The DTM Manager/Coordinator's Guide to Developing an Urgent Action Process

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1 Introduction

DTM does not seek to obtain information on specific protection incidents or individual cases of violence, abuse or neglect[1]. In some circumstances, however, details of a protection incident are disclosed, sensitive information is shared, or a request to support a victim/survivor of violence, abuse or exploitation may reach a DTM enumerator.

When designing DTM's internal urgent action process, it is important to differentiate between information that must be immediately reported to DTM Management because it requires organizational urgent action (such as safety risks to humanitarian staff, increased protection risks that will affect IDPs/Migrants/Host Communities in the near future; and/or human rights abuses currently affecting groups of people), versus disclosed protection incidents that have already occurred or will occur imminently, in which a DTM staff member has been asked by an individual for support in accessing urgent life-saving assistance (such as medical, judicial, police protection, psychosocial support).

The following table provides examples to differentiate between information that should lead to organizational urgent action (either by IOM programmes, through advocacy, or negotiation with external parties); versus protection incidents requiring urgent life-saving assistance for an individual.

Information Requiring Organizational Urgent Action	**Protection Incidents Requiring Life-Saving Urgent Action**
The presence of explosive materials in or near a displacement site	Request for support due to a threat or incident of sexual violence
Denial of an individual or group of access to humanitarian assistance	Request for support due to a threat or incident domestic violence
Forced recruitment by armed groups	A person is a serious threat to themselves or others
Rumours of kidnapping/trafficking	Request for support due to a medical emergency
Reported detention of children	
The entry / incursion of armed groups or forces in a displacement site	

This guideline focuses on how to set up the DTM Urgent Action Process to safely and ethically handle protection incidents requiring life-saving urgent action. When developing the DTM Urgent Action Process, it is recommended to consult a GBV, Protection, and/or Child Protection Specialist in-country to ensure contextualization of the information pathway, and the designation of incidents requiring urgent action.

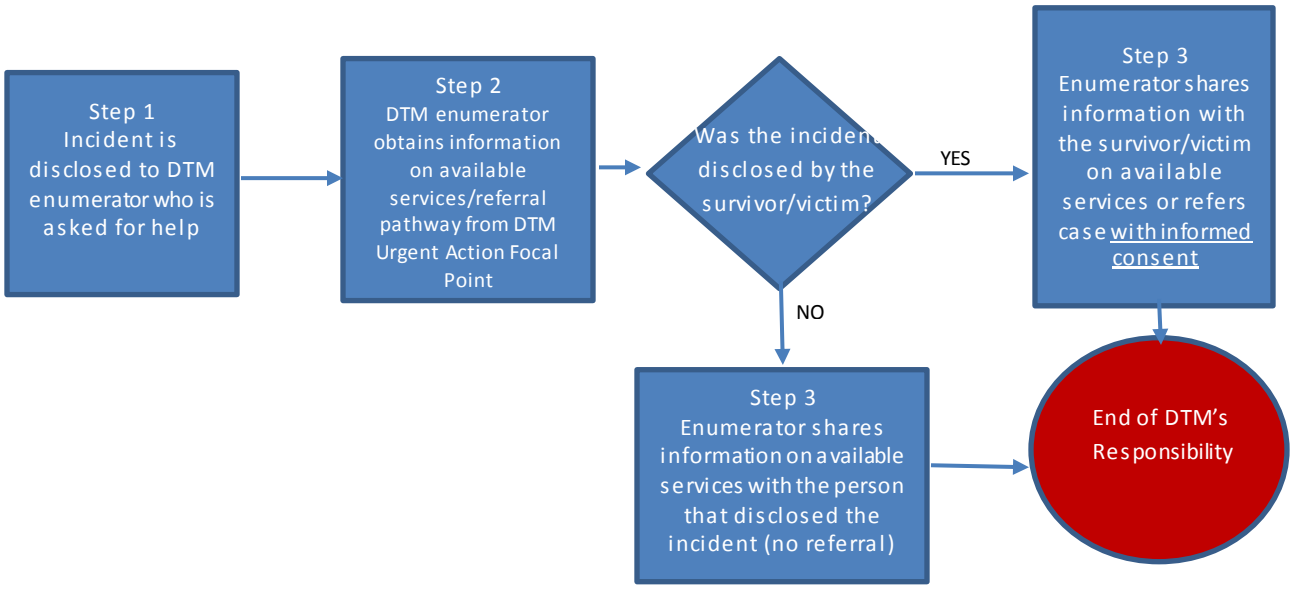
The following sections have been selected from relevant documentation, to provide additional necessary information to compliment/expand upon the annexed GBV Constant Companion.

[1] As part of DTM's standard function, personal and incident data are not collected. DTM may on occasion however, be requested to collect this data within the frame of supporting a specific IOM project request.

2 Guiding Principles to Urgent Action Response[2]

- Safety of the victim/survivor
- Safety of the staff member
- Confidentiality
- Respect for the victim/survivor's right to make decisions
- Non-discrimination

3 SCOPE of the DTM Team's Responsibility in Urgent Action Response



4 Points to Consider When Designing the Process

4.1 Identify a DTM Urgent Action Focal Point

When designing the Urgent Action Process, the DTM Manager/Coordinator should identify a focal point for DTM enumerators to contact in the event that a protection incident is disclosed requiring urgent action. This will ensure that enumerators are provided with up-to-date information on available service providers, and will help to maintain confidentiality by centralizing requests for information or guidance following a disclosure.

The focal point can be the DTM Manager/Coordinator, the IOM Protection Officer, or if not available, an IOM staff in a managerial position.

Responsibilities of the DTM Urgent Action Focal Point:

- Establish regular communication with relevant protection, child protection, and GBV specialists and/or coordinators from clusters/working groups, who can:
    - Provide up-to-date contact lists of agencies in the referral pathway, and/or assist DTM in identifying local service providers that can provide competent relevant services, such as medical care, mental health and psychosocial support, police assistance and legal/justice support.
    - Provide guidance on how to design/contextualize DTM's local Urgent Action Process.

[2] IASC Guidelines for Integrating Gender Based Violence in Humanitarian Action

- Be contacted for guidance on how DTM should respond to complex situations if necessary.

- Maintain an updated list of existing referral pathway agency contact lists and service providers in areas where DTM enumerators are working.

- Ensure that the DTM enumerators are trained in the following:
  - Vulnerabilities and protection concerns, including GBV and CP, and which protection incidents require urgent action.
  - How to maintain confidentiality and when informed consent is required.
  - Internal referral mechanism(s) and (where relevant) external referral pathways or services.
  - How to talk with victims/survivors, while ensuring the guiding principles are respected (see psychological first aid in annexed GBV Constant Companion).
  - How to ensure DTM staff safety, and the safety of the survivor/victim while handling a disclosed protection incident.

4.2 Referral vs Information Provision?

The DTM Coordinator is to decide whether enumerators should only provide a victim/survivor with information on available services (no consent required), or whether enumerators may also refer the case to a service provider (informed consent required). The decision should be based on the perceived capacity of the enumerators to navigate the process without doing harm, the opportunity to provide adequate training to enumerators, and whether there are established referral pathways and/or available services in the DTM implementation area(s).

Information provision process: DTM staff inform the victim/survivor of available relevant services (medical or non-medical) in their area, and of any identified risks that may be associated with seeking these services (access, confidentiality, and limits to service provision). The victim/survivor then makes an informed decision on which services that they choose to access. Information is not shared with an external organization or service provider by DTM staff, and therefore consent is not required.

Referral: The process of referring a victim/survivor to a service provider necessitates that DTM share some information with a 3rd party, which therefore requires informed consent. DTM staff must obtain informed consent from the victim/survivor, then contact the service provider to ensure that the survivor is eligible to access services, then explain the referral process and any potential risks of accessing the services to the victim/survivor. When the victim/survivor confirms that they wish to access a service, the DTM staff member can either physically accompany them to the service provider or provide them with the address. **Please note:** If the incident was disclosed on behalf of someone else (that is, the victim/survivor did not disclose the incident themselves), then a referral cannot be done because informed consent has not be given by the victim/survivor to share information. In this case, a DTM staff should provide information on available services only.

Referral in Remote Management[3]

Prior to referring victims/survivors in remote management contexts, the following criteria must be considered. Protection, CP, and GBV specialists may help to ascertain this:

- Presence: Is the service regularly present and fully functioning on the ground?
- Geographical coverage: Does the service reach the population it is meant to serve?
- Accessibility: Can survivors and/or communities access this service freely, safely and confidentially?
- Accountability: Who is responsible for following up this service?

When there are no relevant services available[4]

- Victims/survivors should be informed accordingly
- Victims/survivors should still have access to information to ensure their safety and basic emotional support. The field staff that received the disclosure should not raise unrealistic expectations about what services and support they may be able to receive. It is important that the DTM team remains up-to-date on what specialized services are operating in their areas.

4.3 What is Informed Consent and When is it Required?

"Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment."[3]

Obtaining informed consent in the Urgent Action Process, is the process of informing the victim/survivor of their options for treatment/referral, and obtaining their consent to share minimal details of the incident with an external agency in the referral pathway, so that this agency can provide treatment or manage their case.

- Consent isn't enough. It must be Informed, which means that:
    - The victim/survivor is informed (and consents to) the type of information that will be shared, with which service providers, what the follow-up steps will be (if any) and any identified risks related to information sharing.
    - The victim/survivor is informed of what assistance can be offered by each service provider including any limitations to services or risks involved.
- To protect confidentiality, nothing should be documented by DTM field staff/enumerators. Informed consent should be obtained verbally.

Procedures for Children[5]

- Children have a right to participate in decisions that affect them
- Informed consent must be obtained by the legal guardian of a child before referral can be made. This may be waived if the DTM Urgent Action Focal Point determines that it is in the best interest of the child to proceed without informed consent of the legal guardian. This may also be waived if the DTM Urgent Action Focal Point determines that the child is between the age of 15-17, and is deemed mature enough to provide their own informed consent.
- If the child is unaccompanied or separated, informed assent can be obtained.

When Informed Consent is NOT required & confidentiality may be broken:

- If the survivor is an adult who threatens his/her own life or who is directly threatening the safety of others, and referrals to lifesaving services are available/accessible. [4]
- When national laws incorporate mandatory reporting for certain disclosed incidents.
- When the survivor is a child who is in danger, and the consent from the legal guardian may not be obtained because they are a perpetrator of the incident, or the decision made for the child by the legal guardian is not in the child's best interest[5].

[3] IASC Guidelines for Integrating Gender Based Violence in Humanitarian Action
[4] SOP Prevention and Response to Gender Based Violence, GBVAoR, Syria (Jordan Hub), 2017.
[5] IASC Guidelines for Integrating Gender Based Violence in Humanitarian Action

IMPORTANT: DTM Managers/Coordinators should stress to field staff that they are not authorized to decide when confidentiality can be broken. If a situation arises in which a field staff feels that consent should not be required, they must first contact the DTM Urgent Action Focal Point for guidance/approval before taking any steps.

5 Staff Care and Safety

5.1 Managing Staff Stress

Hearing a traumatic story, and witnessing the pain, fear and terror that may be expressed when a protection incident is disclosed, can have a profound impact on a staff member's emotional wellbeing and ability to cope with stress.

The following are recommended steps to minimize extreme stress due to traumatic incident disclosure, and to care for staff members that have managed a protection incident disclosure[6]:

- Ensure that all DTM field staff are prepared for a protection incident disclosure, by ensuring that they are well trained in (and have practiced) the Urgent Action Process, are equipped with written lists of recommended local service providers/referral pathways, have a copy of the GBV Constant Companion and are well-versed in the do's and don'ts of incident disclosures.

- Provide the staff member with the opportunity to discuss/debrief following a protection incident disclosure.

- Monitor for signs of vicarious trauma or extreme stress, which include uncharacteristic: frustration or irritability, participation withdrawal, lack of motivation, decreased work quality, tardiness or absenteeism, signs of exhaustion[7]. Provide the staff member with the opportunity to access professional mental health service providers if required.

5.2 Staff Safety During Protection Incident Disclosure

When listening to a protection incident disclosure, a DTM staff member's safety may be threatened for various reasons, such as the perpetrator of the disclosed incident being in the vicinity, the community believing that the staff member is causing harm (particularly if the victim/survivor is distressed/crying), the victim/survivor becoming aggressive, or the family or community attempting to stop the disclosure due to cultural taboos.

When training DTM staff on how to ensure their own safety when handling a protection incident disclosure, it is important to stress the following:

- Breaking confidentiality of a disclosed incident may put themselves at risk, as well as the victim/survivor.
- The steps for prioritizing the safety of a victim/survivor, and respecting the right of the victim/survivor to choose whether they want to access services, as outlined in the GBV Constant Companion, also protect the staff member.
- IOM's security protocols must be respected at all times.
- If someone becomes aggressive/agitated, the staff member should remain calm and not enter into an argument with the person.
- If they feel physically threatened, they should leave immediately.

[6] IASC Guidelines for Integrating Gender Based Violence in Humanitarian Action

[7] American Counseling Association, Fact Sheet #9 "Vicarious Trauma".