in different locations? Have you faced any resistance from communities or other challenges? If yes, how these have been resolved?
5. Does the involvement of other people (families, religious people, etc.) impact the case management or raises any considerations, challenges, or benefits?

REFERRALS

1. How do you make referrals in case management?
2. How well does the referral process work among organizations? What are the challenges?
3. How well does the coordination work among governmental departments like DCVAW, police and medical centers? What are the challenges?
4. What happen if you are working in an area that has the lack of services?
5. Do you evaluate the services before referring cases to them? If yes how?
6. After referring, do you do any kind of follow-up? Who does it and how?
7. Where do you refer girls under 18 years old?