

Service Mapping

It is essential before setting up case management services “to know and understand what services exist in the community and the extent to which they are functioning” and accessible.¹ This will help identify gaps and determine ways to address service or access needs. This information, in fact, may already be collected and available. Try reaching out to other GBV and protection actors before duplicating processes and to minimize assessments. If the information is not available, a mapping exercise can be a helpful way to visualize existing services and identify gaps.

Service mapping is a key activity prior to the delivery of case management services.

How can you refer survivors to services if you do not know what services exist? Or if you do not know whether or not they are functioning, whether or not they are survivor centered, or whether or not they are accessible? Service mapping is the first step to establishing an effective referral pathway. Detailed information about the services available and establishing referral protocols is required to adequately inform survivors about all of their options during the case management process. To do an effective service mapping, in addition to talking to service providers, it is important to consult with community members, women and adolescent girls (separately) about where they feel safe accessing services, the quality of all services identified and barriers to access existing services.

For a multi-sectoral response to GBV, services prioritized include health services (including clinical care for sexual assault survivors), psychosocial support services, safety/ security services and legal /justice services as well as child protection services. However, a thorough mapping can also identify other services available such as livelihood support services, services for persons that identify as LGBTI, disability associations, etc. to meet individual survivor’s needs. In addition, case workers must be “familiar with the range of multi-sector services available and engage regularly with other agencies to ensure a coordinated process of referral, service delivery and follow-up.”²

With each service, it is important to document: the organizations name, location, a (preferably female) GBV focal point, contact phone number, email address, services available, hours available, and any requirements /restrictions to access (such as target populations restrictions, fees or mandatory reporting



requirements). It is also important to identify transportation options and considerations for survivors to get to services. In addition, the below questions should be included:

For focus group discussions with community members (gender- and age-disaggregated):

- Health services: Ask where women or girls who are survivors of violence feel safe and comfortable going to receive medical treatment. Ask about informal health providers, who may have regular access to potential survivors, especially in places where formal services are limited. For example, ask where or to whom women would go for prenatal care and delivery, as well as about the existence of any community health workers that visit the community.
- Safety options: What does the community do to protect women and girls? From whom can women and girls seek assistance in case of an immediate safety risk? Are there other services or support (counseling, women's groups, legal aid, etc.) available for women and girl survivors? Are there any safe houses available to women?

For interviews with service providers:

- Are there any restrictions on who could access services? (For example, do they provide services to people who do not have documentation, etc.?). Are there any fees associated with services? Are there any mandatory reporting procedures? Is there a confidential and safe documentation system?
- Can a means be established for the service provider to pay for transportation costs, which your organization can reimburse?
- What other services are in the community that the team may not be aware of and were not mentioned in the focus groups? For example, are there associations or other organizations that engage with and advocate for the rights of specific vulnerable populations?
- Find out whether service providers can be reached by and receive referrals via telephone, and during what hours.
- Do service providers have concerns about their information being publicly available and distributed on a referral pathway? (E.g. there may be safety concerns for organizations working with the LGBTI population, those working with populations without legal status, or those associated with opposition groups).

Identify Gaps in Service Quality

"Once you have completed your mapping [or accessed previously-collected service mapping information], you can begin to look at critical gaps in quality of services. You will want to examine gaps that prevent survivors from receiving a minimum standard of care.

Examples of gaps in quality of services include not having trained staff, not having equipment or supplies at the health center, or not having a safe place

where survivors can go to tell someone what has happened, get information about their options and receive emotional and practical support. This lack of a safe space is particularly common in humanitarian contexts, and especially concerning as survivors can be at risk of further harm from perpetrators, their supporters and even from their own family members and others in the community. There is no one model for ensuring survivor safety—what works in one setting may not be appropriate in another. You will need to work with community stakeholders to identify a range of safety options that take into account the different needs of survivors.

It is important that all actors responding to GBV are familiar with local service gaps so they do not create false expectations about the existence of services that are not available or are not survivor-centered.

When you know about all the gaps in services, you can work with stakeholders to identify and plan ways to fill them. Strategies for filling gaps might include building the capacity of existing service providers, coming up with creative solutions to adapt existing resources, or advocating for more resources to close service gaps. You won't necessarily be able to fill all the gaps and fix all the problems immediately, but you can work with other stakeholders to prioritize and develop a plan.”³

Understanding the extent to which existing services are functioning and accessible

Understanding the extent to which existing services are functioning i.e. whether they are providing survivors with a minimum standard of care in line with the GBV guiding principles, and accessible i.e. whether GBV survivors, in particular women and girls, are able to access the services in practice, is essential. It is necessary to understand whether services are functioning and whether they are accessible before referring survivors to avail of them. It would be incompatible with the survivor-centered approach to do otherwise and to refer survivors to services that may not provide them with a minimum standard of care or that they may not be able to access.

Improve Accessibility of Services

“Even where services are available, they may not be accessible to all survivors. There are many reasons why GBV survivors find it difficult to access services. Some common ones are:

- Distance to services
- Lack of security
- Cost of services
- Lack of trained female staff
- Lack of privacy and confidentiality in services
- Providers' attitudes towards survivors
- Perceptions of services by people in the community
- Community beliefs about sexual purity and family honor
- Family pressure not to seek services

- Family or community repercussions for disclosing the violence
- Administrative barriers, such as requirements to obtain documentation from police before accessing medical treatment, lack of official identity card, etc.
- Services not provided to foreign nationals or people not from the local area
- Perception that services are not available or friendly to certain groups of people (e.g. LGBTI persons).

To plan how to reduce barriers to services and care, you can do a participatory assessment and work with stakeholders to come up with solutions to problems identified. Note that some barriers may be easy to identify through the assessment, while you may not become aware of others until later.”⁴

What tools are available?

- Inter-agency GBV Case Management Guidelines, Service Gap Analysis and Planning Tool
- Inter-agency GBV Case Management Guidelines, Barriers to Care Analysis and Planning Tool
- GBV Sub-Sector, Case Management Minimum Standards Checklist
- GBV Sub-Sector, Health Minimum Standards Checklist
- GBV Sub-Sector, Women’s Safe Space (WSS) Minimum Standards Checklist
- IRC, GBV Assessment Tools: Community Mapping Guidance Note
- IRC Assessment Toolkit – 2011 Part 2: Service Mapping
- Women’s Refugee Commission, Service Provision Mapping Tool: Urban Refugee Response⁵
- RHRC Consortium, GBV Tools Manual: Situational analysis guidelines⁶

Case Studies for Consideration

- **Mandatory reporting within health services for rape survivors.** In several countries (examples: Iraq, Myanmar, etc.), health providers are mandated to report cases of rape to authorities. Survivors need to understand that, if they access these services, their confidentiality will be compromised. If we do not document this through service mapping and a referral pathway and inform survivors about this requirement of access, we may contribute to further harm. This could be handled by further mapping if emergency contraception is available in pharmacies over the counter. Then, we can document and support access to this intervention/service if survivors are uncomfortable seeking health services requiring mandatory reporting.
- **Service Provider Confidentiality.** In general, after service mapping it is important to increase awareness about all services available to survivors, documenting services/referral pathways and disseminating this information to the entire community. However, some specialized

service providers may be put in danger if their information is distributed associated with their services (i.e. ethnic minority service providers/leaders when the group is in conflict with government authorities or LGBTI service providers in countries with repressive laws/targeted violence). It is important to get the service providers permission before distributing their information.

- **Service Limitations.** Some religious NGOs mistakenly associate emergency contraception with abortion and refuse women access to emergency contraceptive pills. It is important to document the restrictions to services provided.
- **Age-Restrictions on Services.** Adolescent girls may have a difficult time accessing services compared to adult women due to service provider attitudes and age restrictions. Include documentation of population group coverage in your mapping.

Below are checklists to audit services against:

GBV Sub-Sector Case Management Minimum Standards

- ALL WOMEN Staff
- All activity facilitators are female (ie: information/education sessions)
- Two or more staff present in the WSS
- Staff trained on PSS, PFA, risk reduction, VAWG/GBV Guiding Principles, woman/survivor centered support (i.e: Staff can name the Guiding Principles: Safety, Confidentiality, Respect/Dignity, Non-discrimination)
- Staff should be able to describe WSS as a space for women and girls (not a GBV/SGBV center or survivor center or child-friendly space)
- No visible signs with GBV or “SGBV” on it
- Women’s Safe Space (WSS) is clean, welcoming, and maintains privacy from the public
- Group activities, materials, and supplies are sufficiently available
- Women and girls consulted on activities in the WSS
- Staff know safe referral links: know the exact name and number of the health professional who can provide Clinical Management of Rape (CMR)
- Staff know safe referral links: know the exact name and number of the health professional who can provide case management for women and girl survivors of male violence
- Is there a place for more than 10 women to sit (i.e: mat, chairs)
- Confidential room is available (optional)
- Informed consent for referrals is known by staff
- Does the WSS have separate sessions for women and adolescent girls? (i.e: Depending on time of day, observe if activity is happening separately for women and adolescent girls)
- No men present in the WSS – this includes donors and visitors
- Men are not congregating or loitering outside the WSS

Women's Safe Space Minimum Standards Checklist

- ALL WOMEN Staff
- All activity facilitators are female (ie: information/education sessions)
- Two or more staff present in the WSS
- Staff trained on PSS, PFA, risk reduction, VAWG/GBV Guiding Principles, woman/survivor centered support
- (ie: Staff can name the Guiding Principles: Safety, Confidentiality, Respect/Dignity, Non-discrimination)
- Staff should be able to describe WSS as a space for women and girls (not a GBV/SGBV center or survivor center or CFS)
- No visible signs with GBV or "SGBV" on it
- WSS is clean, welcoming, and maintains privacy from the public
- Group activities, materials, and supplies are sufficiently available
- Women and girls consulted on activities in the WSS
- Staff know safe referral links: know the exact name and number of the health professional who can provide Clinical Management of Rape (CMR)
- Staff know safe referral links: know the exact name and number of the health professional who can provide case management for women and girl survivors of male violence
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Health Minimum Standards Checklist

- Medical personnel include clinical health workers trained in provision of clinical management of rape within the last 6-12 months
- Linkage with female case worker/female social worker (internal/external)
- Complete supplies and medications for offering post-rape treatment are available
- Post-exposure prophylaxis
- Emergency Contraception
- STI medicines / antibiotics
- Hepatitis B vaccine
- Tetanus vaccination
- Safe, confidential space for examining patients available
- Facility-level protocols in place for receiving women and girl survivors and managing clinical care (linked to CMR trained medical staff)

- Non-identifying exit/entry into facility and examination spaces for women and girl survivors

¹ From the Inter-Agency Case Management Guidelines, https://gbvresponders.org/wp-content/uploads/2017/04/Interagency-GBV-Case-Management-Guidelines_Final_2017_Low-Res.pdf

² UNFPA, Minimum Standards for Prevention and Response to Gender-Based Violence in Emergencies, available at <https://www.unfpa.org/sites/default/files/pub-pdf/GBVIE.Minimum.Standards.Publication.FINAL_.ENG_.pdf> p.56-57.

³ Ibid.

⁴ Ibid.

⁵ <https://www.womensrefugeecommission.org/images/zdocs/Urban-GBV-Tools-Mapping-Services-Pilot.pdf>

⁶ https://reliefweb.int/sites/reliefweb.int/files/resources/FC881A31BD55D2B3C1256F4F00461838-Gender_based_violence_rhrc_Feb_2004.pdf