3

Designing and Maintaining Quality Protection Case Management Service: A Guide for Technical Staff

Welcome to Module 3. This module supports you and your team to design and maintain quality in your Protection Case Management service. At this stage, you have conducted protection analysis, coordination, and consultation to identify key aspects of your service, including who will be eligible for your service and how your service will interact with existing services and systems.

This module will help you consider aspects of setting up and maintaining a quality Protection Case Management service by helping you to answer the following questions:

- **What are the minimum standards of Protection Case Management?**
  Understanding the minimum required standards to offer Protection Case Management services and where to find further guidance on how to meet this standard throughout this guidance.

- **What are the main design decisions that I need to make with my team to establish a Protection Case Management service?**
  Addressing mode of delivery, understanding budget, and how to approach cash in Protection Case management, staffing and standard operating protocol development.

- **What are the MEAL standards and guidelines for Protection Case Management?**
  Getting to know MEAL standards, observing how you can: *Track progress, assess impact, remain accountable to service users, key stakeholders, and donors, and adjust and improve the Protection Case Management approach.*

What are the minimum standards of Protection Case Management?

To meet Protection Case Management criteria and approaches described throughout this guidance, your service should meet the following foundational, operational and resourcing standards.

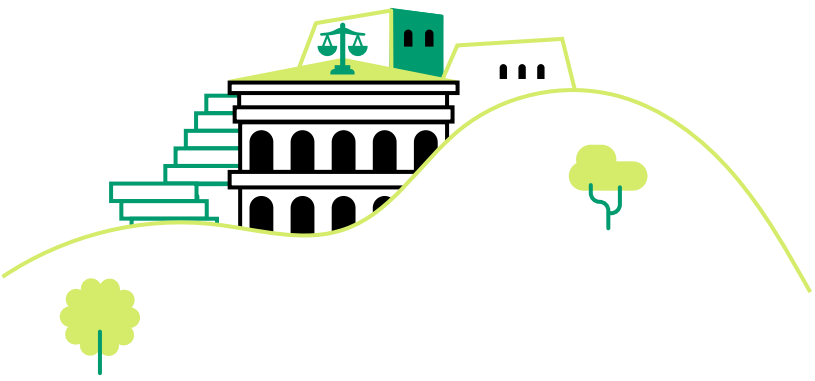
Table 1: A summary of minimum standards in Protection Case Management

Foundational standards	Where you can find guidance to support this standard
Protection Case Management is included in organisational strategy	All
Protection Case Management is designed based on protection and context analysis	Module 2
Localisation, partnership and exit strategies are developed and implemented	Module 2 and 3
Protection Case Management services have the staffing and budget to meet requirements	Module 3

Foundational standards	Where you can find guidance to support this standard
The service is guided by documented process and protocols, including a detailed risk-focused criteria, roles and responsibilities for internal and external actors, and information management and data protection protocols	Module 3
MEAL standards and processes are incorporated throughout the Protection Case Management approach	Module 3

Practice standards	Where you can find guidance to support this standard
Communities and caseworkers understand eligibility and response criteria	Module 2 and 3
Cases registered are consistent with eligibility criteria	Module 2 and 3
Casesworkers are observed taking assent/consent (at intake and whenever relevant)	Module 4 and 5
Caseworkers are observed providing reasonable accommodation where applicable	Module 4 and 5
Case file reviews demonstrate consistent care across risk levels/ caseloads	Module 2, 4 and 5
Caseworkers are observed developing/reviewing case plans collaboratively with service users	Module 4 and 5
Case plans utilise relevant multidiscipline services and respond to individual needs	Module 2, 4 and 5
Caseworkers call for documented case conferences as appropriate	Module 4 and 5

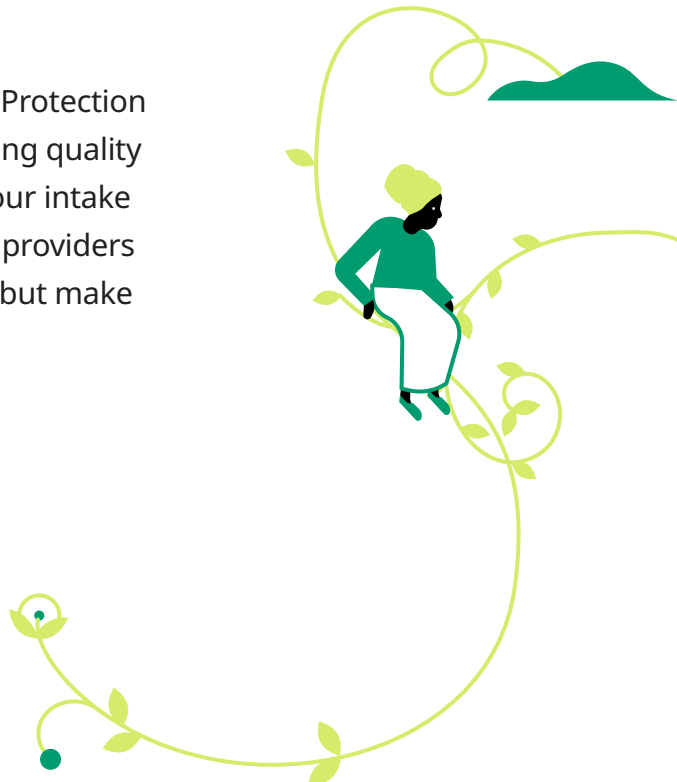
Practice standards	Where you can find guidance to support this standard
Referral systems are functional, incorporating an updated service mapping and ensuring service delays are proactively addressed appropriate to risk level	
Safety plans are developed and team implements as appropriate	Module 4
The Protection Case Management team implements agency documents and shares lessons learned and successful strategies	Module 5
Case plan implementation is conducted according to agreed deadlines	Module 2 and 4
Caseworkers are observed reviewing case plans with service user, as appropriate	Module 4 and 5
Barriers to case plan implementation are identified and addressed by supervisors	Module 5
Case file reviews are conducted regularly by supervisors	Module 5
Cases are closed as per standard operating procedure criteria	Module 3 and 4
Service user satisfaction surveys are conducted with consent, when possible, regularly addressing and discussing complaints and trends in feedback	Module 5



Staffing and staff support	Where you can find guidance to support this standard
Caseworker:service user ratio requirement is met (1:25)	Module 3
Team leader:caseworker ratio requirement is met (1:6)	Module 3
Staff have clear job descriptions	Module 3
Staff have required trainings for their roles	Module 5
Team or individual staff capacity building plans are in place	Module 5
Supervision conducted and actions/recommendations are addressed	Module 5
Staff and volunteers receive staff care and wellbeing support services and have access to MHPSS services	Module 5

Protection Case Management teams use this template as a checklist and planning tool in the development or realignment of similar programming to these standards.

Teams need to have clear written protocols regarding the Protection Case Management process in their programme, establishing quality benchmarks to hold teams accountable. If you have set your intake criteria and agreed on ways of working with other service providers (Module 2), you have completed a large part of this work, but make



sure it is documented and validated. To finalise your standard operating procedures, continue to reflect on the data that you collected in your protection analysis (Module 2), making several programmatic design decisions in consultation with the affected community and your team, including support services and other service providers. Protocol development is discussed below, but you will be developing it and making programmed decisions as you work through this chapter, including:

Assessing and mitigating risk to service users, caseworkers and organisations

Mode of delivery

Budgeting

Use of cash

Staffing, including community members supporting Protection Case Management

Information management and data protection

Part of your protocol development will include putting your documentation tools in place. Here are suggested Protection Case Management tools. This process involves reviewing them with your caseworkers and MEAL team, making any local adaptations as necessary. Do this prior to training your teams so they can become familiar with the documentation tools. For more information on how and when the tools are used, see Module 4.

What are the main design decisions that I need to make with my team to establish a Protection Case Management service?

Assessing and mitigating risk to service users, caseworkers and organisations

Many Protection Case Management service users are at-risk because of their inability to move freely without harm, they face threats in certain spaces, or they cannot approach services due to their circumstances. Likewise, caseworkers can be at risk due to associations with a service user group. As a humanitarian organisation, you may have some understanding of project risk analysis already. Protection Case Management can pose unique challenges associated with some service user groups and modes of service delivery. Work with your team to map potential risks whilst developing your intake criteria and programme design. Consider risks to service users and your organisation that may arise in your operating location. Collaborate with security teams and access working groups to develop safety measures that protect everyone involved in the programme. Connect with key protection actors to get information that informs your risk assessment, including any safety

audits conducted, GBV AoR secondary data reviews, and protection update analyses. Tool 2.1: Project Risk Matrix Template provides support.

Mode of delivery

Protection Case Management services can be delivered in various ways. When deciding *where* and *how* to provide your services, it is essential to consult with the community to ensure safe and confidential access for all who need them. One effective approach is to conduct safety and accessibility mapping with different community groups, asking them to identify spaces they consider safe and protective. Tool 3.1: Accessibility Checklist can guide you through this process.

Through your analysis, you may realise that a flexible approach governed by the needs of your service user is possible and appropriate. To assist in your decision making, consider the following pros and cons in your mode of delivery.

Mode of delivery - Centre-based Protection Case Management

Your centre for delivering Protection Case Management can be where a range of activities take place, such as within an existing national service, community centre, health centre, or elsewhere. Make sure to provide your services in a separate and confidential space or room within the centre. This does not include women's safe spaces.

Table 2: The pros and cons of centre-based services

Pros	Cons
As other services are offered in the centre, it becomes difficult to know who is receiving Protection Case Management support. Sessions can take place outside of influence from the community, in a confidential and anonymous manner.	In volatile security contexts, safety within a centre can be a concern. Authorities could request information about beneficiaries and enter the space.
It can be a visible and known space in the community.	Sustainability may be an issue, certain centres can be resource intensive and expensive to maintain.
Having a stable location can support community acceptance and allow time to build trust, as well as raise awareness of community-based interventions and the local services in the area.	Risk of attack if Protection Case Management is seen as a source of social tension or contrary to social norms.
Within a large centre, comfortable and private rooms for service users and staff can be easily prepared.	Centres may be located in unsafe spaces or far from people's homes, meaning people cannot physically reach the centre.
You can store confidential files and have access to computers and the internet.	Where there is increased population movement, people may not reside long enough in one location.

Pros	Cons
Allows access to a range of people who may choose to seek services.	
You can provide Protection Case Management to some service users for a longer period of time, building a support network within the centre.	
It can present opportunities for close coordination and effective referrals with other service providers e.g. in a health centre where there is also a psychologist they can refer to.	

Mode of delivery - Mobile-based Protection Case Management

Mobile-based Protection Case Management involves setting up a semi-permanent space identified in the community for a period, generally around three to six months. The space can be a room in an established local community centre, place of worship or school. It can also be a tent, a rented space or a container specifically built for this purpose. The IRC GBV Mobile and Remote Service Delivery Guidelines can provide further details on how to arrange mobile Protection Case Management.

Table 3: The pros and cons of mobile-based services

Pros	Cons
The space is often a visible and known space in the community.	Raising awareness of the mobile-based centre's location could be difficult.
If the mobile-based centre is big enough, it can offer other activities. As a result, it becomes difficult to know who is receiving Protection Case Management support as people outside the centre do not know who is receiving it. This ensures sessions can take place outside of influence from the community and in a confidential and anonymous manner.	It can be harder to establish a private and confidential space for Protection Case Management services depending on the building, tent or container. At a minimum, you need to make sure that there is a separate entrance and room for one-on-one sessions.
While not always as comfortable as more centre-based services, you can still make the space comfortable and private for service users and staff.	Mobile spaces might not be accessible far from people's homes, resulting in difficulty for some to physically reach the space. You should always consult with the community first.
Working with the community from the start to manage the space can be sustainable, particularly if you plan to transfer ownership to them for recreational activities when you leave. While this approach can help maintain community support networks, it requires ongoing resources and depends on the space remaining available long-term. Careful planning of your exit strategy is essential.	The temporary nature of the centre and potential lack of infrastructure can make it challenging to store confidential files and secure computers. One solution is to consider employing a security guard from the local community.
This approach can improve access for people in rural or remote areas who might struggle to reach centres in more populated locations.	It can be difficult to establish an internet connection, requiring the use of offline tools.

Pros	Cons
Less resource intensive and expensive to maintain than community centres and therefore more sustainable.	A lack of amenities can make it uncomfortable for staff. For example, without a functioning kitchen or a space to decompress.
	It may prove difficult to establish community acceptance and build trust in a short period of time.
	The temporary nature of the mobile-based centre may disrupt essential services to those that require support longer-term, or if the location is needed for its original purpose e.g. it is in a school and classes are starting. To avoid these situations, plan your exit strategy with the community from the beginning.

Mode of delivery - Outreach or home-based Protection Case Management

Outreach or home-based Protection Case Management normally involves providing services in someone's home or in another private space (if it is not safe to meet at home). In the past, service users and caseworkers have met in locations where there is some level of privacy that the service user determines is safe, such as a walk in a quiet space, the corner of a restaurant, or after hours at a school. In these cases, it is essential to ask the service user if it is safe to do so, where they prefer to meet you, and at what time and day.

Table 4: The pros and cons of outreach or home-based services

Pros	Cons
Services are accessible for those unable to go to centres and provided to people without additional cost (e.g. transportation).	Home visits may not be appropriate in certain contexts, as they could draw unwanted attention. If community members notice these visits, it might indicate someone is receiving special services, potentially compromising the service user's safety, confidentiality and anonymity.
Requires little to no resources (may require additional money on transportation).	Service users not visiting centres have less access to recreational activities or group psychosocial support sessions.
Service users can build relationships and/or draw on the support from community members (i.e. neighbour to visit weekly), leading to a more sustainable outcome.	It is harder to build a community support network for service users.
When requested by the service user, this approach allows appropriate engagement with their family. This engagement can identify additional support needs, such as when a female caregiver might benefit from complementary referral services.	Due to certain location issues, it can be difficult to find a private and confidential space for the service user.

Pros	Cons
Seeing a person's home can provide indications of risk for the caseworker, which can strengthen the safety plan.	Outreach efforts may need to be increased if people in need find it difficult to locate and contact your services.
	Those who are isolated at home have greater reliance on referrals through other service providers or community members. It will be more important to build referral capacities.
	It is unsafe to conduct home visits if the perpetrator of violence is within the home.

If your community consultations and private discussions with service users indicate a preference for home visits, work with them to develop harm mitigation strategies.

For all types of Protection Case Management services, you need to establish how individuals at risk will discover and access your support. This is particularly crucial for those identified as most vulnerable in your protection analysis and intake criteria. Your existing protection analysis may provide insights into these access pathways. You and your team could consider the following questions to understand a service user's access:

- How do people get information in this community? Who do they ask for help?
- Were any risks identified relevant to the spaces in which we meet our service users, their ability to access information and move freely? How can we plan to mitigate these risks? What resources will we need?
- Whilst Protection Case Management teams use technical terms, how should we safely describe our service to others? Do we need to develop different messages for different people?

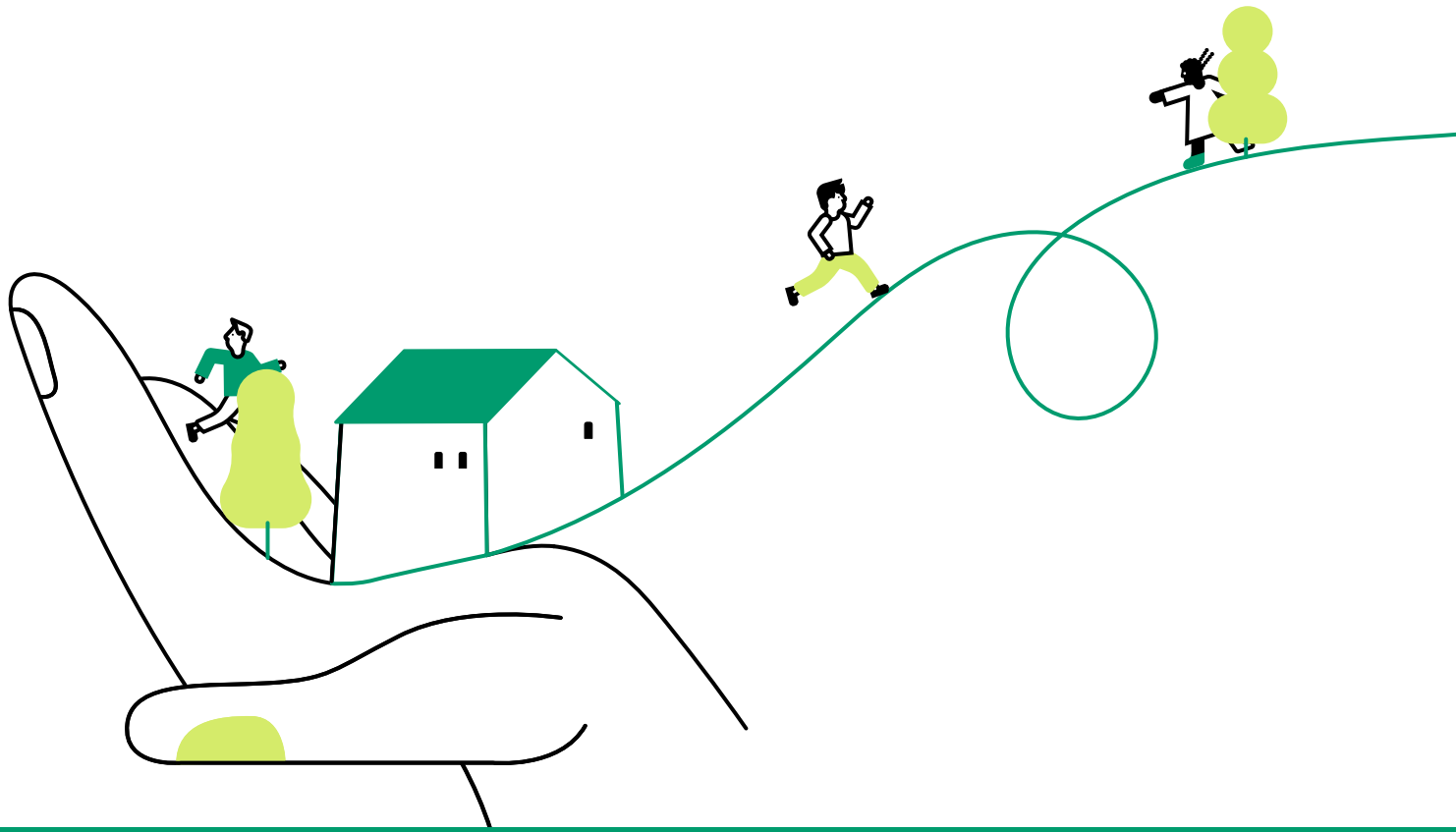
Throughout your project cycle, seek feedback from service users and community members about your approach (refer to the MEAL guidance in this module and Module 5). Use this feedback to adjust your service delivery model and design decisions as needed.

Remote and phone-based Protection Case Management services

During the pilot phase of this guidance, teams were directed to focus only on locations where face-to-face client contact was possible. As a result, remote or phone-only approaches have not been field-tested for Protection Case Management.

For guidance on remote service delivery, consult resources from other case management service providers, including:

- COVID-19 Guidance on Remote GBV Services Focusing on Phone-based Case Management and Hotlines
- Technical Note: Protection of Children during the Coronavirus Pandemic (v.2)



Budgeting for Protection Case Management

Quality Protection Case Management services must be adequately resourced. Your budget will be influenced by your mode of service-delivery and your operational context. Table 5 offers some key budget considerations.

Table 5: Protection Case Management budgeting

Line item	Description	Comments and justification
Staff salaries	Caseworkers, Protection Case Management officers (supervisor), capacity building officer, information management officer, community outreach focal points, volunteers, administration, and monitoring and evaluation staff – see below on staffing structure.	This will depend on the size of your team in line with your staffing structure. Do not add Protection Case Management as an activity onto the load of existing staff, establish a dedicated team.

Line item	Description	Comments and justification
Technical resources	Having assessed your organisational capacity to safely deliver Protection Case Management, you might have identified some technical gaps and decided to budget for the external resources you will need to establish and maintain a quality service. This might include an external supervisor who can provide experienced administrative, technical, and professional development advice to new or inexperienced Protection Case Management teams.	Some Protection Case Management implementers have benefitted from additional support for the 'lift' of setting up Protection Case Management systems; others have identified the need for focused, targeted or specialised training relevant to the intake criteria, such as inclusion and MHPSS support. If you do not have technical resources within your organisation or cohort to provide capacity building and ongoing supervision, consider budgeting for external supervision at least until your team develops their own technical expertise and confidence. You might recognise that the caseload has needs that require dedicated technical expertise in order to develop tailored responses and strategies.
Professional development	Training venues, training materials, trainers, funds to attend external training, see Module 5.	Capacity for on-going training, support and supervision is essential for providing quality services. This does not end with initial training of staff. Your staff will require refresher training(s), as well as training on skills and strategies relevant to the needs of the caseload and capacity gaps in the team throughout the programme period.

Line item	Description	Comments and justification
Staff support and wellbeing services	Staff support and wellbeing services must be provided to Protection Case Management staff. MHPSS for staff and volunteers must be available.	While supervisors play an important role in providing support to caseworkers, mandated staff support and wellbeing services should be made available, overseen by the organisation's human resources department or duty of care team. MHPSS services for all staff and volunteers must be made available.
Office supplies	Storage cabinets with locks for information management such as case files.	Data protection and self-referral purposes.
Comfortable, accessible and private spaces to meet individual needs	Ensure comfortable and private seating for one-on-one meetings that can be accessed by all individuals, including comfortable chairs, pillows, carpets, curtains, door locks and adequate lighting.	This will depend on your mode of service delivery and your entry point for intake. You may simply set up a room in a community centre or health centre, or set up the centre itself as part of your strategy. For community centres, consider having a waiting room with water, toilets and child space.
Accessibility and universal design	Permanent changes in infrastructures and information to ensure access for all. For example, ramps, handrails, wide entrances for buildings and latrines, adjusting height of door handles, and accessible information in several formats. See Tool 3.1: Accessibility Checklist to better understand the accessibility barriers service users might face.	Ensure no barriers are preventing anyone from fully participating in services. If you do not have technical resources within your organisation or cohort to think through these items, consider budgeting for technical support on inclusion.

Line item	Description	Comments and justification
Reasonable accommodations	Ensure accommodations for interpreters, support persons, and required adaption of infrastructure. For more information, see Annex 3.1: Accessibility and Reasonable Accommodation	Despite universal design, some individuals might face specific barriers and need reasonable support to participate in services.
Staff equipment	Equipment to support services e.g. computers, tablets, phones, phone costs, materials for service users to use in sessions like drawing items or fidget toys.	These needs will depend on your modality. Work phones will be needed for caseworkers to contact service users and to be contacted, as well as an additional emergency phone to be shared amongst staff for after hours contact. Caseworkers should not be expected to use their personal phones.
Transportation	Vehicle, fuel and maintenance.	For example, to support caseworkers conducting home visits or helping a service user access a service.
Communication with communities	Materials and leaflets on services, hotline cards, development of materials in different formats, holding community meetings, complaint boxes, creating a hotline.[1]	For two-way communication with service users, ensuring accessible channels for complaint and feedback. Types of will depend on consultation with the community.
Information Management System	Dependent on your Information Management System (IMS).	For organisations using tablets or smartphones to collect, store, organise, and protect service user data in a dedicated IMS.

Line item	Description	Comments and justification
Cash	Cash amount appropriate to context.	For instances where cash is required to achieve items in the case plan or meet urgent needs.

Cash in Protection Case Management[2]

Cash assistance is an available tool for caseworkers to support a service user to meet the goals set in their action plan. There is a growing body of evidence that cash assistance as part of Protection Case Management can contribute to protection outcomes.[3] Cash is recognised as an empowering tool, addressing a service user's protection risk(s) and supporting their recovery. It can enable immediate respite from violence or access to protection-related response services otherwise inaccessible due to prohibitive costs or limited financial resources. The objective of using cash within Protection Case Management is to facilitate and support a protection response, either by reducing an individual's exposure to immediate protection risks or by supporting their recovery from a protection incident that affects their physical safety, psychological well-being, or dignity. The primary aim of providing cash as a part of Protection Case Management should be to address a protection risk. The cash must be used to facilitate an action identified in their action plan, which adresses the protection risk the service user is facing. If a service user is unable to meet their basic needs, this should be addressed through unrestricted cash, multi-purpose cash or sectoral cash, and caseworkers can refer service users to these options.

Figure 1: Using cash in Protection Case Management

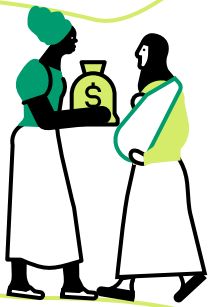
Step 1: Introduction and intake

Step 2: Protection risk assessment

In the initial assessment, the caseworker focuses on understanding the protection risks the client is facing, including their economic and social networks. Here is where the caseworker can identify risks that require cash assistance and analyse risks and barriers to accessing cash.

Step 3: Action planning and safety planning

Based on the identified needs, the caseworker should inform the client about the possibility of cash assistance and plan with the client how they would use the cash, how they will cope once cash assistance ends, as well as put in place enablers to address risks and barriers. Discuss the process of receiving cash and obtain the client's consent. Include cash assistance as an "action" in the action plan.



Step 4: Implementation of the action plan

The caseworker will ensure that they receive cash assistance and work with the client to remove any barriers to receiving the cash and accessing services. Caseworkers should work with the client to implement the action plan/ safety plan to mitigate any risk.

Step 5: Follow-up and monitoring

Caseworkers should assess a client's safety in the home and community, including any risks associated with the cash referral during each visit with the client. Post distribution monitoring should be completed.

Step 6: Case closure

Service users in coordination with caseworkers will define (within the action plan) if cash is an appropriate response to mitigate the protection risk. Caseworkers will analyse possible barriers for the individual to access cash, plan with the service user how cash will be used and the cash transfer value, include cash-based intervention in the action plan with the informed consent of the client, and ensure that the cash is received and the outcome assessed. The amount should be tailored and relevant to the specific protection needs and issues affecting this person/household and, whenever possible, cash should be unconditional and unrestricted to ensure maximum autonomy for service users.

In most circumstances, for cash assistance to be provided, it should satisfy the three S's:

Safe: The cash assistance will not increase risk to the service user.

Sustainability: Cash transfers will be used to meet a specific and non-recurring cost i.e. costs which arose recently that the person/household cannot meet at the time.

Suitability: Cash will effectively address the service user's most urgent needs for protection or when paired with other services within the service user's action plan.

Some examples for how protection cash can be used in Protection Case Management are:

- **Fear for a service user's immediate safety:** Costs for transportation and/or rent in cases of immediate eviction risks.
- **Removing barriers to service access or to community participation:** Based on the need, transportation, and service or equipment costs (e.g. legal assistance, access to assistive devices).

Cash can be used to purchase assistive devices. Assistive devices can improve a person's functioning in areas such as cognition, communication, hearing, mobility, self-care and vision. They can be physical products like wheelchairs, glasses, hearing aids, prostheses, orthoses, walking aids or pads; or digital products like software and apps that help with communication and time management. They can also be adaptations made to the physical environment, such as ramps or rails.[4] The provision of these items can have protection outcomes – especially for groups at risk of marginalisation, discrimination, and exclusion – by empowering them to navigate their environments, communicate effectively and access essential services.

Due to the potential for harm associated with the incorrect use or unsuitable prescription of such aids, ONLY health workers[5] and trained workers experienced in providing assistive technology can facilitate access to these products. Protection caseworkers with adequate training can provide referrals or use cash to support the purchase of assistive devices - only in coordination with specialised service providers. See Annex 3.2: Guidance Note on Provision of Assistive Devices.

Cash as a modality is not inherently riskier than other forms of assistance. However, it is essential that the caseworker and the service user understand if there are associated risks and how to mitigate them.[6] If you want to include cash as a tool within Protection Case Management services, be sure to develop a standard operating procedure for how to identify, assess, deliver, monitor, and evaluate the provision of cash safely and equitably, including identifying and addressing potential barriers that certain service users may face to access this type of support (e.g. digital literacy, accessibility of information, distribution points etc.). This should be developed in conjunction with your finance teams.

For more information on using cash as a part of protection programming, see this guidance on key considerations for cash in specialised and stand alone protection programmes.

Staffing for Protection Case Management

Your staffing structure

Your staffing is the most important resource in Protection Case Management. You can staff your services in different ways, depending on your resources and context. When planning out the size and shape of your team, remember:

- A caseworker should not have more than 25 cases at any given time. This needs to be monitored closely by supervisors who understand that some cases will require more support depending on the service user's needs or the stage of the process.

- Caseworkers should speak the same language as the service users they support whenever possible. If that is not possible, interpreters should be engaged.

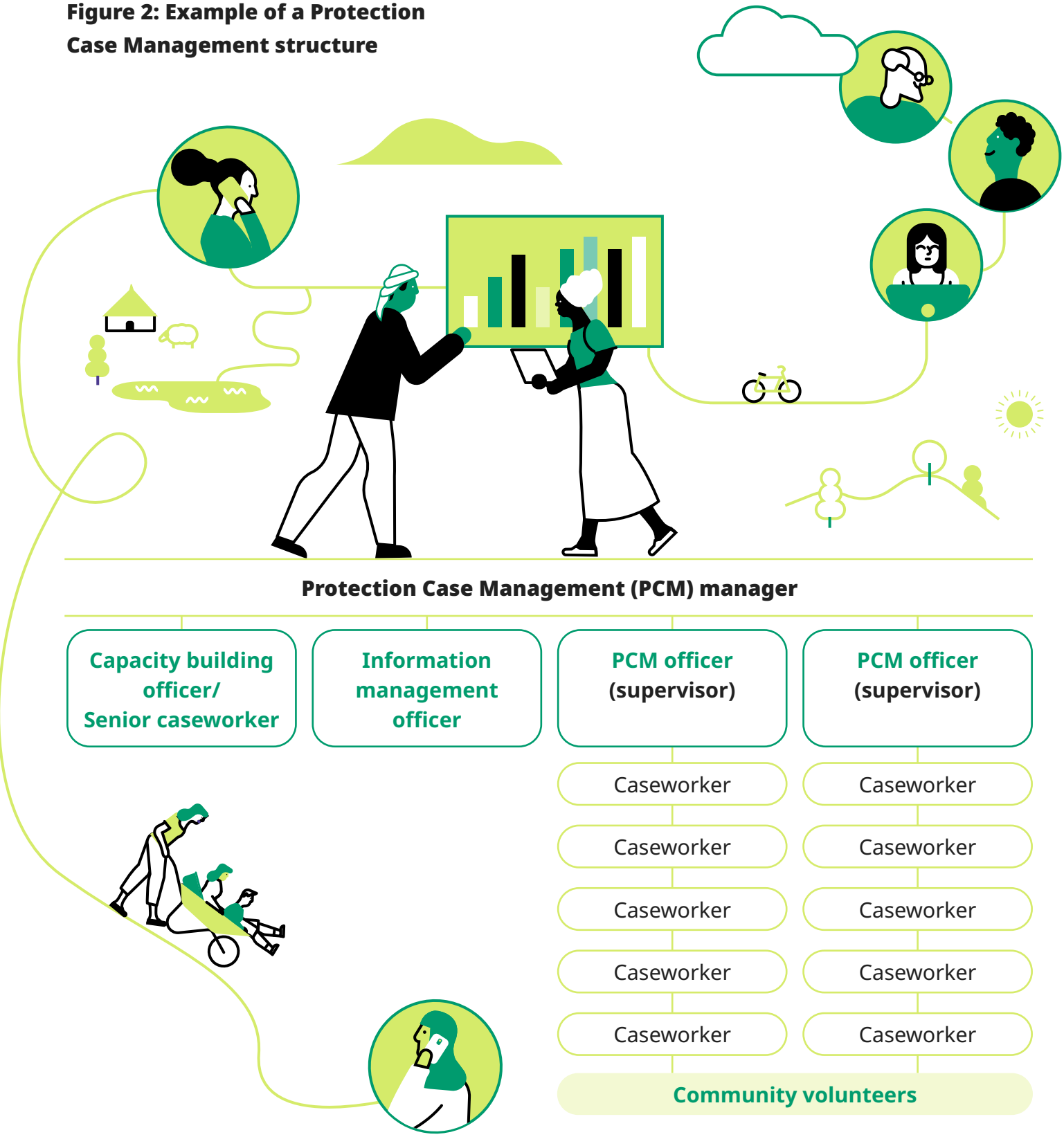
- The gender balance of your caseworkers should be relevant to your intake criteria. Service users might have a preference as to the gender of the caseworker they want to talk to. This should be established as early as possible.

- Supervisors should oversee no more than **six** caseworkers, allowing for proper support to caseworkers, mentorship and due diligence checks.[7]

- Information management and data protection will need to be supported by an information management assistant or officer.

- On-going training, learning and capacity building is necessary for staff. To support this, consider a capacity building officer to offer training and technical development in collaboration with the supervisor.

Figure 2: Example of a Protection Case Management structure



Community-based staff can support caseworkers when visiting service users who require daily or frequent visits until more sustainable care arrangements are put in place. Similarly, a *capacity building officer* who has the experience and technical skills can support the mentorship and training of caseworkers on an on-going basis. This staff member can also provide safe

identification and referral training to other organisations. Please see Annex 3.3: Staff Roles and Responsibilities.

Your staffing structure - community-based staff

Community mobilisers, volunteers, or other community-based staff are an integral part of preventing and responding to cases of violence in humanitarian settings. It is these staff who are often the first entry points into communities and help to identify [individuals] who are at risk of, or who are survivors of, violence.[8] The Alliance for Child Protection and Humanitarian Action has developed a Community Child Protection Volunteer Toolkit and Training Manual, based on a 2020 review of the evidence on the effectiveness of community volunteers. It documents current practices within Protection Case Management for children and other CP programming. Protection Case Management actors have adapted this toolkit for use in support of their adult protection caseloads. Do engage with this resource to ensure quality in your support of community-based personnel. Here is a summary of best practices promoted in this guidance, adapted[9] for Protection Case Management actors:

- **Get to know the community:** Seek out the community's 'natural helpers'[10]. Listen to them about how they are supporting at-risk members of the community.

- **Work with the community**: Invite community groups and leaders and marginalised community members into the process. When selecting community-based staff, be sure to prioritise trusted people who have communication and interpersonal skills.

- **Think carefully about how to work together**: Talk to different groups about the tasks they could take on and the time they have to give. Keep in mind that they may also be members of a vulnerable community and will need time for their families and economic activities. If a community member is doing full-time work and expected to take on responsibilities, they are no longer a "volunteer" and should be considered a caseworker. They must be trained, provided supportive supervision, and paid a fair wage.

- **Follow organisational policies on protection from sexual exploitation and abuse (PSEA) and data protection:** Community volunteers, when formally engaged, must adhere to the organisation's policies on PSEA and data protection. They should receive appropriate training on these commitments to ensure they understand the importance of safeguarding sensitive information and preventing exploitation and abuse. Volunteers should also sign relevant agreements or codes of conduct, ensuring accountability and compliance with organisational standards throughout their engagement.

- **Support ongoing learning with community-based team members:** According to the tasks agreed with volunteers, develop a learning plan together. If you are also utilising the skills and expertise of community members for your programming, do not limit regular support, supervision and coaching.

- **Link community-based staff to the protection team:** Consider ways to manage the power dynamics between staff and volunteers. Involve them in decision making and team discussions, incorporating the valuable insight and knowledge community volunteers bring to the team. If volunteers assist in identification or monitoring of cases, they must be continuously supported by a trained caseworker.

- **Ensure adequate resources for community-based staff to be successful:** Protection actors must have suitable funding for volunteer programming. This includes funds for ongoing training, coaching, and supervision (see Module 5). If sustained funding is not available, protection actors should carefully reconsider the recruitment of community members.

- **Prioritise volunteer safety and well-being:** Working in the community that you are a part of can be risky. Make sure community personnel are safe and protected. Set up regular dialogue groups to listen to volunteers and encourage support circles where personnel meet regularly to share knowledge and support each other. Hold regular 'appreciation' activities so they know they are valued by the protection organisation and the community.

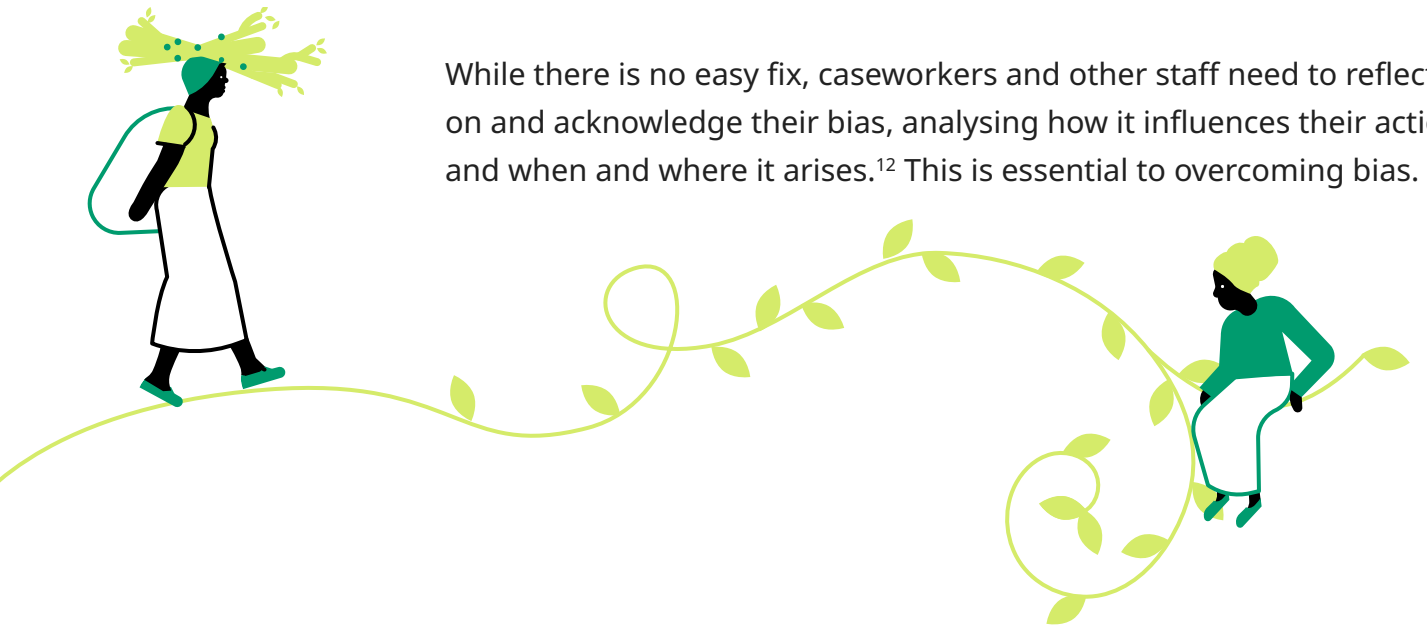
Attitudes, knowledge, skills

Some contexts have a professional social work structure and require certain qualifications in order to practise social work. In those instances, caseworkers need the required qualifications. However, this may not be possible in all contexts. When looking to recruit caseworkers in these contexts, qualifications or humanitarian experience should come second to having the right attitude.

People at risk may have intense emotional reactions, they may be indecisive or take sudden decisions, they may be distrustful, they may feel hopeless, and they may live in unhygienic or cramped conditions. Through these challenges, caseworkers will need to develop healing relationships with their service users. This has been well tested through the GBV case management practice, where the 'qualities of warmth, respect, genuineness, empathy and acceptance are key helping skills' - essential when working to build trust and induce hope.[11]

Attitudes

As mentioned, Protection Case Management relies on caseworkers building a positive and hopeful relationship with their service users. However, caseworkers have their own beliefs and values shaped by their culture, ethnicity, religion, gender, sexual orientation, socio-economic status, as well as their own personal experiences and history. Therefore, caseworkers must be aware of how these beliefs and values may lead to bias which affects their ability to use professional judgement, to actively listen and interpret information, to accurately document information, to develop positive relationships with their service users, and to avoid re-traumatization.



While there is no easy fix, caseworkers and other staff need to reflect on and acknowledge their bias, analysing how it influences their actions and when and where it arises.[12] This is essential to overcoming bias.

Addressing bias in your programme

1. **Interview stage:** During interviews, assess candidates' attitudes toward groups that face discrimination or stigma in your context (as identified in your protection analysis). Pay particular attention to their views regarding sexual orientation and gender identity, HIV/AIDS status, disability, and other locally relevant diversity factors. Candidates who demonstrate negative attitudes toward these groups should not be recruited as caseworkers.

2. **Orientation stage:** Train caseworkers and other staff on conscious and unconscious bias (e.g. patronising attitudes, lack of awareness of barriers faced by certain individuals). Provide them strategies for how to mitigate it in their work. Caseworkers can be asked to take an attitude scale to assess whether it is safe for them to work with service users (see Annex 3.4: Caseworker Capacity Assessment Form).

3. **Supervision:** Supervisors work with caseworkers to address bias through their work and to review progress by re-using the attitude scale.

Knowledge

Caseworkers' knowledge will grow over time through training, supervision and coaching (see Module 5). At a minimum, caseworkers should have knowledge of:

- Potential risks facing the prioritised communities, their capacities, and vulnerabilities
- Basic helping skills and psychological first aid
- Information about common mental health conditions (i.e. depression, anxiety, stress), as well as an ability to identify key signs of stress and psychological distress

- Available services, how to access those services, and the quality of those services, including the accessibility and attitudes of services providers towards diversity
- Data protection protocols and the information management database
- Complaint and feedback mechanisms for service users
- Self-care and well-being approaches

Skills

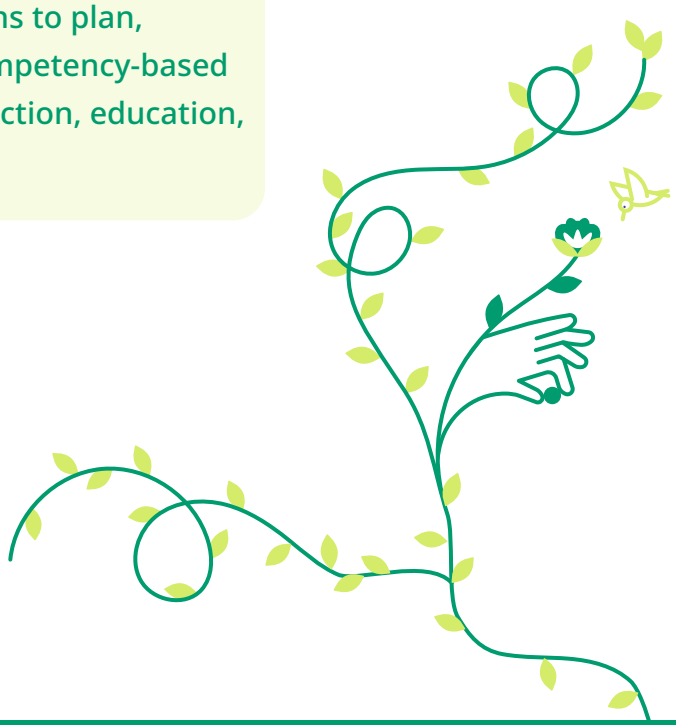
Caseworkers must be able to put their knowledge and attitudes to practise through their skills. This takes practice and comes with experience. They will need time to develop these skills through training, supervision, and peer support.

Caseworkers should be able to:

- Recognise whether a person is at risk, including what type of risk and determine the case's risk-level accurately
- Respond to immediate life-saving needs and develop safety plans
- Collect disaggregated data on disability accurately
- Assess mental health and psychosocial wellbeing and the needs of service providers
- Ask for informed consent/assent
- Identify potential barriers (e.g. accessing the physical environment and information), offering reasonable accommodations to support the service user's participation, if needed
- Build trusting relationships and maintain confidentiality principles throughout the duration of service provision
- Communicate without judgement and demonstrate empathy

- Inform the service user about available services and assistance options
- Conduct a safe, accountable, and timely referral for services
- Support the service user in recognising key issues and developing an action plan
- Use IMS, safely documenting and storing service user data
- Report any incidence of violence or sexual exploitation according to organisation procedures
- Use basic psychosocial support and psychological first aid skills, including active listening, identifying key signs of stress, and responding appropriately

MHPSS Protection Case Management caseworkers should be adequately trained, supervised and supported based on the requirements of the activity or activities that they are involved in. Observing, assessing and supporting the development of competencies (knowledge, skills, and attitudes) helps to ensure high-quality programmes. Assessing and monitoring competencies can also help in tailoring training, support and supervision. The Ensuring Quality in Psychosocial and Mental Health Care (EQUIP) platform and tools support teams and organisations to plan, design, adapt and implement existing and new competency-based MHPSS training for various sectors (e.g. child protection, education, health, etc.).



Protection Case Management protocol

Your Protection Case Management protocol should be reviewed and updated every six to 12 months. To ensure protocol adherence, your standard operating procedure should be developed in cooperation with the national protection sector, avoiding duplication or inconsistency with local social welfare procedures and practices. If this isn't relevant in your context, you will need to develop your own.

A protocol should include the following:

- **Guiding principles:** Create standard operating procedures in line with your guiding principles to ensure services are rights-based and centred on service users.

- **Case prioritisation:** This should be based on your contextual protection analysis, detailing the risk factors and protective factors that can help caseworkers prioritise cases. Programs may have to come up with a system to ensure that they see high-risk cases more regularly. Case prioritisation procedures should be outlined regularly.

- **Case management procedure:** An outline of the case management steps in the country to make them as practical and specific to your context as possible.

- **Caseload limit:** The best-practice guidance is a maximum 20-25 cases per week. However, this may vary from location to location and should be reviewed. The maximum number of caseworkers to be overseen by a supervisor should be not more than six.

- **How 'high-risk' cases will be handled:** A high-risk case is usually one in which there is an immediate threat to the service user's physical or psychological safety. Supervisors should define with their staff what they define as a "high-risk" case and what the procedure will be for handling such cases. For example, to whom and when does the caseworker bring such a case to a supervisor's attention? Should they phone the needed service provider directly rather than sending an email? When does the supervisor bring it to their manager for support?

- **Mandatory reporting:** The protocol should include mandatory reporting procedures and provide detailed guidance on how caseworkers handle such situations, including when they report to the supervisor and when the supervisor must report this to their manager.

- **Case coordination and conferencing:** Clearly mapped areas of responsibility for agencies to support referral between Protection Case Management streams. To assist this, established procedures for triggering case conferences for complex cases should be developed.

- **Referrals systems:** Updated version of the service maps, referral minimum standards and referral pathways.

- **Risk mitigation matrix:** Detailed advice on how to deal with potential risks, including what can be done to mitigate unintended harm and maintain service user safety and security.

- **List of forms:** The protocol should include a checklist of the Protection Case Management forms that a caseworker needs, correctly documenting the process.

- **Data management & protection protocol:** The protocol should outline steps to be taken to collect, store, and share information so that it remains safe and confidential (see Annex 3.5: Standard Operating Procedure Data Management and Protection). An additional agreement should be developed to share data safely between relevant organisations (see: Annex 3.6: Staff Data Protection Agreement).

- **Complaint and feedback, including PSEA protocols:** Contacts, advice and additional information that can be used to inform service users how to report complaints and provide feedback.

Information management

Documenting service user data

Protection Case Management forms document ongoing critical services. It is a standard practice in the field of social work, essential to making data-driven decisions. Standardised forms have been created by protection actors to use in various settings. They have gone through a review process and are the suggested starting point for developing and/or harmonising Protection Case Management forms.

If your programme uses digital documentation, you will need to determine what data platform best suits your needs and context. A data platform should aid in managing your caseload and facilitating documentation. You can explore existing databases within your organisation or context, or conduct a technical software requirements assessment. This process can be as simple as identifying the features and functionality needed in a system, and comparing them to existing or custom options to determine the best way forward. Note that any IMS used should follow Protection Case Management Software Requirements (see Annex 3.7: Software Requirements Specifications). Whether you decide to use a database with electronic forms or a spreadsheet with paper forms, you will need to ensure it is properly maintained by information management staff. These staff should be integrated into the team and trained on data protection and confidentiality. Staff should sign a data protection agreement to be clear that their work is in line with data protection standards (see Annex 3.6: Staff Data Protection Agreement).

Service users should have control over their data and, where possible, caseworkers must facilitate the service user's access to any documentation upon request. Therefore, caseworkers should try to use the same words as the service users when documenting meetings and discussions; this can be a helpful method for caseworkers to monitor the progress made by their service user and recognise new problems. Case notes should be based on facts and professionally substantiated judgement, avoiding bias. Caseworkers should refrain from using dismissive or offensive language.[13]

Protecting service user data

Data protection is the act of protecting personal or sensitive information in terms of how it is documented, stored and shared. During Protection Case Management, a substantial amount of information is gathered about service users. Caseworkers must document service users' personal protection data, details of their discussions, and actions taken on behalf of the service user. This ensures accountability in managing their cases.

Policies, protocols and practices for data protection are essential to our work, as unauthorised access or sharing of data can endanger service users and jeopardise your programme. You will need to establish data protection protocols and have staff sign a data protection agreement if you are to carry out Protection Case Management services (see Annex 3.6: Staff Data Protection Agreement),

For further protection of service user data, you can follow a data protection checklist (see Annex 3.8: Data Protection Checklist). Study a sample data protection protocol that includes the handling of data in emergency situations such as evacuations.

Information sharing

In many contexts, there are several organisations working together to provide services to persons with heightened protection risks. As a result, sharing information about cases and using referral forms becomes necessary. As discussed, actors involved in a referral pathway need to agree on what service user information should be shared, when, and with whom. They must agree how this information will be shared and followed up on - verbally, electronically or by paper - and on appropriate procedures to ensure the confidentiality and protection of persons at heightened risk. This can be documented in an information sharing protocol (see Annex 3.9: Data Sharing Agreement Template)[14].

While the IMS you use is primarily for supporting the Protection Case Management process with your service user, aggregated data analysis from this system can also inform other' advocacy and prevention work or help to prioritise interventions and resources.[15] Bear in mind that sharing this data should only be done after a risk assessment and when

agreed with other case management service providers on how to share it without causing harm. You should never share identifying information e.g. service user bio-data.

For more detailed information on the development of IMS protection, check out the Protection Information Management website.

What are the MEAL standards and guidelines for Protection Case Management?

Humanitarian and development organisations adopt MEAL activities to track progress of their interventions, assess their impact, adjust and improve approaches, as well as remaining accountable to service users, key stakeholders and donors.

Figure 3: Defining MEAL components

Monitoring: The continual and systematic collection of data to provide information on project progress. Monitoring involves the ongoing collection and review of data to provide program managers and other stakeholders with indications of progress against program targets.

Evaluation: User-focused, systematic assessment of the design, implementation and results of an ongoing or completed project. In contrast to ongoing monitoring, evaluations are periodic reflections at specific points of time.

Accountability: A commitment to balance and respond to the needs of all stakeholders (including project participants, donors, partners, and the organization itself) in the activities of the project.

Learning: Having a culture and processes in place that enable intentional reflection. Through learning, teams can make smarter decisions that lead to the best outcomes for service users.

For more information, see Annex 3.10: Common MEAL Terms and Definitions.

MEAL activities for Protection Case Management are specifically designed to consider the sensitive nature of interventions, drawing from the information service users share with their caseworkers. By following MEAL guidance, Protection Case Management teams are ready to:

- **Understand Protection Case Management process, quality and impact:** MEAL activities help to identify and demonstrate the effectiveness, relevance, appropriateness and quality of Protection Case Management interventions, and their impact on service users.

- **Implement evidence-based decision making:** MEAL generates actionable information that caseworkers, supervisors, managers and organisations can use to make evidence-based decisions related to programme design, implementation and resource allocation.

- **Strengthen accountability and transparency:** Systematised MEAL practices help build a culture of accountability and transparency among key stakeholders, including service users, communities, donors and partners. MEAL ensures that organisations are accountable, efficient and responsive to the needs of their service users.

- **Responsible data management and use:** MEAL guidelines and principles help teams to record, process and use information generated as part of the Protection Case Management process in a safe and responsible manner.

The following Protection Case Management **MEAL guidelines** detail:

- **Roles and staffing requirements** for Protection Case Management MEAL activities and processes

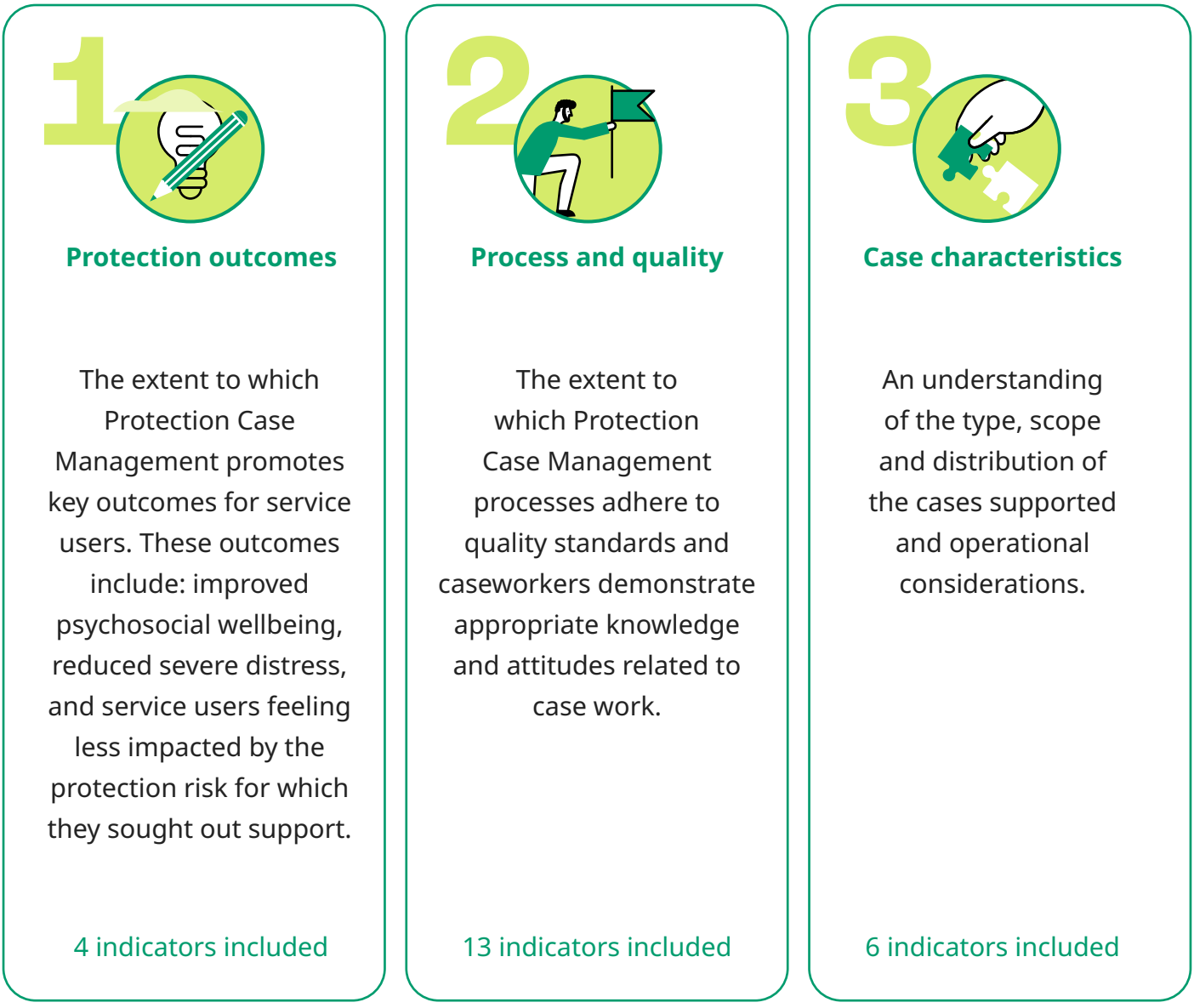
- Suggested Protection Case Management **outcome and output indicators** (with guidance on interpretation and use)

- **Data collection and management flow**, including different stages of the data life cycle (e.g. from planning to end of project archiving and destruction)

- **MEAL templates, tools, and databases** which can be contextualised where possible to fit the purpose and context (e.g. for teams with limited access to technology or those using a digitalised case management)

These guidelines will be structured around three **key categories of Protection Case Management data** (see below), which align with sections found in the Protection Case Management ToC (see Annex 3.11: Measuring the Protection Case Management Theory of Change):

Figure 4: Key categories of Protection Case Management data

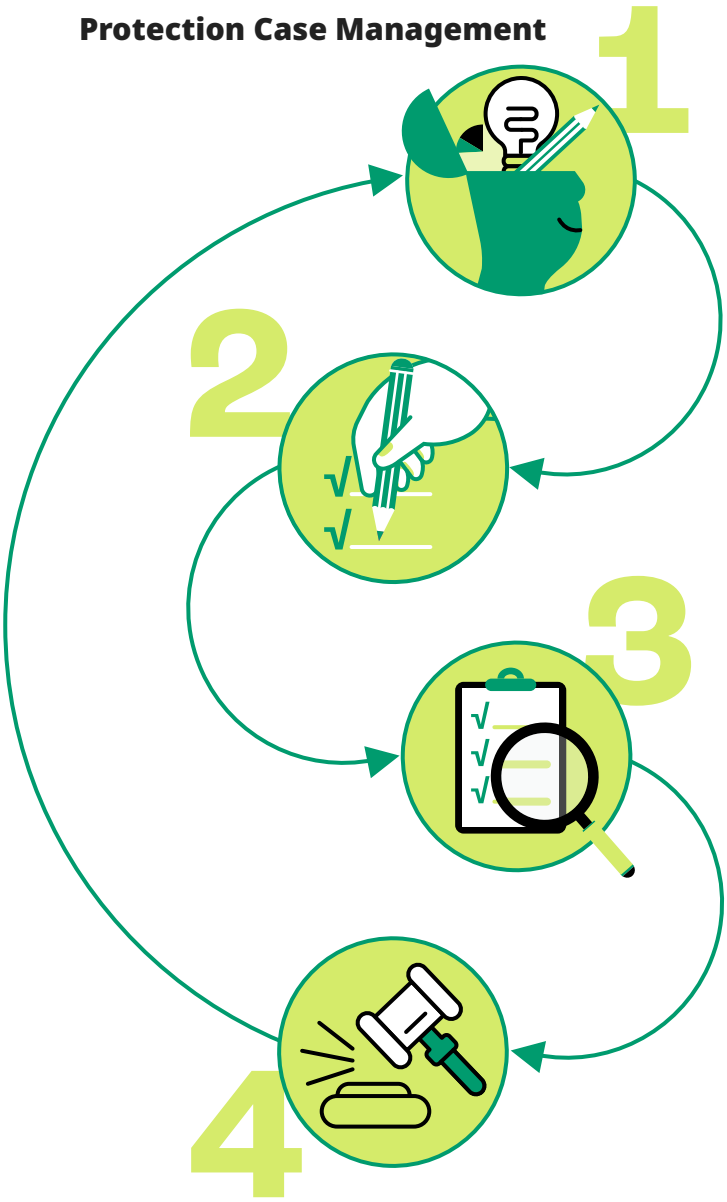


Planning for Protection Case Management MEAL

The Protection Case Management flow

Much of the information collected for Protection Case Management MEAL is captured through existing case management forms and as part of programming processes, rather than standalone data collection activities. Understanding the overall flow of Protection Case Management (see Figure 5) can therefore be very helpful for understanding how MEAL integrates into programming.

Figure 5: MEAL life cycle for Protection Case Management



1. Caseworker capacity strengthening

Capacity assessment form

2. Case intake

(1) Intake form
(1a) Interpreter non-disclosure agreement
(2) Informed consent and registration
(3) Protection risk assessment
(4) Psychosocial wellbeing assessment (baseline)
(5) Basic MHPSS assessment
(6) Case action plan
(5) Basic MHPSS assessment
(7) Referral form
(8) Safety plan

3. Ongoing case monitoring

(9) Follow-up form
(10) Case file checklist
(6) Case action plan
(8) Safety plan
(5) Basic MHPSS assessment

4. Case closure

(11) Case closure form
(4) Psychosocial wellbeing assessment (endline)
(5) Basic MHPSS assessment (endline)
(12) Service user feedback survey

Number in brackets represents form number.
Indicators come from forms in bold. You can find all forms listed, here.

Roles and responsibilities in the MEAL process

Effective MEAL Protection Case Management requires strong collaboration and coordination among different team members. The main responsibilities for each function include:

Case work	Collect data as part of the Protection Case Management process	Contribute to the analysis and trends
Case supervision	Aggregate and validate data	Conduct case reviews and debriefings to improve data quality
	Facilitate service user feedback mechanism	Analyse and use data for action and reporting
MEAL	Design context-specific MEAL systems	Support the selection of indicators
	Analyse and use data for action and reporting	Ensure MEAL standards are met throughout the process
	Train staff on MEAL practices, including service user feedback mechanisms	

Information management	Customise and maintain Protection Case Management IMS, including data processing	Ensure data responsibility standards are implemented throughout the Protection Case Management process
	Analyse and use data for action and reporting	

Project management	Ensure MEAL standards are met throughout the Protection Case Management process	Analyse, use and disseminate data for action and reporting
	Support the selection of indicators	

List of customisable Protection Case Management MEAL indicators

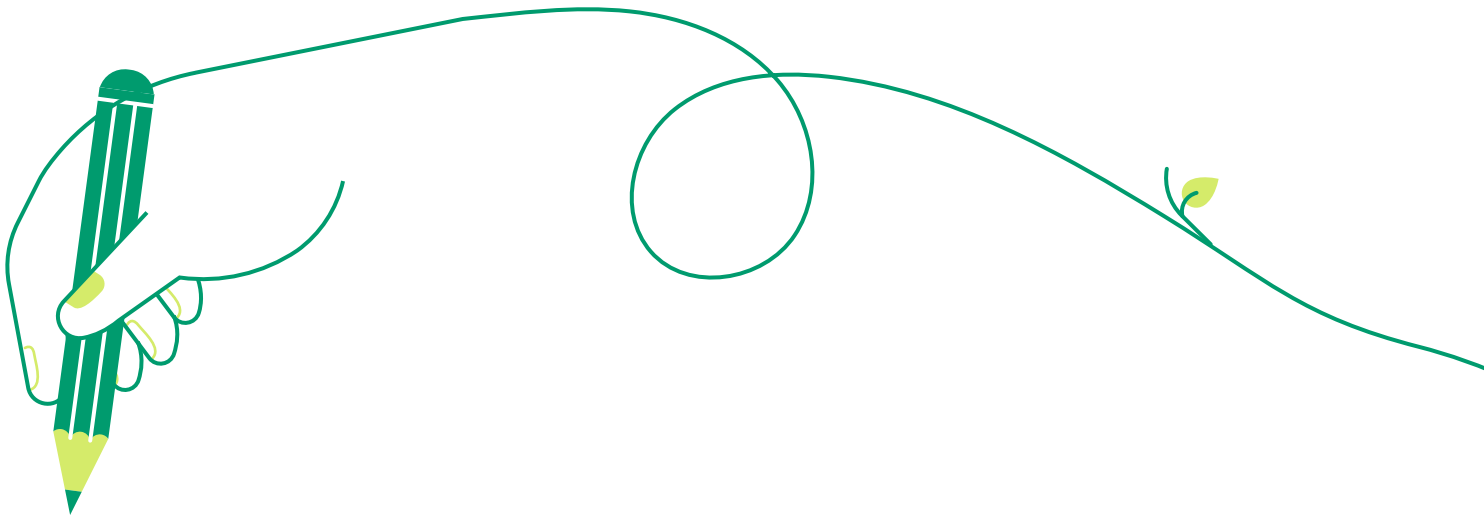
During the initial planning process, Protection Case Management teams select and customise a list of indicators, based on MEAL standards. Table 6 displays a non-exhaustive list of indicators that consider protection outcomes, process/quality standards, case characteristics to understand the population served, donor specifications, specific learning objectives, the change or outcomes that teams aim to contribute to through their Protection Case Management programmes, and context-specific limitations and goals.

Remember, you are not expected to use all indicators. For more details, see Tool 3.2: Protection Case Management Indicator Matrix and Annex 3.11: Measuring the Protection Case Management Theory of Change

Table 6: Protection Case Management MEAL indicators

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-01	Percentage of service users who demonstrate improved psychosocial wellbeing after receiving Protection Case Management support	Form 4: Psychosocial Wellbeing Assessment	At risk assessment and case closure	**Numerator:** Number of service users surveyed whose psychosocial wellbeing scores improved by at least 3 points **Denominator**: Number of service users who participated in both stages of the psychosocial wellbeing survey

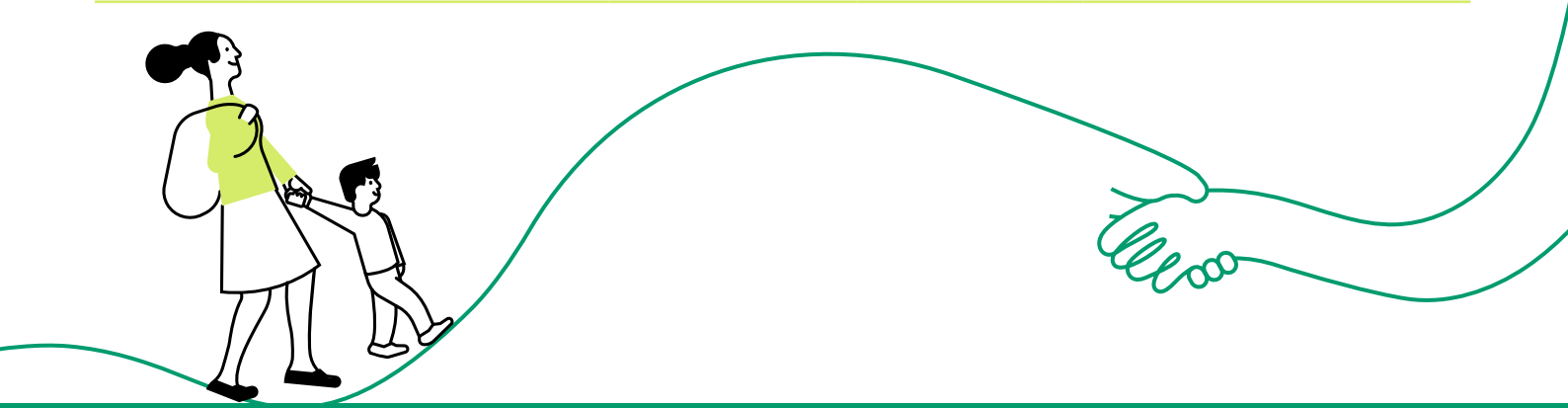
Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-02	Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support	Form 3: Protection Risk Assessment Form 11: Case Closure	At risk assessment and case closure	**Numerator:** Number of service users reporting less impact from the protection risk at case closure compared to the risk assessment stage **Denominator**: Number of service users who shared how much a protection risk is impacting their life at both the risk assessment and case closure stage



Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Protection outcomes				
PO-03	Percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving Protection Case Management support	Form 5: Basic MHPSS Assessment	At risk assessment and case closure	**Numerator:** Number of service users with an initial score of 15 or higher whose final score was 5 or more points lower than the initial score **Denominator**: Number of service users who completed the assessment at least twice and scored 15 or higher at intake
PO-O4	Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support	Form 3: Protection Risk Assessment Form 11: Case Closure	At risk assessment and case closure	**Numerator:** Number of service users who report they are better equipped to reduce or mitigate the risk at case closure than they did at the risk assessment stage **Denominator**: Number of service users who shared their ability to cope at both the risk assessment and case closure stage

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-01	Percentage of intakes eligible for Protection Case Management	Form 1: Intake	Quarterly	**Numerator:** Number of cases meeting the eligibility criteria **Denominator**: Number of intakes
PQ-02	Number of total service users	Form 1: Intake	Monthly	**Numerator:** Number of service users with open and closed cases **Denominator**: N/A
PQ-03	Number of new cases registered for Protection Case Management	Form 1: Intake	Monthly	**Numerator:** Number of cases opened **Denominator**: N/A
PQ-04	Percentage of cases closed due to meeting objectives of the action plan	Form 11: Case Closure	Quarterly	**Numerator:** Number of cases that have been closed because the objectives of those case action plans have been met **Denominator**: Number of closed cases

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-05	Percentage of service users who received cash assistance to address their protection risks through Protection Case Management	Form 6: Case Action Plan Form 9: Follow-up and Monitoring	Monthly	**Numerator:** Number of service users who received cash assistance **Denominator**: Number of service users
PQ-06	Average number of cases per caseworker per month	Form 1: Intake	Quarterly	**Numerator:** Number of open cases **Denominator**: Number of caseworkers
PQ-07	Percentage of caseworkers whose knowledge assessment score is at least 70 per cent	Supervision Form 1: Caseworker Capacity Assessment	Quarterly	**Numerator:** Number of caseworkers who score 70 per cent or higher on the knowledge assessment score **Denominator**: Number of caseworkers who finalised the caseworker capacity assessment



Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-08	Percentage of caseworkers whose attitudes score is at least 80 per cent	Supervision Form 1: Caseworker Capacity Assessment	Quarterly	**Numerator:** Number of caseworkers whose attitudes score is at least 80 per cent **Denominator**: Number of caseworkers who finalised the caseworker capacity assessment
PQ-09	Percentage of case files reviewed that meet 80 per cent of criteria of a case file checklist	Supervision Form 4: Case File Checklist Tool	Quarterly	**Numerator:** Number of case files that meet 80 per cent of criteria within a case file checklist **Denominator**: Number of case files reviewed
PQ-10	Number of caseworkers trained in Protection Case Management	Project records	Quarterly	**Numerator:** Number of caseworkers trained in Protection Case Management **Denominator**: N/A

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-11	Percentage of service users that felt they were involved in decisions during their case management	Form 12: Service User Feedback Survey	Quarterly	**Numerator:** Number of service users who indicated they felt they were included in decisions **Denominator**: Number of service users who agreed to participate in the established feedback mechanism
PQ-12	Percentage of service users that are satisfied with the case management services	Form 12: Service User Feedback Survey	Quarterly	**Numerator:** Number of service users who report being satisfied with the case management services **Denominator**: Number of service users who agreed to participate in the established feedback mechanism

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Process and quality				
PQ-13	Percentage of successful referrals	Form 6: Case Action Plan Form 9: Follow-up and Monitoring	Quarterly	**Numerator:** Number of successful referrals - a referral is considered successful when the client has successfully accessed the service. This information is usually shared by the client during a follow-up visit. **Denominator**: Number of referrals
Case characteristics				
CC-01	Percentage of cases by protection risk	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of cases per protection risk **Denominator**: Number of cases
CC-02	Percentage of cases by risk level	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of cases per risk level **Denominator**: Number of cases

Indicator number	Protection Case Management MEAL indicator	Data source	When to collect	Calculation
Case characteristics				
CC-03	Percentage of cases by duration	Form 1: Intake Form Form 11: Case Closure	Quarterly	**Numerator:** Number of cases per duration **Denominator**: Number of cases
CC-04	Percentage of service users that have a disability	Form 3: Protection Risk Assessment	Monthly	**Numerator:** Number of service users that have a disability **Denominator**: Number of service users
CC-05	Percentage of cases with a finalised safety plan	Form 8: Safety Plan	Monthly	**Numerator:** Number of cases with a finalised safety plan **Denominator**: Number of cases
CC-06	Percentage of service users reporting symptoms of moderate to severe distress in the 14 days prior to survey completion	Form 5: Basic MHPSS Assessment	Quarterly	**Numerator:** Number of service users reporting symptoms of moderate to severe distress in the past 14 days prior to survey completion **Denominator**: Number of service users

A note on outcome monitoring

Outcome monitoring is a process by which the impact of Protection Case Management is measured. Annex 3.13: Outcome Monitoring Guidance provides guidance on how to measure impact on service users psychological wellbeing, reduced severe distress, and the impact of protection risks on service users' day-to-day lives. Country teams can select one or more of these three potential outcomes to measure as part of their service delivery.

Protection Case Management data flow

Different Protection Case Management data collection and data management tools must be implemented throughout the case management process, as well as at predefined moments during the project cycle. **Figure 6 outlines the different tools across the three categories of Protection Case Management learning**.

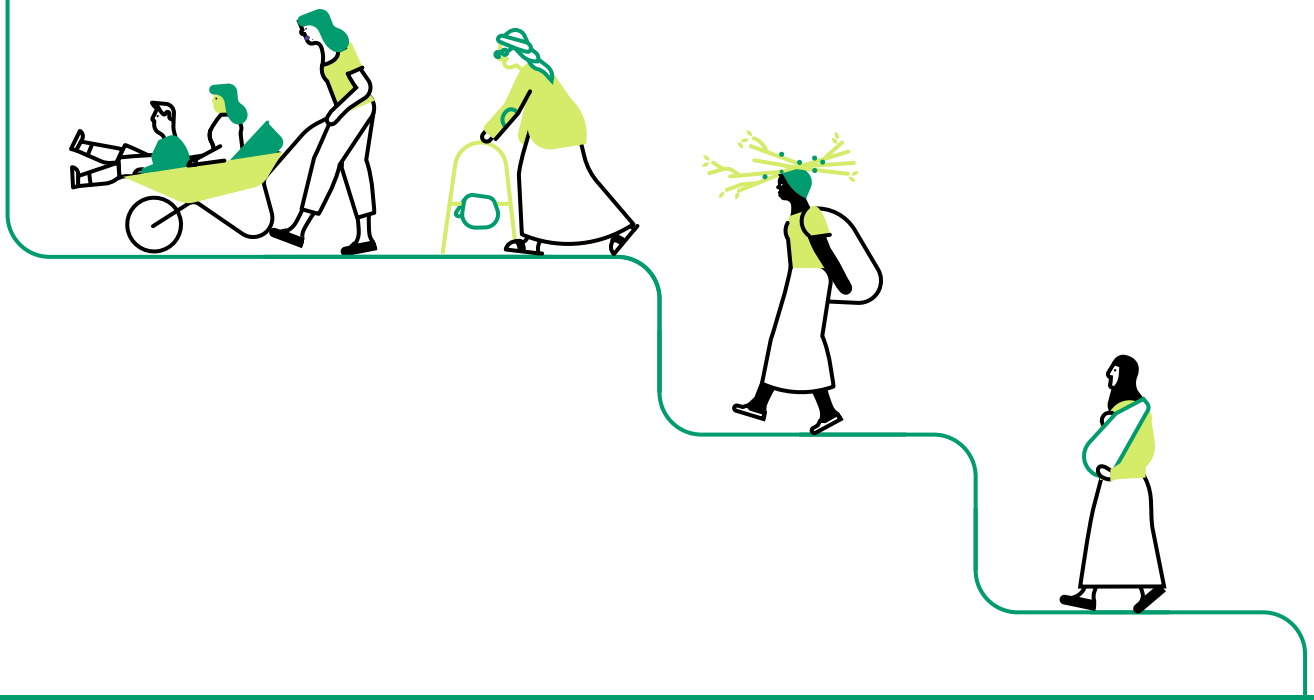
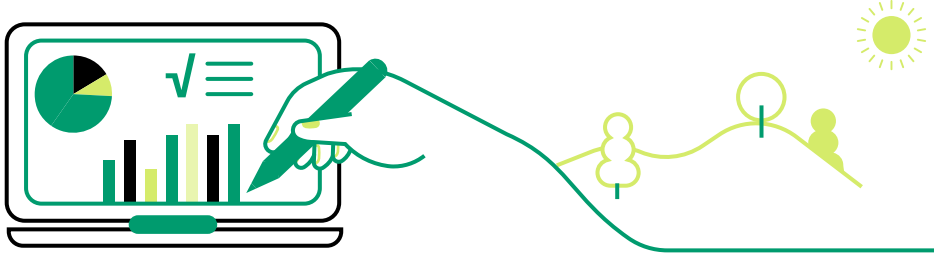


Figure 6: Data flow for Protection Case Management MEAL tools and dashboards

	Protection Case Management process and quality	Case profile	Protection outcomes
Step 1 Contextualise indicators / forms and train staff on use			
Step 2 Administer forms as part of the Protection Case Management and supervision process	• Capacity assessment • Case file checklist	• Intake and registration • Protection assessment • Safety assessment • Action plan • Follow-up • Case closure • PHQ9	• Interim client feedback • Reactive channels • Protection outcome survey • End line client feedback
Step 3 Process, analysis and interpretation	Analysis dashboard	Analysis dashboard	Output TBC
Step 4 Implement measures to improve data quality			



Centering service user MEAL approaches: Service user-centred Protection Case Management MEAL activities and programming rely on responsible data management and analysis. An important component of this is informed consent of the service. For each component of the service delivered, gather informed consent, including participation in the Protection Case Management process, participation in any monitoring and feedback activity, and sharing of data for other purposes. Always make it clear that they can refuse participation in any monitoring activities, which does not affect their ability to receive Protection Case Management services. See Module 4 for further guidance on how to obtain consent that is meaningful and informed. MEAL components should strengthen delivery of quality services for service users, helping programmes be responsive to service user needs and feedback. Service user feedback is seen as a core part of routine monitoring. Service users are encouraged to provide feedback at any point during the case management service, by using reactive feedback channels such as hotlines or during conversations with their case managers. To collect structured feedback on the service provided, all service users should be invited to participate in the service user feedback survey. See Annex 3.12: Client Feedback Modalities for more information on the modalities that can be used to administer this survey.

Caseworkers should ensure that service users are aware of these feedback mechanisms, and that programme staff receive actionable updates generated by feedback data collected.

All feedback received by service users requires tailored follow-up by teams.

Table 7: Feedback follow-up by teams

Type	Examples	Follow-up
General feedback/ other	Positive feedback and other issues raised that do not require follow-up, such as thanking the caseworker for their support	If required, direct follow-up with the Protection Case Management team, within one month

Type	Examples	Follow-up
Programmatic complaint – minor dissatisfaction	Most complaints related to the relevance, quality or impact of interventions; access related issues such as the timing or location of services; issues related to a lack of voice and empowerment	Direct follow-up with the Protection Case Management team, within 14 calendar days
Programmatic complaint – major dissatisfaction	Complaints about safe access to services, unfair treatment, lack of respectful and dignified treatment by staff, attitude, exclusion of a minority/ vulnerable group	Direct follow-up with the Protection Case Management team, within 7 calendar days
Breach law or safeguarding misconduct by Protection Case Management staff or external service providers	• Exploitation and abuse (sexual, economic, other) • GBV • Bribery, corruption, and kickbacks • Child safeguarding • Fraud • (Sexual) Harassment or discrimination • Physical safety risks • Procurement fraud • Retaliation • Threat	**Critical**: Immediate follow-up required, in line with the response specific referral process. Aid workers must report any known or suspected allegations of sexual exploitation and abuse in line with the survivor-centred approach and be aware of their organisational policy. For detailed guidance on how to handle complaints, refer to the Guidance Note: INTER-AGENCY SEXUAL EXPLOITATION AND ABUSE REFERRAL PROCEDURES

For further detail, see Form 12: Client Feedback Survey.

MEAL data collection tools and guidance

This section includes an overview of all key data collection tools, as listed in Figure 6: Data flow for Protection Case Management MEAL tools and dashboards.

Protection Case Management process and quality forms

Annex 3.4: Caseworker Capacity Assessment (knowledge and attitude)

- **Purpose of tool:** To understand and monitor caseworker's attitude, knowledge and skills. It contains minimum competency standards for all caseworkers offering user-centred Protection Case Management services. It tests caseworkers' internal biases and attitude as it pertains to the cases they support. Once the assessment is complete, the supervisor and caseworker agree on the suggested priorities in each area for technical capacity building and development.
- **Key MEAL indicator(s)**:
  - Percentage of caseworkers whose knowledge assessment score is at least 70 per cent (PQ-07)
  - Percentage of caseworkers whose attitudes score is at least 80 per cent (PQ-08)

Supervision Form 4: Case File Checklist Tool

- **Purpose of tool:** A guide for supervisors to review a single protection case by reviewing all of the different core Protection Case Management tools (identification and intake, protection risk assessment, action plan, safety plan, follow-up and case closure). This tool is part of regular coaching, and feedback should be provided in individual supervision sessions. It can also be used to review multiple case files independently. Where common trends are observed (i.e. mistakes or challenges), these can be addressed in group sessions together.

- **Key MEAL indicator(s)**:
  - Percentage of case files reviewed that meet 80 per cent of criteria of a case file checklist (PQ-09)

Case profile forms

Form 1: Intake Form

- **Purpose of tool:** To gather essential information about individuals seeking assistance or support to receive Protection Case Management services. The form serves as a foundational document that enables caseworkers and service providers to understand if the service user is eligible for Protection Case Management services, basic bio-data information, and any barriers the service user might face with access case management.
- **Key MEAL indicator(s)**:
  - Percentage of intakes eligible for Protection Case Management (PQ-01)
  - Number of total service users (PQ-02)
  - Number of new cases registered for Protection Case Management (PQ-03)
  - Average number of cases per caseworker (PQ-06)
  - Percentage of cases by duration (CC-03)

Form 3: Protection Risk Assessment

- **Purpose of tool:** To understand the circumstance of the service user and their protection risks. The assessment will include detailed bio data information, as well as information about the service user and their protection risks, including any vulnerabilities and strengths the service user will have. This process involves gathering comprehensive information to determine the most appropriate course of action for each service user.
- **Key MEAL indicator(s)**:
  - Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support (PO-02)
  - Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support (PO-04)
  - Percentage of cases by protection risk (CC-01)
  - Percentage of cases by risk level (CC-02)
  - Percentage of service users that have a disability (CC-04)

Form 6: Case Action Plan

- **Purpose of tool:** To record and plan agreed interventions needed to address the service user's risks.
- **Key MEAL indicator(s)**:
  - Percentage of service users who received cash assistance through Protection Case Management (PQ-05)
  - Percentage of successful referrals (PQ-13)

Form 8: Safety Plan

- **Purpose of tool:** To record and plan for how to mitigate risk of harm for service users whose safety is at risk.
- **Key MEAL indicator(s)**:
  - Percentage of cases with a finalised safety plan (CC-05)

Form 9: Follow-up and Monitoring

- **Purpose of tool:** To re-assesses service user needs, including safety, mental health and referral tracking.
- **Key MEAL indicator(s)**:
  - Percentage of service users who received cash assistance through Protection Case Management (PQ-05)
  - Percentage of successful referrals (PQ-13)

Form 11: Case Closure

- **Purpose of tool:** To record information on why the case is closed, and ensures the caseworker, supervisor and service user agree on the next steps.
- **Key MEAL indicator(s)**:
  - Percentage of service users who report being less impacted by protection risks after receiving Protection Case Management support (PO-02)
  - Percentage of service users who report that they are better equipped to reduce or mitigate the protection risk after receiving Protection Case Management support (PO-04)
  - Percentage of cases closed due to meeting objectives of the action plan (PQ-04)
  - Percentage of cases by duration (CC-03)

Protection outcomes forms

Form 4: Psychosocial Wellbeing Assessment

- **Purpose of the tool:** Designed to gather information from the service user about different aspects of service users wellbeing. It is a questionnaire with 14 statements about feelings and thoughts, covering a number of areas relevant to Protection Case Management, including:
  - Positive functioning and competence
  - Autonomy and empowerment
  - Coping, resilience and hope
  - Positive affect and emotions
  - Relationships and social support

To measure change for a specific service user, the tool is administered at two points in the process: At the start and end of the service delivery. The aggregate results can be shared with donors and other stakeholders to prove the value of Protection Case Management.

- **Key MEAL indicator(s):**
  - Percentage of service users who demonstrate improved psychosocial wellbeing after receiving Protection Case Management support (PO-01)

Form 5: Basic MHPSS Assessment

- **Purpose of the tool:** To identify signs and symptoms of distress in individuals, through nine questions. It helps case managers understand how these problems are impacting the service users life and ability to take care of themselves. It assists decisions regarding immediate referral and tailored MHPSS support. To use the tool as a way to measure the impact of case management, the tool can be administered at the start of case management and at case closure. This is especially relevant when working with service users who report severe distress at the start of the Protection Case Management process.
- **Key MEAL indicator(s):**
  - Percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress after receiving Protection Case Management support (PO-03)
  - Percentage of service users reporting symptoms of moderate to severe distress in the 14 days prior to survey completion (CC-06)

Form 12: Service User Feedback Survey

- **Purpose of the tool:** To enable the service user to provide feedback on the services provided in a confidential manner - the service user feedback survey is administered during or after the process. The tool measures the service user´s perspectives on access and safety of the services, whether they received respectful and dignified treatment, their sense of empowerment throughout the process (and its relevance), and satisfaction with the services.
- **Key MEAL indicator(s):**
  - Percentage of service users that felt they were involved in decisions during their case management (PQ-11)
  - Percentage of service users that are satisfied with the case management services (PQ-12)

Note: The third protection monitoring outcome (indicators PO-02 and PO-04) is measured at the protection risk assessment and case closure stages.

Data sharing considerations

Before sharing data with anyone outside the Protection Case Management process, consider certain characteristics of your collected information. See Table 8 for more information.

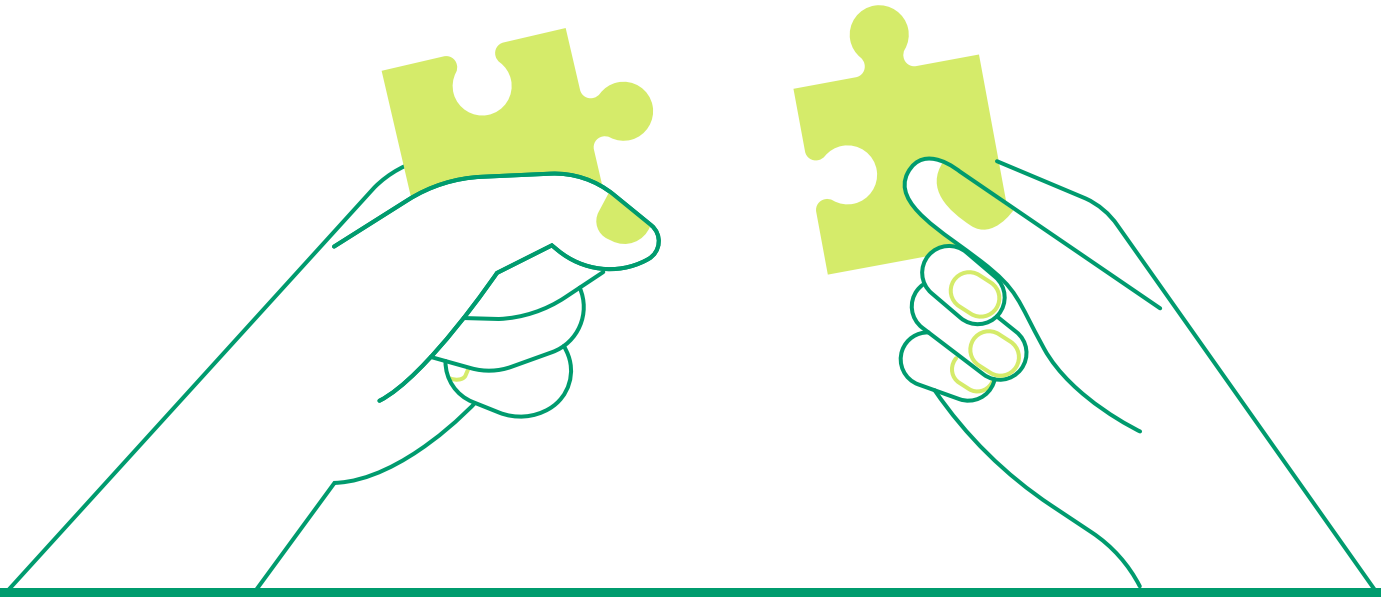


Table 8: Data considerations before sharing

	Strictly confidential	Restricted
Definition	Information or data that, if disclosed or accessed without proper authorisation, **are likely to cause severe harm or negatively impact** service users, caseworkers, supervisors or the organisation. Highly limited, bilateral disclosure only. Determined and approved on a case-by-case basis, with assurance of upholding the highest standards of data protection.	Information or data that, if disclosed or accessed without proper authorisation, **are likely to cause minor harm or negative impacts and/or be disadvantageous** to caseworkers, supervisors or the organisation. Can be shared - based on a clearly specified purpose and related standards for data protection.
Forms	Form 1: Intake Form Form 3: Protection Risk Assessment Form 6: Case Action Plan Form 8: Safety Plan Form 11: Case Closure	Supervision Form 1: Caseworker Capacity Assessment Supervision Form 4: Case File Checklist Tool
Groups who have access to individual level data	Service user, supervisor, case manager, and data processor (MEAL or information management focal point)	Supervisor and data processor (MEAL or information management focal point)

Data management and analysis

To report on the key MEAL indicators selected (see Table 3: Protection Case Management MEAL indicators), case managers, supervisors and coordinators report on key characteristics for each case and the overall process. If the Protection Case Management team uses hard copy forms to capture service user-specific data, this reporting can be systematised using the Tool 3.3: Protection Case Management Dashboard. This information is updated as the case progresses. For instance, when its status changes from open to closed. The information is cleaned and consolidated by the information management focal point, who uses the Protection Case Management Excel dashboard to share these insights with the Protection Case Management team, and other stakeholders (see Annex 3.7: Software Requirements Specifications).

The Protection Case Management dashboard interface

Using a digital platform to populate and store Protection Case Management forms facilitates this type of reporting. It enables the monitoring of case and service user characteristics in real time, without additional reporting requirements for case managers, supervisors and coordinators. For more information on the requirements for such a platform, see Annex 3.7: Software Requirements Specifications.

Overall interpretation guidance

In general, all interpretation is guided by the following questions:

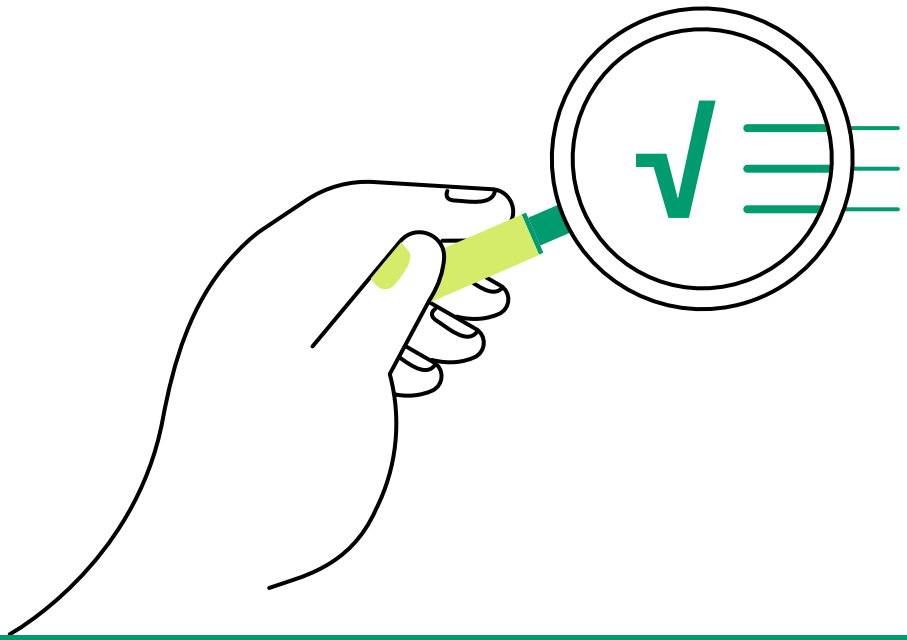
- What does this data mean? What trends can be seen? Which cases are outliers and why so?
- What could the data possibly be telling us about our (programme, services, outreach, etc.)? What doesn't it tell us?
- How does this data compare to last month, last year? How is this quarter different from last quarter?
- How can this information be used? For our programme design? For our prevention programming? For our information dissemination/ awareness raising? For our advocacy efforts?
- Who else needs to know about this? How do we safely share our findings?

Detailed interpretation guidance by indicator is available in Annex 3.14: Indicator Interpretation.

Table 9 offers questions that can generate actionable insights for each outcome (based on indicators).

Table 9: Reflection questions to support outcomes

	Reflection questions by recommended disaggregation	Use
Protection outcomes *Indicators PO-01 to PO-04*	• Does the outcome of the Protection Case Management service differ when looking at **gender, age, disability status, displacement status, risk level,** and/or **type of protection** risk exposed to? • To what extent do outcomes differ between **geographic areas?** • How does service user feedback on the service provided differ between **caseworkers** and between **geographic locations**?	• Supervision and caseworker skills development • Donor engagement • Case management planning, strategies, and service adaptation • Coordination with other actors and advocacy



	Reflection questions by recommended disaggregation	Use

Process and quality
 	
Indicators PQ-01 to PQ-13
	• Have **referrals been successful**? For all types of services required, in all geographic areas? If not, what are the main barriers?
	• Have all service users who report safety and security concerns **finalised a safety plan** with their caseworkers? If not, why not?
	• How do Protection Case Management processes and quality indicators, including case to caseworker ratio, differ between **caseworkers** and **geographic areas**?
	• When looking at a summary of the case file checklist, what is the **percentage of cases that meet the following criteria:**
	  ◦ Was informed consent/assent to collect, store and share information obtained?
	  ◦ Was the risk assessment carried out within one week of the identification?
	  ◦ Was the case plan developed with the service user?
	• How do they differ between **age, gender, risk level, and type of protection risk** the service user has been exposed to? *(include reference to indicator(s))*
	• How has this changed as compared to the **previous review period?** *(include reference to indicator(s))*
	• What can the capacity scores for different **caseworkers** tell us about current strengths and capacity limitations? *(include reference to indicator(s))*
		• Supervision and caseworker skills development
		• Staffing and budget programmatic decision making
		• Donor engagement

	Reflection questions by recommended disaggregation	Use
Case characteristics *Indicators CC-01 to CC-06*	• What can the number of intakes by service user **age, gender, place of residence, and disability status** tell us about the key characteristics of our service users? *(include reference to indicator(s))* • Do these findings indicate **specific barriers** to accessing services for potential service users with certain characteristics (e.g. of a certain age, with a disability, those living in a specific geographic area)? *(include reference to indicator(s))* • What are the most common **types of protection risks** reported by service users and what can this tell us about the resources and referral mechanisms required? Are service users facing certain types of violations more likely to reach out to Protection Case Management? *(include reference to indicator(s))*	• Staffing and budget programmatic decision making • Donor engagement • Advocacy

Use of Protection Case Management data for strategic programming

Protection Case Management data serves multiple purposes:

1. Supporting operational staff (case managers, supervisors and coordinators)
2. Meeting donor reporting requirements through aggregated data
3. Enabling broader contextual analysis for advocacy and strategic planning

Before using data for these purposes, ensure proper informed consent procedures are followed (see Module 4).

Donor relationships

At the project design phase, promote the use of standard indicators to monitor progress towards goals set out in the Protection Case Management grant agreements, including:

- **Outputs:** The number of caseworkers trained, the number of new cases registered, the percentage of service users who received cash assistance.

- **Quality and outcome:** The percentage of service users that are satisfied with Protection Case Management services, the percentage of service users who demonstrate improved psychosocial wellbeing after receiving support, the percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress over the course of the process, the percentage of service users who report to be less impacted by protection risks after receiving support.

Negotiate data-sharing restrictions at grant inception

Protection Case Management services handle highly sensitive information, requiring careful consideration when sharing data with external actors, including donors. The most critical restriction concerns numerical targets: neither the total number of service users nor specific violations should be predetermined. Setting quotas - such as specifying a minimum number of torture survivors to receive support - must be avoided in project documentation.

This restriction stems from the complex nature of Protection Case Management. A quota-driven approach inevitably compromises service quality, as caseworkers may feel pressured to prioritise specific profiles or, more worryingly, turn away those who fail to meet target criteria. There's also the risk of caseworkers feeling compelled to force disclosure simply to meet donor requirements. Moreover, service users typically present multiple, interconnected concerns, making it impractical and potentially harmful to predict specific case numbers or types during the proposal stage.

Data that reflects the quality and coverage of the service can be provided instead:

- **Outcome indicators**: For example, the percentage of service users who demonstrate improved psychosocial wellbeing after receiving support, the percentage of service users with mental health needs who demonstrate a reduction in symptoms of severe distress over the course of the process, or the percentage of service users who report being less impacted by protection risks after receiving support.

- **Output indicators**: For example, the number of cases opened and closed, the number of caseworkers trained in Protection Case Management, or the number of service users per caseworker.

One of the guiding principles of Protection Case Management is the right to confidentiality (see Module 1). Such confidentiality is based on strict data sharing agreements and only based on explicit service users permission. As such, personally identifiable data cannot be shared with donors, unless these criteria are met. Alternatively, aggregated data can be shared. For instance, on service users and case profiles reached.

Data for advocacy and analysis

Aggregated Protection Case Management data provides further insights into the protection risks service users are facing, existing barriers to services, rights, and their preferred solutions. As it does not require additional primary data collection, reviewing Protection Case Management data can be a cost-effective method to inform context analysis and strategic planning. It can help answer questions such as:

- What are examples of barriers that people face when trying to access services and/or rights?
- Which services are requested by service users but not available?
- What are some of the key drivers of violence against the population in areas of service?
- Who is included among the perpetrators of these threats?
- What are common coping mechanisms and solutions service users prioritise to address the issues?

However, as Protection Case Management only includes the experiences of those able to access the services, there are several considerations when using Protection Case Management data for context analysis:

- Do consider the **context** of the data and who have provided their consent to share their data as part of wider statistical analysis. It does not include the experiences of survivors unable to reach one of the service providers who use the Protection Case Management IMS. As such, Protection Case Management data **can never provide insights on prevalence of protection incidents** in a certain geographic area.

- In light of these limitations, **do not share the number** of incidents reported. Instead, use percentages. With percentages, round up or down rather than using decimal points. Numbers should not get too specific to avoid a recalculation into absolute numbers. Instead, report any important proportional increase or decrease.

- **Be careful with trend analysis.** Protection Case Management data reflects the level of access to Protection Case Management services. As such, an increase in *reported* violations does not necessarily mean an increase in the *occurrence* of such violations. It could reflect an increased trust in programming or service providers, or an expansion of services provided.

- Information should **always be interpreted by the team directly involved in Protection Case Management**. Sharing descriptive data without interpretation to those unfamiliar with Protection Case Management is likely to lead to misinterpretation of trends and issues.

- Do **triangulate** data with other available information sources, including protection monitoring and analysis initiatives.

Evaluations

Learning from evaluations supplements routine monitoring. It allows for key reflection questions to be asked at specific points in the Protection Case Management programming cycle, test underlying assumptions, and bring in voices beyond service users. It is recommended after the closure of any Protection Case Management process. If budget allows, conduct the evaluation process externally. Key programme components that are covered within evaluations include the relevancy and adequacy of an intervention, coherence with other interventions, efficiency, effectiveness, impact, and sustainability.

Summary of key points

This Module builds on the protection analysis that was conducted and foundational decisions that were taken during the steps outlined in Module 2. Work through Module 2 before proceeding with the design steps outlined in this chapter.

In order for your service to be a Protection Case Management service aligned with this guidance, it must meet or be actively working to meet the minimum standards outlined in this module. There is guidance for how to do this in this module and in others.

Develop your service delivery design and related protocols before training your teams and delivering the service. It will take time to consider which mode of delivery is appropriate, what resources you need, and how they will be used. This is important for the safety of your service users and staff, as well as the quality of the service.

Learning from your service through monitoring and service user feedback is important to improving your protocols, identifying the professional development needs of your staff, as well as your accountability to donors, service users, and other stakeholders. Plan to do this by using this guidance to finalise your own MEAL standards and guidelines.

Up next

Module 4: Delivering Protection Case Management: A Guide for Supervisors and Caseworkers

This module will guide supervisors and caseworkers in creating a comprehensive, user-centred approach to Protection Case Management, answering the following questions:

- **How do I establish a trusting and supportive service user relationship?**
  Taking a more considered look at how to build a safe and secure environment for service users throughout the entire Protection Case Management process.

- **What is the step-by-step process of Protection Case Management?**
  Preparing for Protection Case Management sessions with service users by providing a more in-depth look at the steps of Protection Case Management:
  - Step 1: Introduction and intake
    - Introductions
    - Urgent needs
    - Explaining service user rights
    - Explaining confidentiality
    - Determining initial risk level
  - Step 2: Protection risk assessment
    - Risk and vulnerabilities
    - Protective strengths and capacity
    - Strengths-based approach
  - Step 3: Case action planning
    - Goal setting with service users
    - Safety planning
    - Accompaniment
  - Step 4: Implementation of case action plan
    - Direct service provision
    - Referral
    - Lead case coordination
  - Step 5: Follow-up and monitoring
  - Step 6: Case closure and case transfer

Forms

Form 1: Intake Form

Form 1A: Interpreter Non-Disclosure Agreement

Form 2: Informed Consent and Registration

Form 3: Protection Risk Assessment

Form 4: Psychosocial Wellbeing Assessment

Form 5: Basic MHPSS Assessment

Form 6: Case Action Plan

Form 7: Referral Form

Form 8: Safety Plan

Form 9: Follow-up and Monitoring

Form 10: Case File Note

Form 11: Case Closure

Form 12: Service User Feedback Survey

Tools

Tool 3.1: Accessibility Checklist

Tool 3.2: Protection Case Management Indicator Matrix

Tool 3.3: Protection Case Management Dashboard

Annexes

Annex 3.1: Accessibility and Reasonable Accommodation

Annex 3.2: Guidance Note on Provision of Assistive Devices

Annex 3.3: Staff Roles and Responsibilities

Annex 3.4: Caseworker Capacity Assessment

Annex 3.5: Standard Operating Procedure Data Management and Protection

Annex 3.6: Staff Data Protection Agreement

Annex 3.7: Software Requirements Specifications

Annex 3.8: Data Protection Checklist

Annex 3.9: Data Sharing Agreement Template

Annex 3.10: Common MEAL Terms and Definitions

Annex 3.11: Measuring the Protection Case Management Theory of Change

Annex 3.12: Client Feedback Modalities

Annex 3.13: Outcome Monitoring Guidance

Annex 3.14: Indicator Interpretation

Endnotes

1 Best practice is to coordinate with other agencies which already have a hotline. This avoids setting up multiple hotline numbers for the same service in the same area, which can be confusing for people..

2 Thanks to the GPC C4PTT for reviewing this section of the guidance as part of this revision.

3 GPC, *Cash and Voucher Assistance for Protection*. https://globalprotectioncluster.org/publications/1886/policy-and-guidance/policy/cash-protection-stocktaking-paper-march-2024-updated

4 WHO, Global Report on Assistive Technology: Summary. https://cdn.who.int/media/docs/default-source/assistive-technology-2/3128-emp-summary-landscape-local-print-081222.pdf?sfvrsn=37f41429_5

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

6 Overseas Development Institute, Risk and Humanitarian Cash Transfer Programming, 2015. https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9727.pdf

7 As recognised by established sources for supervision ratio standards: the *Child Welfare League of America, the Council on Accreditation, and the Child Protection Supervision and Coaching Package.*

8 The Alliance for Child Protection in Humanitarian Action, Community volunteers and their role in case management processes in humanitarian contexts: A comparative study of research and practice, 2021. https://alliancecpha.org/sites/default/files/technical/attachments/cp_community_volunteers_-_low_res.pdf

9 The Alliance for Child Protection in Humanitarian Action, 7 Best Practices to Support Community Volunteers. https://alliancecpha.org/sites/default/files/technical/attachments/7_best_practices_poster.pdf

10 Natural helping refers to the informal style of the untrained lay helper. Natural helpers rely on intuition, familiarity, natural responsiveness, and personal opinions.

11 Chang, V., Scott, S., Decker, C. (2009). *Developing Helping Skills: A Step-by-Step Approach to Competency*. Brooks/Cole Cengage Learning: California. 93.

12 ACAPS, *Cognitive Bias*, 2016, 7. https://www.acaps.org/fileadmin/Technical_notes/acaps_technical_brief_cognitive_biases_march_2016.pdf

13 Global CP WG, *Inter-Agency Guidelines for Case Management and Child Protection*, 2014, 44. https://alliancecpha.org/sites/default/files/technical/attachments/cm_guidelines_eng_.pdf

14 Ibid. 34.

15 GPC PIM Guidance, 2018, available at: http://pim.guide/