Referral Guidelines

for Women and Girl Survivors of Gender-Based Violence

2016

Developed with support from:

Australian Aid

អនុវត្តដោយ:

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

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PREFACE

The 'Guidelines for Referrals for Women and Girls Survivors of Gender-based Violence' (Ministry of Women's Affairs, 2016) are to be used by relevant service providers, including Judicial Police Agents (JPAs) of the Ministry of Women's Affairs (MoWA), to improve the quality of service delivery to women and girls survivors of Gender-based violence.

These guildelines have been developed in line with the Strategy 2 "Legal Protection and Services" of the Second National Action Plan to Prevent Violence against Women (2014-2018) and the Fourth, Five Years Strategic Plan for Gender Equality and Women's Empowerment (2014-2018), known as Neary Ratanak IV of MoWA, in order to ensure that women and girls have equal access to legal protection. These guidelines complement the existing legal framework in Cambodia to end Violence against Women and Girls, especially the Law on Prevention of Domestic Violence and Protection of Victims (2005) and the Criminal Procedural Code (2007).

The development of these guidelines are part of the significant efforts made by the Royal Government of Cambodia to reinforce national policies and laws in alignment with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the international human rights framework.

I have a strong confidence that these guidelines will become a useful tool to enhance further collaboration among relevant ministries, institutions, civil society organizations, development partners, and the private sector by ensuring timely and effective referral of women and girls victims/survivors of gender-based violence, which are an essential part of the overall response to Violence against Women and Girls.

On behalf of the Ministry of Women's Affairs, I would like to express my sincere thanks to all relevant government institutions and non-governmental partner organizations at sub national level and national and international experts for their good cooperation and inputs during the formulation process of these guidelines. I would like also to thank the development partners for their technical and financial support especially for the technical expertise provided by GIZ-ATJW II to develop these guidelines, in particular the German Federal Ministry for Economic Cooperation and Development (BMZ) and the Australian Department of Foreign Affairs and Trade (DFAT) and GIZ, a bilateral partner of MoWA for the implementation of the Access to Justice for Women II program (2014-2016).

Issued in Phnom Penh, 04 - August 2016

Minister of Women's Affairs

Dr. Ing Kantha Phavi

ACRONYMS

AECID	Spanish Agency for International Development Cooperation
ATJW I	Access to Justice for Women phase 1
ATJW II	Access to Justice for Women phase 2
BMZ	German Federal Ministry for Economic Development and Cooperation
CCA	Client Center Approach
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
DFAT	Australian Department of Foreign Affairs and Trade
GBV	Gender-based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammernarbeit
MoH	Ministry of Health
MoSAVY	Ministry of Social Affairs Veteran and Youth Rehabilitation
MoWA	Ministry of Women Affairs
2nd NAPVAW	National Action Plans to Prevent Violence Against Women 2014-2018
PDoWA	Provincial Department of Women's Affairs
Referral Guidelines	Referral Guidelines for Women and Girl Survivors of Gender based Violence
UNFPA	United Nation Population Fund
STIs	Sexually transmitted infections
WHO	World Health Organisation
WCCCs	Women and Children Consultative Committees

DEFINITION OF KEY TERMS[1]

Basic counselling: The way service providers communicate with survivors and provide care for their immediate emotional and practical needs.

Case management: A method of service delivery based on an assessment of need, coordination of service delivery of multiple services from different providers to respond to survivor needs.[2]

Case Manager: The staff persons that coordinates the process of case management including assessment of need, and coordination of services, referrals to other service providers, follow-up and case closure. The case manager is also responsible for documentation of all services or referrals provided.

Child: A person under the age of 18 years old unless under the law applicable to the child, majority is attained earlier.

Coercion: Forcing, or attempting to force, another person to engage in behaviour against her/his will by using threats, verbal insistence, manipulation, deception, cultural expectations, or economic power.

Community of Practice: A community of practice is a group of people who share a common concern, a set of problems, or interest in a topic and who come together to focus on sharing best practices, fostering collaborative relationships and creating new knowledge to advance an area of shared interests in a defined area of specialization.[3]

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1 Definitions adapted from National Guidelines for Managing Violence Against Women in Health Settings, WHO Clinical Handbook for Women Subjected to Intimate Partner and Sexual Violence in Cambodia, and Minimum Standards of Counselling to Survivors of Gender-based Violence Against Women, unless otherwise referenced.

2 National Association of Social Workers. Accessed at http://work.chron.com/social-work-case-manager-9271.html

3 GIZ. Capacity Works Success Factor Tool 5 and Community of Practice Design Guide accessed at https://net.educause.edu/ir/library/pdf/nli0531.pdf.

Consent: Making an informed choice freely and voluntarily to do something. There is no consent when agreement is obtained with threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.

Domestic violence: Domestic violence as defined by the Law on the Prevention of Domestic Violence and Protection of Victims, (2005) includes violence against a husband or wife, dependent children or persons living under the roof of the house, and those who are dependents of the households.

Duty Bearer: Duty bearers are those actors who have a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations. The term is most commonly used to refer to State actors, but non-State actors can also be considered duty bearers. Individuals (e.g. parents), local institutions, private companies, aid donors and international institutions can also be duty-bearers.

Gender-based violence: Gender-based violence is defined in this document as "violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, emotional, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."

Indecent Assault: Article 246 of the Penal Code of Cambodia (2010) defines indecent assault as touching, fondling or caressing the sexual organs or other parts of a person without that person's consent or coercing another person to perform such acts on the perpetrator himself or herself or a third person for the purpose of arousing the perpetrator or providing sexual pleasure to the perpetrator constitutes indecent assault.

Indecent Exposure: Article 249 of the Penal Code of Cambodia defines indecent exposure as any incident exposure of sex organs to others in a place that is accessible to the public eyes.

Intimate partner violence: Behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours.

Institutions: Refers to service providers or agencies that are government or non-government organisations.

Perpetrator: A person, group or institution that directly or indirectly inflicts, supports, and condones violence or other abuse against a person or a group of persons.

Rape: Article 239 of the Cambodian Penal Code defines rape as all acts of sexual penetration, of any kind whatsoever, or an act of penetrating any object into sexual organs of a person of either the same sex or different sexes by violence, coercion, threat or surprise.

Referral: The process of sending survivors to appropriate services. Referral can take place at three different levels as follows:

1) **Survivors' self-referral:** this occurs when a survivor makes direct contact with a service provider and is not referred or sent by another person.

2) **Inter-agency referral:** referrals that take place among agencies. For example, referrals from legal aid organisations to shelter based institutions or referral from state agencies to non-governmental institutions.

3) **Intra-agency referral:** referral that takes place within an institution for different services. This type of referral could take multiple forms, e.g. referral from volunteers, who work at the community level, to the offices of the service provider in the provincial capital; or referral between organisational departments, for instance, referral from a first contact person to the counsellor.

Service provider: All staff of institutions which are state and non-state entities, volunteers and duty-bearers providing services and support to GBV survivors.

Sexual harassment: Article 250 of the Penal Code of Cambodia defines sexual harassment as an act where a person abuses the power which was vested in him/her in his/her functions in order to put pressure again and again on other persons in exchange for sexual favours.

Sexual violence: Any sexual act, attempt to obtain a sexual act, unwanted comments or advances or acts to traffic, or otherwise directed toward a person's sexuality, using coercion, by a person, regardless of their relationship to the victim, in any setting, including but not limited to home and work.

Survivor: A person who has been physically, sexually and/or psychologically violated and is being served by a service provider. Some service providers call survivors clients, patients, crime victims or other labels.

Violence against women: Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

PART 1 INTRODUCTION

1.1 BACKGROUND

The Referral Guidelines for Women and Girl Survivors of Gender-Based Violence (Referral Guidelines) were developed to promote comprehensive services to women and girl survivors of gender-based violence (GBV) through a system of case registration, assessment and referral to services based on the individual needs and agreement of the survivor.

Gender based violence against women is a human rights violation with consequences that impact women's lives. According to the World Health Organisation 1 in 3 women in the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner.[4] Past research has shown that female survivors of GBV in Cambodia have multiple and complex needs and that response services are scattered and not adequately coordinated.[5] The Second National Action Plan to Prevent Violence Against Women (2014-2018) –known as Second NAPVAW- has prioritized improved provision of comprehensive services to GBV survivors, specifically to better coordinate and improve referrals between services.[6]

The development of the Referral Guidelines was based on research and consultation with key stakeholders through multiple processes. In the first phase of Access to Justice for Women 2011-2013 (ATJW 1), implemented jointly by the Ministry of Women's Affairs of Cambodia (MoWA) and

4 http://www.who.int/reproductivehealth/publications/violence/VAW_infographic.pdf?ua=1

5 MoWA (2012). Feasibility Study for One-Stop Service Center. Phnom Penh, Cambodia.

6 MoWA (2014). National Action Plan to Prevent Violence Against Women 2014-2018. Phnom Penh, Cambodia.

GIZ[7] a baseline study was conducted. This survey examined the quality of the services provided by both state and non-state actors in two Cambodian provinces –Siem Reap and Kampong Thom - and revealed that referrals were problematic amongst both state and non-state actors at almost all levels. Next consultations were held to better understand experiences in service provision and referrals with service providers in non-governmental organisations and state agencies at the national and sub-national levels working in GBV. This study helped to understand the current practices and identify referral pathways. The findings of the two studies helped to inform the draft Referral Guidelines.

In the second project phase of ATJW (2014-2016)[8], a third process of information gathering focused on understanding GBV case handling by District Women's Affairs, Women and Children Consultative Committees (WCCCs) and other key stakeholders in the same target provinces. Based on these consultations, the draft Referral Guidelines were finalised in a participatory consultation meeting of the Community of Practice and with key stakeholders.

The Referral Guidelines follow guiding principles compatible with both national and international women's human rights standards as outlined in Part 2 and are compatible with other Cambodia Minimum Standards outlined in Part 3. The Referral Guidelines highlight the responsibilities of service providers when referring and receiving GBV survivors in Part 3. The Annexes to this document include models of Case Registration and Referral Forms to be used by service providers, to ensure consistency and quality in documentation of GBV cases to support effective case management.

7 Supported with funds from the German Federal Ministry for Economic Development and Cooperation (BMZ) and the Spanish Agency for International Development Cooperation (AECID),

8 Supported by BMZ and co-financed by Australian Aid.

1.2 SCOPE OF THE GUIDELINES

Referral for services is part of the standard Case Management Process (See Annex 5) all service providers are expected to follow. In Cambodia, research has documented intra-agency and inter-agency referrals lack clear guidelines and are limited in number resulting in survivors not receiving all needed or available services.

The Referral Guidelines are meant to guide the referral practices of all service providers working with women survivors of GBV and their children, particularly intimate partner violence (including spousal domestic violence) and sexual violence.

Service providers include both state and non-state service providers including government bodies, legal aid organisations, safe shelters, community based GBV services, psychosocial support services, volunteer groups and others.[9]

All state and non-state service providers are covered by these guidelines including but not limited to counsellors, caregivers, case managers, doctors, nurses, volunteers, lawyers, local authorities (police, commune counsellors etc.), case interviewers, program coordinators, and other relevant persons.

9 It should be recognized that some volunteers of non-governmental organisations come from different sources (e.g. commune council members).

1.3 LIMITATIONS OF THE GUIDELINES

These Referral Guidelines do not provide guidelines for the entire case management process, but provide guidance for referrals within and between service providers in institutions. Effective referrals are essential for effective management of GBV cases. Additionally, the Referral Guidelines do not address the specific needs of children of GBV survivors. Addressing the needs of children of GBV survivors in a responsive and effective way requires further specialization from service providers.

PART 2 GUIDING PRINCIPLES FOR SERVICE PROVIDERS REFERRING AND RECEIVING GBV SURVIVORS[10]

When referring and receiving GBV survivors, the work of service providers shall be guided by the following principles:

Human Rights Approach

Gender-based violence against women is a human rights violation and unacceptable in any form.

Ensure Safety

The first priority is the safety of the survivor. All actions are aimed at restoring or maintaining safety and not placing survivors at greater risk.

Empowerment in Practice

Providing information on options can help the survivor make informed choices for themselves. Survivor's opinions, thoughts and ideas shall be listened to and treated with respect. This is called using a survivor-centred or empowerment approach. While information can empower the survivor to make informed choices the survivor has the right to decide what assistance they want and can refuse any service.

10 Adapted from the MoWA and MoH (2016). Minimum Standards for Basic Counselling. Phnom Penh, Cambodia

Non-Blaming and Non-Judgemental Attitude

Survivors of intimate partner violence, sexual violence or other violence will not be blamed for the violence. Any violence against women is against the law of Cambodia, and the perpetrator is responsible.

Privacy and Confidentiality

At all times the privacy and confidentiality of the survivor and their families shall be respected. Services should be provided in a quiet, private space. When a survivor discloses violence, other people who are around should be asked to leave or move to another area so that no one can hear and the survivor's privacy can be protected.

GBV survivors' identities should not be shared or discussed in any meeting or with other service providers inside or outside of the institution/ organisation without the survivor's permission. For consultation or advice on how to manage the case from another service provider, do not use the survivors name unless permission is given.

Non-Discrimination

All survivors are equal and shall be treated the same and have equal access to services. There shall be no discrimination or different treatment for any GBV survivor based on ethnicity, religion, social class, disability, age, sexual orientation, or other factors.

PART 3 RELEVANT CAMBODIAN MINIMUM STANDARDS AND GUIDELINES

Cambodia has a number of relevant minimum standards and guidelines for service providers of GBV. These have been reviewed to ensure that the Referral Guidelines are compatible, and to inform the development of implementation and oversight mechanisms.

Standards and guidelines relevant to GBV response include:

- Legal Protection Guidelines for Women and Children's Rights in Cambodia (MoWA, 2014).
- National Guidelines for Management of Violence Against Women in the Clinical Handbook field-testing on Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence (prepared by MoH to be implemented in 2016).
- Minimum Standards for Basic Counselling for Women and Girl Survivors of Gender-Based Violence, (prepared by MoWA and MoH to be finalized in 2016).
- Policy and Minimum Standards to Protect the Rights of Victims of Human Trafficking (MoSAVY, 2009).
- The Minimum Standards on Residential Care for Victims of Human Trafficking and Sexual Exploitation (MoSAVY, 2014).
- Minimum Standards on Alternative Care for Children (MoSAVY, 2008).

PART 4 ROLES AND RESPONSIBILITIES FOR REFERRALS OF GBV SURVIVORS AND THEIR CHILDREN

This section outlines the specific tasks and roles for service providers receiving and referring survivors to other services within (intra-agency) and outside (inter-agency) their institution or organisation.

The responsibilities laid out below are not sequential. Some roles and responsibilities provide guidance on intra-agency referrals whereas others provide guidance on inter-agency referrals.

4.1 COORDINATING AGENCY ROLES

A *referral system* requires a coordinator to facilitate the relationships between the different agencies to ensure the flow of cases. With multiple service providers with specialized roles, there is a need to ensure referrals flow and to identify, prevent or remedy blockages in the response and service systems.

Case managers from both state and non-state agencies are responsible for ensuring effective referrals of female survivors of GBV and their children. Therefore, all service providers involved in referrals and service provision are entitled to cooperate with each other and to work in the best interests of female survivors of GBV and their children.

The Provincial Departments of Women's Affairs (PDoWAs) shall have the role to coordinate with state and non-state service providers in order to ensure an effective referral system. PDoWAs have the following

responsibilities:

- Facilitating the flow of referrals to ensure survivors' access to the services they need, including intervening to find solutions to bottlenecks that occur, e.g. in the court or with the police.
- Monitoring the referral system ensuring that victims are referred to the services they need (in line with the Referral Guidelines) by all members of the referral system; and ensuring that service providers within the referral system report on GBV cases, while protecting the privacy and confidentiality of the survivors.
- Convening regular Service Providers Network meetings on GBV, at least once every three months.
- Development and distribution of a Service Provider Directory that includes services and contact information (with regular updates).

4.2 SERVICE PROVIDER SPECIALISATION AND REFERRALS BASED ON NEEDS ASSESSMENT

Service providers often specialize in a particular service or have a specific mandate. Service providers shall be aware of the limitation of their own services. This awareness does not necessarily demonstrate the poor performance of the institution; rather it demonstrates the recognition of the service provider's own expertise and its knowledge of other services.

As part of the basic counselling process, service providers will conduct a basic needs assessment with survivors providing information on available options in addition to their own specialized service. Providing adequate information on options empowers the survivor to make her own informed choice about the assistance she wants based on her own needs.

Immediate consideration should include safety of the survivor and her children and urgent health care needs (See 4.6 and 4.7). Further assessment of need should include legal referral and/or representation, safe shelter, counselling, emergency support and other needs as identified in consultation with the survivor.[11]

Service providers can then refer survivors to other service providers if their institution does not offer the service requested by the survivor. The survivors themselves shall agree to the referral for all services.

4.3 COORDINATION OF INTRA-AGENCY REFERRALS

Survivors have the right to information on available options internally within institution[12]. Each service provider delivering services to survivors of GBV shall coordinate intra-agency referrals (between departments for example) through case assessment, planning and referral based on the needs of survivors.

Within institution, the privacy of survivors is to be respected and their information handled with confidentiality.[13] Information should only be shared with others within the institution when the survivor requires the services of that department.

When a survivor is referred internally, all information shall be communicated clearly. This is to avoid the survivor repeatedly being asked for the same information from different departments, as this can

11 MoWA and MoH (2016). Standard 3 Minimum Standards for Basic Counselling. Phnom Penh, Cambodia.

12 MoWA and MoH (2016). Standard 3 Minimum Standards for Basic Counselling. Phnom Penh, Cambodia.

13 MoWA and MoH (2016). Standard 5 Minimum Standards for Basic Counselling. Phnom Penh, Cambodia.

cause further trauma. However, service providers in each department can clarify information with the survivor, and suggest additional referrals if required.

A focal person or case manager in each institution shall be the responsible person to ensure the smooth flow of information.

4.4 COORDINATION OF INTER-AGENCY REFERRALS USING CASE REGISTRATION AND REFERRAL FORMS

Service providers in the referral system should all collect the same minimum information using Case Registration Forms for all GBV cases. Additional information can be collected by each service provider to support effective case management and service delivery. The sample Case Registration Form is a model form that records minimum information on survivors.

This case registration process can vary from one institution to another but requires minimum information for making a referral, so the receiving organisation can respond to the survivor's needs and contribute to seeking accountability of perpetrators more effectively. Completing the Case Registration Form and sharing it with the service provider receiving the referral prevents the survivor from having to repeat continually their story, reducing re-victimisation of the survivor.

The Case Registration Form (See Annex 1)[14] is to be provided to the institution receiving a referral, and shall be sent with the survivor in a sealed envelope or with a person who is accompanying the survivor to the institution receiving the referral.

Together with this Case Registration Form, a Referral Form (see Annex 2)

14 Institutions/organisations can use their own forms if the forms include all information on the same in Annex 1

shall be completed and sent to the receiving institution/organisation so that the needs of the survivor are clearly communicated.

The receiving institution shall then complete a Referral Feedback Form (see Annex 3), which is sent back to the service provider who initially made the referral. This process allows each service provider to follow up on referrals, and receive confirmation that the referral was completed and that the survivor received the services they needed.

Additionally, to document the referrals a Summary of Case Referral Form (see Annex 4) is provided to collect information at each institution on all referrals made for each case.

For both staff and survivors, there has to be proper transportation. If possible, involve a third party, e.g. a friend or a family member of the survivor.

4.5 DESIGNATED FOCAL PERSON AT THE RECEIVING INSTITUTION

Each service provider shall have a designated staff serving as the 1) first contact person for survivors, 2) a case manager, and 3) a focal person for referrals. Service providers consolidate these three roles in the same person.

Staff in these key roles should have training in the Minimum Standards of Basic Counselling, and be able to provide information and referral to other services effectively in addition to their other required job skills.[15]

15 MoWA and MoH (2016). Minimum Standards for Basic Counselling. Phnom Penh, Cambodia.

4.6 CRISIS INTERVENTION AND HEALTH CARE REFERRAL

All service providers should facilitate immediate access to urgent medical care for injuries of survivors based on their individual needs.

The survivor of violence against women that is injured should be informed of the option to seek a medical certificate for documentation of injuries for referral to the legal system. The medical certificate documents injuries and can be later used in prosecution of the perpetrator and to document the violence.

Survivors of sexual violence should also be informed of, and with their consent, provided immediate access to the Forensic Examination as directed by the National Guidelines on the Management of Violence Against Women in the Health System. The Forensic Examination is a systematic examination conducted at a Referral Hospital that provides medical examination, immediate health care and collects evidence for possible legal action. The survivor should be informed that sexually transmitted infections (STIs) and HIV/AIDS prevention, emergency contraception and the evidence collection for the Forensic Examination are only effective when conducted within 72 hours of the assault.[16]

If the sexual violence survivor does not consent to the Forensic Examination, she should be informed of the importance of a medical examination, and provided access to urgent health care, preventive treatments for sexually transmitted infections (STIs) and HIV/AIDS, and emergency contraception immediately. All treatments should be with the informed consent of the survivor.

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16 MoH (2014) National Guidelines for Management of Violence Against Women and Children in the Health System. Phnom Penh Cambodia.

4.7 IMMEDIATE SAFETY FOR SURVIVORS AND THEIR CHILDREN AND SERVICE PROVIDER

Consideration for the safety of survivors of GBV and their children should be a priority for service providers. A risk assessment and further steps to ensure immediate safety of the GBV survivors and their children will be conducted in accordance with the Minimum Standards of Counselling as follows:[17]

If no other protocol is available, some questions to ask are:

- Is the perpetrator a threat right now? (If so, consideration should be made to call the police)
- Has the violence happened more often in the last 6 months?
- Has he used a weapon or threatened you with a weapon?
- Have you ever been beaten when pregnant?
- Is he extremely jealous of you?

If the woman answers yes to at least three of the questions above, it may not safe for her to return home.

If the woman and her children are considered to be at immediate risk of further violence from the perpetrator, the police or other responsible authority should be called immediately.

If the woman refuses to call the authorities, immediate steps to ensure safety should be undertaken. Options include referral to safe shelter, a relative or friend's home, or other safe place of her choosing.

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17 MoWA and MoH (2016). Standard 2. Minimum Standards for Basic Counselling. Phnom Penh, Cambodia.

If the service provider determines that any children in the immediate care of the survivor are at risk of imminent violence, the nearest local authority, Department of Social Affairs, Veterans and Youth Rehabilitation, or Police should be contacted to provide safety for the dependent children.

The service providers must also assess their own immediate safety.

For various reasons, including safety, survivors shall be also accompanied to referring agencies. Emotional and physical safety of survivors must be ensured by referring agencies when making the referral, particularly if the accompanying staff member is male and the survivor is a woman or a child. Agencies should also ensure the physical and emotional safety of accompanying staff.

4.8 GUIDANCE AND SUPERVISION OF COMMUNITY GROUPS AND VOLUNTEERS

Service providers supported with volunteers or community groups should have clear policies on the roles and responsibilities of volunteers in service provision.

Volunteers or community groups are likely to have varied capacities in GBV response and should be trained on the Minimum Standards of Basic Counselling and the Referral Guidelines.

4.9 FOLLOW UP AFTER REFERRAL

As part of the case management process and to improve the quality of referrals, service providers should follow-up with survivors after referrals to other service providers. Follow up provides an opportunity to learn if the referral was effective and assess if the survivors requires further services based on provision of information and informed consent.

Survivors maintain the right to decide the services and/or the assistance they want and can refuse any service.

4.10 SERVICE PROVISION SHOULD BE BASED ON DIFFERENT TYPES OF GBV

Gender-based violence is defined as "violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, emotional, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."

In Cambodia, GBV commonly includes intimate partner violence, domestic violence and sexual violence. Service providers should know the options for response and services for survivors experiencing each type of violence, and provide services and make referrals accordingly. The type of GBV will have an impact on the survivors needs and referrals made (e.g. as identified above a survivor of rape should be informed of the Forensic Exam and the need for immediate medical care).

Types of GBV are separated in the Case Registration Form according to sexual violence and domestic or intimate partner violence. It is important to note that determination is based on the report of the survivor and not a legal determination of the crime.

Sexual Violence: sexual harassment, indecent exposure, indecent assault, rape

Intimate partner or domestic violence: physical violence, sexual violence, emotional violence, and economic violence.

Other: The category of other is available on the form to document other types of gender- based violence against women not categorized above.

ANNEX 1 CASE REGISTRATION FORM

Confidential, please do not share this document; make a copy of this form for the receiving services

(File N°: .....)

<table>
<tr><th colspan="4">Part I – Initial Information</th></tr>
<tr><th colspan="4">A – Victim information</th></tr>
<tr><td colspan="3">Name of the survivor:</td><td>Sex: Male ☐ Female ☐</td></tr>
<tr><td colspan="2">Date of Birth:</td><td>Age:</td><td rowspan="4">Civil Status:
Married ☐
Single ☐
Separated ☐
Divorced ☐
Widow ☐
Other (specify):.....</td></tr>
<tr><td colspan="3">Place of Birth:</td></tr>
<tr><td>Ethnic Background:</td><td colspan="2">Nationality:</td></tr>
<tr><td>Education attained:</td><td colspan="2">Occupation:</td></tr>
<tr><td colspan="2">Total number of children: .....
1. Name.....sex.....age.....year
2. Name.....sex.....age.....year
3. Name.....sex.....age.....year</td><td colspan="2">4. Name.....sex....age.....year
5. Name.....sex.....age.....year
6. Name.....sex.....age.....year</td></tr>
<tr><td colspan="4">Disability of survivor: Is the survivor a disabled person? Yes ☐ No ☐
If yes, please describe type of disability of the survivor:</td></tr>
<tr><td colspan="2">Address of survivor:</td><td colspan="2">Survivor contact N°:</td></tr>
<tr><td colspan="4">(If survivor is a child)
Name of the father ☐ mother ☐ or caregiver .....</td></tr>
</table>

Address:	Contact number:

B – The Incident

Type of Violence related to GBV – You can check more than one

☐ Sexual Violence

☐ Sexual Harassment ☐ Indecent Exposure ☐ Indecent Assault ☐ Rape

☐ Intimate Partner or Domestic Violence

☐ Physical ☐ Sexual ☐ Emotional ☐ Economic

☐ Other Please describe: .....

Location of the incident:	Date:	Time of the incident:	.....

Description of the incident (summarize the circumstances, exactly what occurred and what happened afterwards) - attach additional page with narrative if needed.

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C – Alleged Perpetrator Information	
Number of perpetrators:	
1. Name: .....Sex: .....Age: .....Nationality: ..... Ethnicity: .....Marital status (married ☐ single ☐ widow ☐) Occupation:..... Address: ..... Relationship to victim if any:	
2. Name: .....Sex: .....Age: .....Nationality: ..... Ethnicity: .....Marital status (married ☐ single ☐ widow ☐) Occupation:..... Address: ..... Relationship to victim if any:	
3. Name: .....Sex: .....Age: .....Nationality: ..... Ethnicity: .....Marital status (married ☐ single ☐ widow ☐) Occupation:..... Address: ..... Relationship to victim if any:	
If perpetrator is unknown, describe him/her a description with any identifying marks:	
Is the perpetrator a continuing threat? Yes ☐ No ☐ *If so please conduct a risk assessment and develop a safety plan with the survivor.*	
If the perpetrator is a child (below 18 years old), please write name of parents/care givers:	
Address:	Relationship: Contact number:

D – Witness (use additional paper if needed)	
Name, address and contact number:	Describe the event witnessed:

E – Actions taken/service received prior to this interview			
Answer for prior incidents	**Yes**	**No**	Notes:
Is this the first incident with this perpetrator?	☐	☐	
If no, were prior incidents reported?	☐	☐	
Who were the prior incident was reported to?	Yes	No	Action taken
Police/ Gendarmerie	☐	☐	
Local authorities (e.g. commune council, village chief)	☐	☐	
Other: Please Describe	☐	☐	
Has the client received any social services already? **Yes** ☐ **No** ☐			
Please check <u>prior</u> social services received	Yes ☐	No ☐	Service provided by
Counselling			
Legal			
Medical			
Other			
Does she need further services or actions? **Yes** ☐ **No** ☐ **If yes,** see Part II for the Assessment, Service and Referral planning guide			

Part II: Assessment, Service and Referral Planning Guide					
What are the services or actions that she needs or wants? Share with her the different options for actions/ services (Use additional pages if needed for more services)					
Current Needs of Survivor	Check if she needs	Planned Actions (date of this form)		If Refer - to whom will you refer? Please be specific and complete a referral form	Notes, Survivor Comments, Circumstances to Follow-up, Etc.
		Provide	Refer to Other		
Health					
Emergency Care for Injuries	☐				
Forensic Exam	☐				
Legal					
Legal consultation	☐				
Legal representation	☐				
File complaint	☐				
Other (List)	☐				
Safety Plan					
Safe Shelter	☐				
Drop-in Center	☐				
Other (list)	☐				
Counselling					

Primary Counselling	☐				
Longer-term Counselling	☐				
Other (List)	☐				
Economic					
Emergency Aid	☐				
Occupational Guidance	☐				
Vocational Training	☐				
Other services (list)	☐				

Prepared by:.....

Case manager/Focal person/interviewer

Confirmed by: .....Date: .....

Name and signature of client .....Date: .....

ANNEX 2 REFERRAL FORM

(to be completed by the Referring Service Provider)

Confidential, do not share this document with unauthorised persons

Instructions	This form should be completed when referring a client for services not provided by your own agency. Be specific about what services are requested. As the Referring Service Provider, please provide appropriate documents to the Receiving Service Provider to complete the referral. Seal the envelope containing this form and the documents attached. Give it to the survivor (or the person accompanying her) to take to the receiving service provider. After completing this form, keep a copy for your own reference; then document in the Summary of Case Referral Form (Annex 4).

1. File Number:..... Date of referral (registered in database):.....

2. Type of violence (see categories in case registration form-Annex 1):

.....

3. Receiving Institution : .....

Receiving Institution address: .....

.....

4. Receiving Institution contact person:.....

5. Client name (or code number): .....Age of client:..... Sex of client:.....

6. Address of client: .....

(do not record this if it could cause a security risk)

7. Name of Family/Guardian:.....Contact .....

Number.....

Address:.....

.....

8. Reason(s) for Referral: .....

9. Service(s) requested:.....

Please refer to attached intake form/report/summary for more information

Please send a Referral Feedback Form (Annex 3) to the Referring Institution at the following address:

Address: _____

Cell Phone number: _____ Fax number: _____

Email address: _____

Contact person: _____

Referred by:_____Received by: _____

_____ _____

Signature and date Signature and date

ANNEX 3 REFERRAL FEEDBACK FORM

to be completed by Receiving Service Provider

Confidential, do not share this document with unauthorised persons

Instructions	This form should be completed by the Receiving Institution and sent back to the Referring Institution, after the services have been provided to the client. Please include the date of when the client first came to you as well as the date(s) of when the service(s) were provided. Client satisfaction feedback should only be filled out by the client's case manager. This form may be given to the client in a sealed envelope or sent to the Referring Institution through a courier or other means. The information on this form will be part of the database and give input to data collection and reporting needs. Accuracy of information is very important. Note: the referring agency should follow up the cases at least one per two month after the referring date.

Name of Receiving Institution providing feedback: .....Date:.....

File Number:	Type of violence	Name of Client:	Age:	Sex:
Name of original Referring Institution :				

Service(s) requested	Was the service provided?	Staff member who provided the service	Date(s) when the service(s) were provided	Further information/ comments (e.g. problems encountered)	Client's satisfaction feedback (only for case managers)

Receiving Institution staff member

ANNEX 4 SUMMARY OF CASE REFERRAL FORM

Confidential, do not share this document with unauthorised persons

Instructions	This form should be completed by the Institution in order to keep the track and monitor referral. The source of information is the Referral Form (Annex 2) and the Referral Feedback Form (Annex 3).

File Number: .....Name of Client:..... Type of violence: .....

Referring Institution	Name of referring staff member	Date referral sent	Receiving Institution	Name of receiving staff member	Service requested	Date Referral Feedback Form sent	Remarks

Name and signature of respective official/agents (who complete the form)

ANNEX 5 THE CASE MANAGEMENT PROCESS

The case management process provides a systematic framework for service providers to address the needs of survivors. The case management process begins when survivors are identified (including self-referrals) and ends when survivors are living safely, terminate services, or if separated from their home, are reintegrated back in the community. The following are standard elements of an effective case management process.

Case assessment refers to the process of assessing the situation and identifying the needs of the survivors based on her agreement applying the Minimum Standards of Basic Counselling and the Guiding Principles for Receiving and Referring Survivors of GBV in this document. Case assessment includes a risk assessment.

Risk assessment is the decision-making process through which the service provider determines the best course of action by estimating, identifying, qualifying, or quantifying risk of women survivors of GBV and their children. It refers to the likelihood of further occurrence and/or severity of the violence. In cases where it is properly applied, risk assessment is the basis for identifying further security or protection measures for women survivors of GBV and their children.

Crisis Intervention is the process of responding to immediate short-term help to survivors. This includes safety planning, and urgent health care. This could require immediate referral to other service providers.

Case planning is the process where the service provider's works together with survivors to develop an agreed upon intervention plan. The plan shall set goals to solve the problems identified jointly between the service provider and survivor and includes planned interventions, services and referrals. Case planning is based joint assessment and revisited periodically to review progress toward goals.

Referral is the process of referring survivors to appropriate services.

Recovery relates to the process of service providers implementing the case plan with the survivor. Not all survivors of GBV have gone through the same experiences and will have received different services based on their own situation. Survivors are recovered when she no longer requires or desires services.

Reintegration is the process of survivors' return and settlement in her selected community if she has been living in residential care or away from her home.

Successful reintegration is the goal for women living in residential care, so any case plan should include steps toward independent living.

Follow up refers to the process of following up after services have been provided. This can be after any service is provided including residential care.

Case closure is the process to cease support and service to survivors, in consultation with the survivor and finalizing her needs. The case can be re-opened if necessary.

* For survivors that are re-integrated from a residential setting, MoSVY is the responsible authority to manage the re-integration. MoSVY considers reintegration successful and the case closed if:

- Relationship between the family and the reintegrated person are stable and sustainable
- The economic situation of the family is stable and they can survive by themselves.
- The reintegrated person can participate in the usual and regular daily activities such as schooling, income (inside or outside of the house), getting vocational training and so on.
- There is enough proof indicating that the reintegrated person is both economically and psycho-socially stable.

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