INTER-AGENCY EMERGENCY STANDARD OPERATING PROCEDURES FOR PREVENTION OF AND RESPONSE TO GENDER-BASED VIOLENCE and VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF CHILDREN IN JORDAN

2014 Edition

Section 1: Procedures

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The Inter-Agency Emergency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence and Child Protection in Jordan was developed under the umbrella of the National Council for Family Affairs (NCFA), the Child Protection and SGBV sub-Working Groups. The 2014 revision of the SOP was led by the SOP Steering Committee composed by Save the Children, International Rescue Committee, NCFA, UNHCR, UNICEF and UNFPA. The document is the result of extensive consultations with national and international stakeholders involving over 40 ministries, institutions and organizations. The SOP steering committee sincerely thanks all those involved in the production and revision of these procedures.

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INTRODUCTION

The purpose and scope of the Inter-Agency Standard Operating Procedures (SOPs)

These Inter-Agency Emergency Standing Operating Procedures (SOPs) describe guiding principles, procedures, roles and responsibilities in the prevention of and response to gender-based violence (GBV) and in child protection(CP) for everyone in Jordan including those affected by the Syrian crisis living in urban contexts, camps and/or other Informal Tented Settlements. The SOPs have a focus on Syrian refugees, but include information on services for other refugees or the host population where available. Building on best national practices, they have been developed through an inter-agency consultative process with Jordanian governmental partners, UN agencies and national and international civil society actors working in GBV, CP and other key sectors (see signatory page for organizations which endorse the SOPs).

The SOPs detail the minimum procedures for prevention and response to GBV and for CP. They also present more comprehensive prevention and response interventions. They indicate which organizations and/or institutions are responsible for actions in the four main response sectors - health, psychosocial support, law/justice and security. They are designed to be used together with existing resources related to prevention and response to GBV and CP.

In light of the current revision of the Family Protection Framework and the recent adoption of the Juvenile Law, this is an interim revision of the SOPs, to be further revised in 2015 in accordance with the national framework. The SOPs will also be reviewed on an annual basis in order to ensure that they are up-to-date and reflect practices and operational agencies in the field.

CHAPTER 1:

DEFINITIONS AND TERMS

1.1 DEFINITIONS SPECIFIC TO GENDER-BASED VIOLENCE

Gender: Refers to the social differences between men and women that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures.[1]

Gender-based violence (GBV): GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. The nature and extent of specific types of GBV vary across cultures, countries, and regions.[2]

The following table provides definitions of terms used in the Jordanian framework, drawing on both international and national sources: Service providers need to be aware of international and national definitions. Government agencies and national bodies refer to national definitions. Furthermore, whenever a case requires legal services, national definitions will apply.

GBVIMS[3] Definitions	National Definitions
Sexual Violence: The GBV IMS does not define sexual violence as one of the core types of GBV, but rather, as a category that encompasses rape and sexual assault.	**Sexual Assault:** Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion. This includes **Child Sexual Abuse**, which involves forcing, or enticing a child to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, or non-contact activities, such as involving children in looking at, or in the production of, pornographic material or in watching sexual activities, or encouraging children to behave in sexually inappropriate ways. (From the National Framework for Family Protection).
Rape: Non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.	**Rape:** Rape is intercourse with a female, other than the wife of the alleged offender, where force of one kind or another is used. (The crime of rape is defined in Articles 292, 293, 294, 295, 300 and 301 of the Penal Code).
Sexual Assault: Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. This incident type does not include rape, i.e., where penetration has occurred. Female genital mutilation/female genital cutting (FGM/FGC) is an act of sexual violence that impacts sexual organs, and as such will be classified as a sexualized act. This harmful traditional practice should be categorized under sexual assault.	**Indecent Assault:** Is an indecent and immoral act committed against someone's body or honor. The act of indecent assault is not specific to a particular part(s) of a person's body, but includes touching any part of the body that is considered private, and in a manner that brings shame to that person. (The Penal Code refers to these crimes in Articles 296 to 301).

1. IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.
2. Ibid
3. The Gender-Based Violence Information Management System (GBVIMS) is an initiative that enables humanitarian actors responding to incidents of GBV to effectively and safely collect, store, analyze and share data reported by GBV survivors.

GBVIMS Definitions	National Definitions
Physical Assault: An act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.	**Physical Violence:** Intentional use of physical force whether by threatening or actual use of it against the person himself or any other person in the family, and which may lead to a physical injury, not limited to the family members, punching, biting, burning or other ways of harming. (From the National Framework for Family Protection). **Harm:** The Penal Code defines a number of circumstances that amount to the crime of assault (Articles 333 to 338 of the Penal Code).
Forced Marriage: The marriage of an individual against her or his will. This also includes**"early marriage"** which is any marriage under the age of 18.	The legal age of marriage in Jordan is set at 18 years, according to Article 36 of the Personal Status Law, 2010.Marriage of children who have completed 15 years of age, but not 18 years is allowed under special circumstances and with the approval of Chief of the Shariah judges[4].
Denial of Resources, Opportunities or Services: Denial of rightful access to economic resources/ assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner/ spouse or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.	**Socio-economic Violence:** The legal age of marriage in Jordan is set at 18 years, according to Article 36 of the Personal Status Law, 2010. Marriage of children who have completed 15 years of age, but not 18 years is allowed under special circumstances and with the approval of Chief of the Shariah judges. **Encouraging Prostitution:** The Penal Code defines a number of crimes related to the encouragement of a woman to engage in prostitution in addition to controlling and benefiting from this woman's activities as a prostitute. (The specific offences are defined in Articles 309 to 318 of the Penal Code).
Psychological/Emotional Abuse: Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.	**Psychological Violence:** Severe psychological or emotional pain, or harassment. This includes, although is not restricted to, verbal attack, humiliation, insults, unacceptable photographing, harassment, and isolating vulnerable adults (e.g. the elderly) from their family and friends. (From the National Framework for Family Protection). **Emotional Violence:** Committing an act or refraining from committing an act which weakens the person's ability to deal with their social environment and includes rejection, humiliation, neglect, sarcasm, intimidation and making unrealistic demands. (From the National Framework for Family Protection).

4. Personal status law, number 36, 2010, Article 10, paragraph b "If there is a marriage under 18 it should be approved by the Chief of Shariah Judges and according to special instructions issued by him if the marriage is necessitated by the best interest of the child. Accordingly, the person who marries gains full legitimacy in everything related to marriage and divorce and their effects."

GBVIMS Definitions

Domestic Violence/Intimate Partner Violence: The GBV IMS does not define this kind of violence as one of the core types of GBV. It is, however, defined by the relationship between perpetrator and survivor and may include multiple forms of violence (rape, sexual assault, physical assault, psychological/emotional abuse).

National Definitions

Violence in the Family: Any activity or behaviour that causes physical, emotional, psychological harm to any member of the family whereby the perpetrator is a member of the same family. ww (From the National Framework for Family Protection).

Article 5 of the family Protection Law defines violence in the family as "any offence not classified as felony, which is committed by a family member against another."

Note: All of the above definitions apply to both children and adults.

1.2 DEFINITIONS SPECIFIC TO CHILD PROTECTION[5]

- **Child:** Child: any person under the age of 18, unless under the (national) law applicable to the child, majority is attained earlier [6]. The new Jordanian Juvenile Law no. 32 for the year 2014 defines a juvenile as every person who has not reached 18 years of age.
- **Child protection:** the prevention of and response to abuse, neglect, exploitation of and violence against children in emergencies. [7]
- **Children without parent/caregiver care:** all children not living in the overnight care of at least one of their parents/caregivers, for whatever reason and under whatever circumstances. Children without parent/caregiver who are outside their country of habitual residence or victims of emergency situations may be designated as unaccompanied or separated.
- **Unaccompanied child:** a child who has been separated from both parents/caregivers and relatives and who is not being cared for by an adult who, by law or custom, is responsible for doing so. This means that a child may be completely without adult care, or may be cared for by someone not related or known to the child, or not their usual caregiver e.g. a neighbour, another child under 18, or a stranger.
- **Separated child:** a child who is separated from both parents/caregivers or from his/her previous legal or customary primary caregiver, but not necessarily from other relatives.
- **Orphan:** an orphan is a child, both of whose parents/caregivers are known to be dead. In some countries, however, an orphan is defined as a child who has lost one parent/caregiver.
- **Abuse:** child abuse is a deliberate act of ill treatment or omission that can harm or is likely to cause harm to a child's safety, wellbeing, dignity and development. Abuse includes all forms of physical, sexual, psychological or emotional ill treatment and results in harm: Harm can take many forms, including impacts on children's physical, emotional and behavioural development, their general health, family and social relationships, self-esteem, educational attainment and aspirations for the future.

5. International child protection definitions do not differ from those used in the Jordanian framework, so only one set of definitions is given.
6. Convention on the Rights of the Child, or CRC, Article1,1989and Juvenile Law, number 24, 1968, Article 2.
7. Global CPWG definition: www.cpwg.net

- **Physical abuse:** the use of physical force to cause actual or likely physical injury or suffering (e.g. hitting, shaking, burning, torture, stoning, etc.). Physical abuse can take place in the home, the community and in schools.

- **Emotional abuse:** emotional or psychological abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development and psychosocial wellbeing. It includes humiliating and degrading treatment (e.g. name-calling, constant criticism, belittling, persistent shaming, confinement and limiting social interaction).

- **Violence:** the intentional use of physical force or power, threatened or actual, against a child, by an individual or group, which either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity. This can also include self-inflicted violence, such as self-harm or suicide.

- **Neglect** [8]**:** persistently failing to provide for, or secure for a child, their basic physical, developmental or psychological needs, whether deliberately, or through carelessness or negligence. Neglect is sometimes called the 'passive' form of abuse, as it relates to the failure to carry out some key aspects of care and protection resulting in the impairment of the child's health or development. It may include unresponsiveness to meet the child's most basic emotional needs. Neglect does not include situations of poverty, where a parent/caregiver cannot afford to provide for their child but is trying to do so.

- **Alternative care**: care that is provided when the child's own family is unable, even with appropriate support, to provide adequate care for the child, or abandons or relinquishes the child. It may take the form of informal or formal care, including kinship care, foster care, other forms of family-based or family-like care placements, residential care, or supervised independent living arrangements.

- **Child's legal guardian**: a person who has been formally recognized under national law as responsible for looking after a child's interest when the parent/caregiver of the child do not have parent/caregiver responsibility over him or her or when both parents or according to Jordanian law when the mother has died. Under Shariah Law in Jordan, when the father dies, "welayah" (similar but not identical to legal guardianship)[9] is transferred to the paternal grandfather while the mother retains "wasayah" (similar but not identical to custody). If grandfather is not available or fit, then the court will assign someone to have "welayah"[10] (for example, paternal uncle, mother, adult brother). Marriage does not change the child's "welayah".

- **Child labor:** any work performed by a child which is detrimental to his or her health, education, physical, mental, spiritual, moral, physical or social development. The concept of child labor is based on the ILO Minimum Age Convention (No.138), which represents the most authoritative international definition of minimum age of admission to employment or work. In Jordan the minimum age for employment is 16.

- **Worst forms of child labor:** these include slavery; prostitution and pornography; illicit activities; and work likely to harm children's health, safety or morals, as defined in ILO Convention No. 182. The worst forms of child labour are prohibited for all children under the age of 18, even those who have reached the legal working age of 16.[11] According to a Decision from the Ministry of Labour, 2011this includes hazardous, harmful or exhausting labour that affects the health of children and these forms of labour are forbidden under Jordanian Law.

8. Jordan Penal Code number 16, 1960, Articles 289 and 290.
9. This concept is closest to legal guardianship..This person is responsible for all legal, medical, travel documents and other major decisions in the child's life. They do not necessarily provide day to day care nor control any funds that the child may have (for instance, inheritance).
10. This concept is closest to custody. The person provides day to day care for the child and controls their financial resources (if any). They do not have the right to take other major decisions on behalf of the child, as these remain with the child's "Welayeh".
11. Jordanian Labour Law, number 8. 1996, Articles 73 and 74

- **Children associated with armed groups or forces (CAAFAG)**: any person below 18 years of age who is or who has been recruited or used by an armed forces (government military or other security forces) or armed (opposition) groups in any capacity, including but not limited to children (boys and girls) used as fighters, cooks, porters, messengers, spies or for sexual purposes. This includes children who provide information to armed groups or forces, who distribute pamphlets on behalf of these groups/forces, or who transport material or work as mechanics. It does not include children who show support for either the opposition or government forces without any instruction from or agreement from members of armed groups (e.g. through participation in demonstrations, throwing stones or writing slogans on walls).

- **Trafficking:** recruiting, transporting, transferring, harboring or receiving a person through the use of force, coercion or other means, for the purpose of exploiting them. For example, a child has been trafficked, if he or she has been moved within a country or across borders, whether by force or not, with the purpose of exploiting the child.

- **Child survivor**: a person under the age of 18 who has experienced any form of violence, especially gender-based violence.

- **Children in conflict with the law**: children who come into conflict with the justice system as a result of being suspected, accused or convicted of an offence.

- **Children in contact with the law:** is the general term for all children in contact with the justice system. This includes children in conflict with the law and child victims or witnesses.

- **Juvenile:** a child who, under the respective legal system, may be dealt with in relation to an offence in a manner which is different from an adult. In Jordan Juvenile Law Number 24, 1968, a juvenile is a child of 7 to under 18years of age. This includes juveniles in conflict with the law and juveniles in need of care and protection (including child victims and witnesses).

- **Justice for children:** efforts to protect the rights of children who come into contact with the justice system, as victims, witnesses or alleged offenders of a crime, or as parties or beneficiaries of other legal proceedings. Whereas the term generally comprises all criminal, civil or administrative proceedings, it is used here with regards to children in conflict with the law and victims and witnesses of offences against criminal or other laws.

- **Best interest of the child:** broadly describes the wellbeing of a child. Wellbeing is determined by a variety of individual circumstances, such as the age, the level of maturity of the child, the presence or absence of parents/caregivers, the child's environment and experiences. (For ways to determine the best interest of the child, see the UNHCR Guidelines on Determining the Best Interests of the Child, 2008).

1.3 OTHER RELEVANT DEFINITIONS AND TERMS

- **Actor(s):** individuals, groups, organizations, and institutions involved in preventing and responding to gender-based violence. Actors may be refugees, local populations, employees, or volunteers of UN agencies, NGOs, host government institutions, donors, and other members of the international community.[12]

- **Arrest, threat of refoulement or need for bailing:** any cases where a person is arrested or threatened with arrest, any threat of repatriation (that is, non-voluntary return to country of origin) or any case that needs to be bailed due to vulnerability.

12. IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.

- **Case management:** is a collaborative, multidisciplinary process promoting quality and effective outcomes through communication and the provision of appropriate resources to meet an individual's needs. In this context this refers to managing child protection and GBV cases.[13] Under the Jordanian National Framework for Family Protection case management is defined as "A systematic process that entails planning, evaluation, coordination, counselling, monitoring and follow up on intervention procedures with the case. It also entails provision of necessary services in coordination with relevant partners through a series of procedures that specify the roles and responsibilities from case intake to closure."

- **Community:** the term used to refer to populations affected by an emergency including refugees and host populations.

- **Confidentiality:** an ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.[14]

- **Disability:** is an evolving concept that results from the interactions between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.[15] According to the Jordanian Law on the Rights of Persons with Disabilities, a person with a disability is defined as: "any person suffering from a permanent, partial or total impairment affecting any of their senses or their physical, psychological or mental capabilities, to an extent that undermines their ability to learn, work, or be rehabilitated and in a way which renders their unable to meet her/his normal day-to-day requirements under circumstances similar to those of non-disabled persons".[16]

- **General service providers:** Refers to all actors, including UN, NGO and governmental actors, providing services that are not specialized in child protection and/or SGBV.

- **Informed consent**: the voluntary agreement of an individual who has the capacity to give consent for general services (for legal age of consent see below). To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be capable of giving their consent. Parents, caregivers or other legal guardians are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some cases, it may be in the child's best interest to have other persons provide consent – these situations are described in section 3.3.3 "Obtaining informed consent/informed assent from children and caregivers".

- **Legal Age of consent:** In Jordan, the legal age of maturity is 18[17] and therefore any signature of official documents for children under 18 must be done by the parent or relevant legal guardian as per Personal Status law and Civil Code. According to the Criminal Proceedings law, children 16 – 17 can press charges provided the parent or legal guardian also consents.

- **Informed assent:** the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services.

- **Mandatory reporting:** state laws which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

13. SGBV Emergency Response and Preparedness. Participant Handbook. IRC.
14. Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.
15. Preamble of the United National Convention on the Rights of Persons with Disabilities. 2006.
16. Article 2 of the Law on the Rights of Persons with Disabilities. 2007.
17. Civil Code number 43/2, 1976, Article 43 states that "The age of maturity is 18 years"

- **Perpetrator:** Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will.[19]

- **Psychosocial support:** support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.[20]

- **Refugee:** any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country.[21]

- **Survivor/victim:** person who has experienced gender-based violence. The terms "victim" and "survivor" can be used interchangeably. In Jordan "victim" is a term often used in the social and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency (see IASC GBV Guidelines). The term "victim" is defined by the National Framework for Family Protection as "the person or persons exposed to violence in the family, either directly or indirectly."

- **Torture:** any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[22]

19. IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.
20. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007.
21. UN Refugee Convention, Article.1, 1951.
22. UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.1984.

CHAPTER 2:

GUIDING PRINCIPLES

All actors agree to extend the fullest cooperation and assistance to each other in preventing and responding to GBV and child protection and agree to adhere to the following set of guiding principles:

2.1 GUIDING PRINCIPLES FOR ALL ACTIONS

2.1.1 GBV guiding principles for all actions[23]

- Understand and adhere to the ethical and safety recommendations in the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (WHO 2007);
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analysis and assessment information to avoid duplication and maximize a shared understanding of the situation;
- Establish and maintain carefully coordinated multi-sectoral and inter-organizational interventions for GBV prevention and response;
- Engage the community fully in understanding and promoting gender equality and power relations that protect and respect the rights of women and girls;
- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programmes through the systematic use of participatory methods;
- Integrate and mainstream GBV interventions into all programmes and all sectors;
- Ensure accountability at all levels; and
- All staff and volunteers involved in prevention of and response to GBV, including interpreters and refugee incentive staff, should understand and sign a code of conduct or similar document setting out the same standards of conduct (see Annex V: Sample Sexual Exploitation and Abuse Code of Conduct).

2.1.2 Child protection guiding principles for all actions[24]

- **Avoid exposing people to further harm as a result of your actions:**
  - Before introducing new interventions, find out how the issues to be addressed were handled previously by children, families, the communities and the authorities;
  - Gain a full understanding of the expected behaviours and social norms for girls and boys of different ages, and take these into account when planning interventions;
  - Promote meaningful and safe child participation in programme planning and evaluation so that the views and interests of children, as well as those of adults, can be determined;
  - Avoid restricting services and benefits to specific categories of children or families, e.g., separated children;
  - When dealing with sensitive issues, guarantee confidentiality and informed consent and ensure that interventions are carefully planned to respect privacy;
  - Set up and adhere to child safeguarding protocols, including procedures for reporting and addressing suspected infringements.

23. Adapted from: SGBV Resource Tool: Establishing SGBV Standard Operating Procedures (SOP Guide). 2008. IASC Sub Working Group on Gender & Humanitarian Action.
24. Minimum Standards for Child Protection in Humanitarian Settings. Global Child Protection Working Group, 2012.

- **Ensure people's access to impartial assistance:**
  - Ensure that humanitarian assistance is available to all those in need;
  - Ensure that assistance is provided without discrimination and is not withheld from children in need or their families and caregivers, and access for humanitarian agencies is provided as necessary to meet the standards;
  - Child protection interventions need to use innovative and creative ways to reach these children who are often those most in need for protection;
  - Child protection workers need to respond quickly when patterns or cases of discrimination or exclusion are identified.

- **Protect people from physical and psychological harm arising from violence and coercion:**
  - Ensure children are protected from violence, from being forced or induced to act against their will and from fear of such abuse;
  - All child protection responses should seek to make children more secure, facilitate children's and families' own efforts to stay safe, and reduce children's exposure to risks.

- **Assist people to claim their rights, access available remedies and recover from the effects of abuse/violence:**
  - Ensure that children are assisted to claim their rights through information, documentation and assistance in seeking remedies;
  - Ensure children are supported appropriately in recovering from the physical, psychological and social effects of violence and other abuses;
  - Child protection workers and other humanitarians must ensure that wherever possible, interventions support children in claiming their own rights, and support others such as parents/caregivers and carers in claiming children's rights on their behalf.

- **Strengthen child protection systems:**
  - Identify and build on existing capacities and structures;
  - Avoid the creation of parallel structures, such as agency-based staff that replace or bypass government or community employed social workers;
  - Build the capacity of national and state-level authorities as well as civil society;
  - Ensure and systemize representative participation of the community, including meaningful participation of children in analysis, planning, and evaluations;
  - Link and coordinate with others working on child protection and related issues;
  - Prioritize local ownership of child protection interventions wherever possible;
  - Engage early on with development actors and processes to plan the transition to the post-emergency phase, if appropriate.

- **Strengthen children's resilience in humanitarian action:**
  - Ensure that child protection programming strengthens protective factors that reinforce children's resilience, and deal with those that expose children to risks;
  - Ensure that programmes are accessible to all children and that they build on and reinforce children's skills and strengths;
  - Ensure that programmes involve those close to children, and reinforce supportive relationships between children, their parents/caregivers, caregivers, peers and other important people;
  - Ensure that programmes strengthen the structures, practices and services that help to protect children in the community;
  - Ensure that programmes take into account the social and legal norms that influence children's lives and circumstances;
  - Ensure that programmes tie all of the above elements together and take a consistent approach.

2.2 GUIDING PRINCIPLES FOR WORKING WITH SURVIVORS[25]

- **Ensure the safety of the survivor(s) and their families at all times.**

- **Respect the confidentiality of the affected person(s) and their families at all times:**
  - If the survivor gives his/her informed and specific consent, share only pertinent and relevant information with others for the purpose of helping the survivor, such as referring for services. This should be guided by the GBV referral information-sharing agreement for non-identifiable information to access services;
  - Do not discuss any information with the survivor, related to the incident, perpetrator or legal response in the presence of other beneficiaries or the survivor's children.
  - All written information about survivors must be kept in secure, locked files.

- **Respect the wishes, choices, rights, and dignity of the survivor:**
  - Consult the survivor on where he/she wishes to seek help and respect his/her wishes. Do not push, suggest or otherwise guide his/her in any specific direction;
  - Conduct interviews in private settings;
  - Conduct interviews and examinations with staff of the same sex of the survivor or as preferred by the survivor, including translators.
  - Be respectful and maintain a non-judgmental manner. Do not laugh or show any disrespect for the individual, or his/her culture, family, or situation;
  - Be patient; do not press for more information if the survivor is not ready to speak about his/her experience;
  - Provide emotional support – show empathy, understanding and willingness to listen
  - Ask only relevant questions. (For example, the status of the virginity of the survivor is not relevant and should not be discussed);
  - Avoid requiring the survivor to repeat the story in multiple interviews.

- **Ensure non-discrimination in all interactions with survivors and in all service provision.**

2.2.1 Guiding principles for working with persons with disabilities[26]

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion in society;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equality of opportunity;
- Accessibility;
- Equality between men and women;
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

SPHERE standards identify **the rights of all persons to receive humanitarian assistance** as a necessary element of the right to life with dignity. This encompasses the right to an adequate standard of living, including adequate food, water, clothing, shelter and the requirements for good health, which are expressly guaranteed in international law. The Sphere core standards and minimum standards reflect these rights and give practical expression to them, specifically in relation to the provision of assistance to those affected by disaster or conflict. Any such assistance must be provided according to the principles of **impartiality and non-discrimination**: noting that no one should be discriminated against on any grounds of status, including disability.[27]

25. Adapted from: SGBV Resource Tool: Establishing SGBV Standard Operating Procedures (SOP Guide). IASC Sub Working Group on Gender & Humanitarian Action. 2008.
26. General Principles of the United National Convention on the Rights of Persons with Disabilities. 2006.
27. SPHERE 2011.

2.2.2 Guiding principles specific to working with child survivors[28]

- **Promote the child's best interest:** A child's best interest is central to good care. A primary consideration for children is securing their physical and emotional safety—in other words, the child's wellbeing—throughout their care and treatment. Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that children's rights to safety and ongoing development are never compromised.

- **Ensure the safety of the child:** Ensuring the physical and emotional safety of children is critical during care and treatment. All case actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short and long terms.

- **Comfort the child:** Children who disclose sexual abuse require comfort, encouragement and support from service providers. This means that service providers are trained in how to handle the disclosure of sexual abuse appropriately. Service providers should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced. A fundamental responsibility of service providers is to make children feel safe and cared for as they receive services.

- **Ensure appropriate confidentiality:** Information about a child's experience of abuse should be collected, used, shared and stored in a confidential manner. This means ensuring 1) the confidential collection of information during interviews; 2) that sharing information happens in line with local laws and policies and on a need-to-know basis, and only after obtaining permission from the child and/or caregiver; 3) and that case information is stored securely. In some places where service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery. In situations where a child's health or safety is at risk, limits to confidentiality exist in order to protect the child.

- **Involve the child in decision-making:** Children have the right to participate in decisions that have implications in their lives. The level of a child's participation in decision-making should be appropriate to the child's level of maturity and age. Listening to children's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent/caregiver manner with maximum respect. In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

- **Treat every child fairly and equally (principle of non-discrimination and inclusiveness):** All children should be offered the same high-quality care and treatment, regardless of their race, religion, gender, family situation or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.

- **Strengthen children's resiliencies:** Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the child and family's natural strengths as part of the recovery and healing process. Factors which promote children's resilience should be identified and built upon during service provision. Children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from abuse.

28. Caring for Child Survivors of Sexual Abuse. UNICEF/IRC.2012.

2.2.3 Guiding principles for working with children with disabilities[29]

- Take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
- In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
- Ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

All actors who may interview or have direct contact with survivors will be familiar with the guiding principles and put them into practice. These actors will also be aware of their responsibility to listen carefully and give information and are trained on basic survivor-centered approaches.

29. Article 7, UN Convention on the Rights of Persons with Disabilities. 2006.

CHAPTER 3:

CASE MANAGEMENT, REPORTING, AND REFERRAL MECHANISMS

3.1 OVERVIEW OF CASE MANAGEMENT PROCESS AND RESPONSIBILITIES

Case management is a collative, multidisciplinary process promoting quality and effective outcomes through communication and the provision of appropriate resources to meet an individual's needs.[30] These processes include assessment, planning, implementation, coordination, monitoring and evaluation of options and services. The goal of case management is to empower the survivor/child and, where appropriate their caregiver, by giving her/him increased awareness of choices they have in dealing with the problem, and assisting her/him to make informed decisions about what to do about the problem. Case management ensures that the survivor/child is involved in all aspects of the planning and service delivery. A case management approach is useful for persons with complex and multiple needs who seek access to services from a range of service providers, organizations and groups.

The basic principles that underpin case management include:

- Ensuring the survivor/child is the primary actor in case management;
- Empowering the survivor/child and ensuring that he/she is involved in all aspects of the planning and service delivery;
- Respecting the wishes, the rights, dignity needs and capacity of the survivor/child;
- Providing emotional support by demonstrating a caring attitude towards the survivor/child;
- Providing information to the survivor/child to allow him/her make informed choices about services requested;
- Listening and establishing rapport and a trusting relationship, which creates a supportive environment in which the survivor/child can begin to heal;
- Ensuring confidentiality which is critical to protecting the survivor's/child's safety and security and to prevent misuse of information;
- Ensuring non-discrimination by treating every survivor/child in a dignified manner irrespective of his/her sex, background, race, ethnicity or circumstances of the incident(s);
- Obtaining informed consent from the survivor/child prior to sharing any information.

Case managers must have the skills to manage cases in line with the above principles, an understanding of their roles and responsibilities, and an ability to handle difficult situations professionally and with cultural sensitivity.

The steps of case management are:

- Identification;
- Initial assessment;
- Initial response and intervention also known as case planning and implementation including referral to other services);
- Follow-up, review (sometimes including a case conference) and closure;
- Service evaluation.

The case management flowchart summarizes the basic steps of the process (See Annex III).

Standards for case managers and case management organisations dealing with child protection and GBV cases as part of the Syrian refugee crisis have been developed by the Interagency Case Management Taskforce reporting to the CP and GBV Sub-Working Groups. These standards have been integrated into an interagency case management training package that is currently available for case managers working for organisations providing CP and/or GBV case manager as per the child protection and GBV referral pathways.

30. GBV Emergency Response and Preparedness. Participant Handbook. IRC.

Roles of Case managers:

Case management agencies are responsible for assessing CP and GBV cases and providing full case management services which includes all the steps above. Case managers may be responsible for identifying cases or other services providers may identify the case and refer it to case managers, who then conduct the initial assessment. Case managers' key roles include:

- Establishing rapport and developing a trusting relationship that creates a supportive environment in which the survivor/child can begin to heal;Providing emotional support by demonstrating a caring attitude towards the survivor/child;
- Being the contact point for needs assessment and follow up
- Providing and coordinating services and follow-up of service provision.

Roles of non-case managers

Child protection and GBV staff who are not case managers (such as programme managers, staff in children or women's centers) as well as staff from other sectors may be involved in the case management process in the following steps:

- Disclosure/Identification. Many child protection and GBV cases may disclose or be identified by staff working closely with the beneficiaries in various roles.
- Case implementation. Other sectors usually provide services to child protection or GBV cases, such as health, education, cash or shelter services. The provision of these services is coordinated and overseen by the case manager who works closely with staff providing these other services.

For information on how general services providers should respond and refer GBV cases that are disclosed to them, see section 3.2.2 "GBV Disclosure: Roles and Responsibilities", 3.2.3. "Informed consent and information sharing" and 3.2.4 "Mandatory reporting". For information on how general services providers should respond and refer child protection cases, see section 3.3.1 "Identification of child protection cases by general service providers" and section 3.3.3. "Obtaining informed consent/informed assent from children and caregivers".

Referral of cases to another organisation

General service providers refer child protection and GBV cases (with appropriate consent) to child protection or GBV cases managers as described in the child protection and GBV referral pathways. Case managers may refer the cases to other organisations or a different case manager in their own organisation if the case is not within their roles and responsibilities.

When referring a case all necessary procedures to respect the client's wishes, protect children's best interest, keep clients safe and respect their confidentiality described below should be respected. In addition, when making a referral, the service provider should do everything in his/her power to ensure that the beneficiary receives the services s/he needs.

To make a referral the service provider should:

- Listen to the person's problem or need;
- If needed, ask only those questions required to clarify what service they need;
- Do not ask intrusive or unnecessary questions;
- Give honest and complete information about available services.If needed check with service provide;
- Answer any questions as best you can. If you don't know, say so;
  If the client agrees to referrals, he/she must give his/her informed consent before any information is shared with others. Parental consent should be obtained in cases including children (except where it might put child in danger or otherwise be against their best interest);
- If appropriate/needed, accompany person to the service;
- Document the referral;

- Follow up to ensure that the beneficiary receives the services needed;
- Adult clients can choose to not be referred;
- Certain child protection cases may be referred even without parental or child consent (see section 3.2.4 "Mandatory Reporting"). If General Services Providers are not sure whether they should seek the consent of the parents, or refer child protection cases without consent of the child or caregiver, they should consult with a child protection case manager without giving identifying details of the case.

Methods of referral

There are different ways to make a referral. The main ones are described below:

1. **Accompany person**
This is recommended for emergency or urgent child protection and GBV cases (see Case Prioritisation Table Annex IV). The referral should be documented by either email or referral form.

2. **Referral by phone**
This is recommended for emergency or urgent cases if accompanying the person is not possible or is not in their best interests. The referral should be documented by either email or referral form.

3. **Referral by email**
Email referrals are the preferred way to document all GBV cases and sensitive child protection cases. Sensitive child protection cases include but are not limited to children in conflict with the law, illegal activity, recruitment, torture victims etc. For emergency and urgent cases (see Annex IV for examples of emergency, urgent and moderate risk cases), email referral should be done as a documentation following either in person or phone referral. For moderate risk cases the referral may be done only by email. It is recommended that for moderate risk cases, cases are collated and referred on a regular basis (e.g. every week) to allow for easier tracking of cases referred between organisations. When using email for referral, it should only be sent to the relevant focal point from the referral pathway, and others not involved in managing the case should not be put in copy.

4. **Referral by interagency referral form**
The interagency referral form is recommended in child protection cases where leaving a copy of this form with the child or their parents would not present a risk to the child e.g. such as child labour or bullying. The benefit of this form in these cases is that it provides important information to the child/caregiver about the referral, and ensures that a copy of the referral form is available to both the service provider who makes the referral and the service provider who receives the service. For GBV cases the use of the interagency referral form is discouraged.

5. **Referral by online system**
Some organisations have online systems that allow for the referral of cases. These systems should only be used child protection and GBV cases within an organisation or between organisations with data sharing protocols that respect standards of confidentiality. If general online systems do not have sufficient confidentiality protections are used to refer child protection or GBV survivors to other services (e.g. cash assistance) no information about their protection concerns should be included in this online system.

Remember: Never put identifying data on paper referrals for sensitive cases, which includes all GBV cases and some child protection cases.

- When service providers refer a case to a case manager:
- Responsibility for managing the case moves to that organization
- The service providers' responsibility is to ensure that the case manager from that organization received the case and can provide the relevant service
- Case management organisations should acknowledge reception of the case and confirm when they will be able to meet client. If they cannot provide services to the client for any reason they should inform the referring organisation that they cannot do so and if appropriate the reason (e.g. the case does not fit within their mandate, the service cannot accept new clients etc.)
- If the referring organisation continues to provide services, and needs to coordinate with lead case manager, they can request a case management meeting

- Case managers can only provide referring organisations information on a need-to-know basis. If an organisation is not continuing to provide services to the case, the only information the case manager can provide the referring organisation is whether or not they will provide services to the case and when they can start to provide these services.

3.2 | GBV CASE MANAGEMENT [31]

As mentioned above, the goal of case management for GBV survivors is to empower him/her by giving increased awareness of choices and support in taking informed decisions, raising awareness of the services that are available. Case management for GBV survivors is focused primarily on meeting the survivor's health, safety, psychosocial and legal needs following the incident(s).

Case management for GBV cases is provided by the agencies listed in the table below. These agencies will assess any GBV case they receive or that is referred to them for support, including GBV cases involving children. The basis for case management is the coded GBV IMS Inter-Agency Psychosocial Intake and Assessment Form (see Annex VII) and for child survivors the Inter-Agency Best Interest Assessment (BIA) Form (See Annex XIII) which is completed by the case manager upon receiving a GBV case. If the organization is also part of the GBVIMS Information Sharing Protocol (ISP), the GBVIMS Psychosocial Intake and Assessment Form will also be completed. Other interview or protection assessments are also being used for GBV Cases. Throughout the process, the case manager and the agency ensure that:

- All paper documentation is stored in its own individual file and is coded;
- All referrals and case information shared by email should be password protected to access documents and computers;
- Confidentiality and safety of information is maintained. Original copies of completed initial intake forms and consent forms should be filed in the respective offices in lockable cabinets. All forms with identifying information including consent forms are kept separate from intake forms, which are coded and include details of the incident. Completed intake forms should never be transferred or shared between agencies to maintain the safety, security and confidentiality of information;
- All paper files are kept in a secure place in a lockable cabinet. Rooms containing paper and electronic information must be locked securely when staff leaves the room. All staff should be aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.

Case management for GBV child survivors requires caseworkers to have specialized knowledge and skills in working with children. Caseworkers should follow the standard case management steps used with adult survivors, but adapted to meet children's needs. When dealing with child survivors of sexual abuse[32] , caseworkers should be able to:

- Apply technical understanding of sexual abuse to educate and support children and families throughout the case management process;
- Apply appropriate child-friendly skills through case management process (see section 3.3 on child protection case management below);
- Adapt case management steps and procedures for child survivors. This includes:
  - Observing the guiding principles for working with child survivors;
  - Following informed consent/assent procedures (see section 3.3.3 on informed assent for children and section 3.2.4 on mandatory reporting including, in cases where referrals take place without the assent of the child or consent of the caregiver it is important to inform the child and/or the caregiver of interventions that will be made on their behalf);
  - Assessing a child survivor's immediate health, safety, psychosocial and legal/justice needs and using crisis intervention to mobilize early intervention services that ensure the child's health and safety;

31. Adapted from: GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide). 2008. IASC Sub Working Group on Gender & Humanitarian Action.
32. Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.

- Conducting ongoing child safety assessments in the family and other social contexts after disclosure of abuse;
- Taking decisive and appropriate action when a child needs protection;
- Proactively engaging any non-offending caregivers throughout case management;
- Knowledge of child-friendly service providers and making appropriate referrals (see Annex XVIII: GBV referral pathways);
- Interact appropriately with children with disabilities and their caregivers, including caregivers with disabilities, and present information in a manner that they can understand.

Organization	Case Management
IRC	Adult and child survivors
JWU/UPP	Adult survivors
IMC	Child survivors
JRF	Child survivors
IFH	Adult survivors
UNHCR	Adult and child survivors
FPD	Adult and child survivors
MOSD	Child survivors

3.2.2 GBV Disclosure[33]: Roles and responsibilities

A survivor has the freedom and the right to disclose an incident to anyone. He/she may disclose his/her experience to a trusted family member or friend. He/she may seek help from an individual or organization in the community. Any service provider contacted by a survivor who then discloses an incident has a responsibility to give honest and accurate information about services available; to give a reasonable time period within which services can be expected; and the consequences (pros and cons) of accessing and particular service.

Disclosure: General Service Providers

- Service providers should create a safe, supportive, confidential environment that allows survivors, children and/or their caregivers to disclose violence should they choose to do so. It often takes time to build trust for the child or survivor to disclose that they have experienced violence. General services providers or community volunteers should not attempt to actively identify survivors of GBV or child protection issues as this can lead to stigma and put survivors/children and staff/volunteers at risk.[34] All actors coming into contact with GBV survivors are responsible for knowing the GBV referral pathways and the forms of assistance that are available. The appropriate referral pathway for GBV response is shown in Annex XVIII.
- **Non-specialized actors should not interview survivors or respond directly;**
- The wishes of the survivor must always be respected as to where or with whom to seek help. He/she should not be urged into a particular course of action.
- **Non-specialized actors should ask the survivor's consent to contact a primary focal point on the GBV referral pathway and facilitate the contact between service provider and survivor. If a survivor consents to share their information, the referral should be made by accompanying the survivor, phone or email and documented by email;**
- All information should be kept confidential, even if family or community members request feedback on support given.

33. The term "disclosure" is used to emphasise that it must be the survivors' choice to disclose that they have experienced SGBV and to whom they make that disclosure.
34. Questions about whether people have experienced SGBV or child protection issues should only be asked during individual, confidential interviews by qualified child protection or SGBV cases managers or protection staff.

Disclosure and Initial Assessment: GBV Specialized Service Providers

Specialized actors include medical services or case management organizations specialized in dealing with GBV cases (see Annex XVIII: GBV Referral Pathways). Specialized actors can receive cases either through disclosure from survivors or through referral from other actors. All specialized service providers should ensure that:

- Frontline services are accessible, safe, private, confidential and trustworthy. Survivors are more likely to come forward to seek help and report a GBV incident under such conditions; Trained female and male personnel are available;
- Throughout the entire process survivor is treated in respectful and non-judgmental manner;
- The survivor accessing services is comfortable. Ask if he/she have someone they trust and is supportive and who will wait with him/her, with their permission;
- Once the survivor is comfortable and has given her/his informed consent, determine together with survivor her/his immediate needs;
- Initial emotional support and information about the support options (medical, psychosocial, legal, safetysecurity) is provided. Benefits and consequences of such support are discussed. Survivors should give their permission before any organization is contacted;
- **The importance of receiving medical attention as soon as possible after an incident of sexual violence is explained to the survivor to prevent sexually transmitted diseases, HIV/AIDS and unwanted pregnancy;**
- Needs, dangers and strengths are assessed collectively with the survivor;
- An action plan and/or a safety plan (including social support and services) are established together with the survivor addressing the survivor's needs. If the survivor is in imminent danger, **develop a safety plan** based on the best interest of the survivor to maximize her/his safety. (See section 4.3 on security/ safety response);
- The GBVIMS Psychosocial Intake and Assessment Form, the BIA Form and the GBV IMS Consent Form (see Annexes I, VI and VII) are completed only after having discussed all options with the survivor and agreed an individual plan. All case managers must be trained on survivor-centered approaches and must use the GBVIMS Psychosocial Intake and Assessment Form appropriately;
- Informed consent is obtained before any intervention and referral (see section 3.2.3 below on informed consent);
- The number of people informed of the incident and the information shared is limited. Identifying information about a survivor should never be shared in meetings and individual cases should never be discussed;
- Appropriate interaction with persons with disabilities and their family members.
- Case prioritization: During the assessment, GBV cases for children and adults should be prioritized using the case prioritization table in Annex IV. This case prioritization table helps case managers and others providing services to GBV cases to prioritise cases and ensure that timely support is provided to clients. Cases are classified into:

    1. **Emergency cases –** immediate danger to client or someone else. Initial response by case manager should be immediate or at maximum within 1 day. Case should be reviewed with supervisor.
    2. **Urgent cases –** risk to client safety or wellbeing. Initial response by case manager should be provided within maximum 3 days. Supervisor should be informed of decision/action.
    3. **Moderate risk –** client requires services but is not in immediate danger or risk. Initial response by case manager should be undertaken within 1-3 weeks.

3.2.3 Informed consent and information sharing

Sharing any information about a GBV incident can have serious and potentially life threatening consequences for the survivor and those helping her/him. Great care is therefore needed in managing information:

- After disclosing information, the GBV survivor has the right to control how information about his/her case is shared with other agencies or individuals;
- The survivor must be made aware of **any risks or implications of sharing information about her/his situation;**
- **The survivor has the right to place limitations on the type(s) of information to be shared, and to specify which organizations can and cannot be given the information.** He/she must also understand and consent to the sharing of non-identifying data about her/his case for data collection and security monitoring purposes. Sharing of information between agencies should be guided by the Inter-Agency GBV Referral Information-Sharing Protocol (see Annex VIII);
- If a survivor agrees and requests referrals, she/he must give **informed consent** before any information is shared with others. Before an agency shares any information about a case, or makes any referral, the survivor should be given honest and complete information about possible referrals and their implications. This will enable the survivor to make an informed decision on how or if information is shared;
- The GBVIMS Psychosocial Intake and Assessment Form, the Inter-Agency BIA Form and the GBV IMS Medical Intake and Assessment Form (Annexes I, VII and II) include a consent form (Annexes IV and VI) to be signed by the survivors. This gives options, with the consent of the survivor, of (i) sharing information with selected agencies according to his/her needs and wishes and (ii) sharing non-identifiable information for monitoring and data collection purposes;
- Confidentiality and informed consent should always be given priority, except in **very exceptional circumstances:**
  - when a survivor threatens his/her own life;[35]
  - when a survivor threatens to seriously harm another person;
  - when person is non-responsive or persons with disabilities that impair their ability to provide informed consent
  - when child abuse or neglect is suspected and it is in best interest of the child;
  - when mandatory reporting rules apply.
- If the survivor is a child, the best interest of the child should always be given priority. The case manager should consult with his/her supervisor and/or consult with other relevant actors in a case conference before taking any decision in this regard. Note that the potential harm caused by non-disclosure of the confidential information should be weighed against the potential harm caused by disclosure of the information.

Informed consent should be taken to provide individual services to survivors, to refer them to other services as well as to share information. To ensure consent is informed, service providers must explain:

- all the options that are available;
- that information (as agreed with the survivor) will be shared with others in order to access other services;
- exactly what is going to happen as a result of accepting other services;
- the benefits and risks of the service;
- that survivors have a right to decline or refuse any part of the service;
- the limits to confidentiality;
- information in such a way that persons with disabilities understand it, using alternate means of communication (sign language, pictures, written/verbal information, etc.) where necessary.

Informed consent for survivors, especially survivors of sexual violence, may require time to build trust with the survivor, ensure that they fully understand the options and support them to take informed decision. During case management, informed consent is an ongoing process which involves discussing with the survivor different options over time. For details on obtaining consent from children/caregivers, see section 3.3 on child protection case management below.

35. Confidentiality should only be broken when there are indications that the person is planning to take their own life. Suicidal thoughts can be common among survivors of violence and are by themselves not sufficient to indicate that the person is planning to take their own life. If in doubt, case managers should consult a mental health professional. In all cases when a person reports thoughts of suicide they should be counselled on available mental health services.

3.2.4 Mandatory reporting

Confidentiality and informed consent should always be given priority. However, the rules of mandatory reporting are such that actors receiving information about certain types of violence are compelled by law to report this information to the police. It is important that survivors are made aware of these mandatory reporting rules, the types of information which may trigger them, and the possible consequences of reporting, before beginning an interview. In this case, a survivor may choose not to disclose vital information, which is within her/his rights. Services should still be provided according to the information that is shared and in accordance the wishes of the survivor. Sharing information without the survivor's consent will result in a loss of trust and will have very negative consequences.[36]

1. **UN, NGO and CBO non-medical staff should refer adult GBV survivors to FPD if they have witnessed or have been told that the incident was a result of domestic violence.**[37] There are no criminal consequences or penalties for not reporting.

2. **UN, NGO and CBO non-medical staff should refer cases of family violence and sexual violence to FPD involving child GBV survivors with the informed consent of the relevant person** (see section 3.3.3. on informed consent for children to determine how to get informed consent for children). Under Jordanian law, the same rules regarding mandatory reporting apply to children and adults. **However in line with international standards it is recommended that in cases where the child and/or caregiver do not consent, the case worker should refer the child to FPD if it is in the child's best interest.** This includes situations where referral to FPD is considered necessary to address an immediate risk to the child's safety. Determining the child's best interest in cases of sexual violence or safety concerns should always be reviewed by a case worker and their supervisor and/or in case conference. The reasons for reporting the case to FPD should be explained to the child and/or caregiver (see section 3.3.3)

3. **All public officials[38](government employees) are required to report misdemeanours and felonies, including incidents of rape, sexual assault and physical assault, according to the Penal Code.** As such, all government employees should inform survivors of this obligation at the beginning of any interview or discussion with a survivor.

   According to the Criminal Procedural Law Article 25, every official authority or employee who knows while on duty of a felony or misdemeanour should report to the Public Prosecutor and send all documentation and information related to the crime.

36. Adapted from: SGBV Resource Tool: Establishing SGBV Standard Operating Procedures (SOP Guide). IASC Sub Working Group on Gender & Humanitarian Action. 2008.
37. Under the Jordanian Penal Code non-medical personnel are not required to report crimes (misdemeanours and felonies). Misdemeanours: offences punishable with a fine or imprisonment/detention of 3 years or less (Art. 15,21,22 Penal Code); Felonies: offences punishable by imprisonment of more than three years, hard labour or capital punishment (Art. 14,18,19,20 Penal Code). Crimes under the Penal Code include rape, sexual assault and physical assault.
    Under the Family Violence Protection Law No. 6 of 2008, social, educational and medical service providers are required to report family violence (Article 8 of the Family Protection Law). According to the Family Protection Law the obligation to report family violence cases arises under the following conditions: It is an act of family violence (defined in Article 5); it does not constitute a criminal offence; the service provider is aware of or witnesses signs of violence; the service provider was informed that the act or signs of violence resulted from family violence.
38. Penal Code, Article 207.1.2

4. **All medical personnel are required to report misdemeanors and felonies against a survivor including incidents of rape, sexual assault and physical assault according to the Penal Code.**[39] However, according to the Ministry of Health Internal Protocols, cases involving adult survivors should only be reported without consent in cases of attempted suicide, sexual violence, and serious injuries resulting from family violence or if the children of the survivors are in danger (see annex VIIIa: MOH Health Care Procedural Diagram for Cases of Family Violence against Women).Furthermore, according to the Ministry of Health Internal Protocols all cases involving child survivors should be reported (see annex VIIIb: MOH Health Care Procedural Diagram for Cases of Family Violence against Children). **In these cases, service providers must inform the GBV survivor of the mandate to report before soliciting any case information during an interview.**
5. **Protection against sexual exploitation and abuse (PSEA):** The Secretary General Bulletin provides that all forms of sexual exploitation and abuse must be reported and investigated through established agency reporting mechanisms. All service providers should incorporate measures for PSEA into their programmes. **Relevant service providers must inform a GBV survivor of the mandate to report on SEA before soliciting any case information during an interview** (see section 4.8.1).

3.2.5 Immediate response and Intervention (including referral)

- Provide direct interventions, including psychosocial interventions where appropriate;
- With the consent of the survivor, refer he/she to the appropriate services for follow-up supportand advocate (if required) in accessing the required services;
- Accompany survivors to social, medical and legal services, and provide support in accessing these services;
- Referrals should be done using the coded Inter-Agency GBV Referral Form (see Annex III) which does not include the name, address, or any other information that might identify the survivor. Always prioritize the confidentiality and security of survivors. The referral form is sent by email and is password protected. (Only focal points know the passwords for the referral forms);
- Home visits should always be conducted very discretely and are not recommended when supporting GBV survivors, unless agreed with the case manager and the survivor. Do not conduct any home visits if this action might put the survivor at risk or be stigmatizing. When conducting home visits always keep a low profile. Be aware that any information you request of the survivor in the presence of relatives or other members of the community might have an impact on her/his protection;
- All agencies within the GBV referral pathway should identify two referral focal points (RFP) per agency (i.e. one RFP and one deputy who will manage referrals in the absence of the RFP). Ensure that focal points are trained and know how to receive and to make referrals.

3.2.6 Case follow-up

- Conduct monitoring and follow-up to ensure the response is efficient and effective and review the action plan;
- Ensure the survivor is getting the help and services needed to improve her/his situation and solve her/his problems;
- Identify additional needs and action points and plan accordingly with the survivor. If a child survivor is being followed up, this plan of action should be agreed with the consent of the child and/or caregiver. The plan of action should be time-framed and based on the survivor's needs;
- Following a review with the survivor, the plan of action will either be further pursued, revised or closed. For a child survivor, additional informed consent/assent procedures should be followed, if new referrals are required. The case is closed following review if needs have been met successfully (for child survivors, complete the Inter-Agency Case Closure Form) (see Annex XVII);
- When appropriate, and with the survivor's consent, and for child survivors with the assent/consent of the child and/or caregiver, conduct case conferencing to ensure close coordination with other service providers.

39. According to the law, medical personnel that fail to report may be sanctioned with one week to three months in prison (Penal Code, Article 207.3).

3.2.7 Case conferences (closed forum)

For GBV cases, regular meetings may be held to review individual cases requiring an inter-agency response. The focus is on addressing any immediate protection problems and coordinating response actions for each individual case:

- Case conferences are small, closed meetings at the camp or governorate level, where highly sensitive information concerning specific cases is discussed. Case conferences are only attended by individuals who are directly providing services to the survivor. Information should be shared on need-to-know basis in case conferences, and information that is not relevant to the work of a particularly services provider should not be shared with them – for instance, health providers do not need to know details of the who perpetrated the violence or how the case is being handled. If necessary to ensure that this principle is respected, specific service providers should attend only part of the case conference where issues related to their work are discussed;
- For adults, the survivor must consent to information sharing with participants in case conferences who are not directly providing services (such as a technical expert).If consent has not been given, then the individual case must not be discussed;
- In the case of children, consent/assent should be provided to share information with participants of a case conference. In some circumstances, if it is in the best interests of the child, information may be shared on need to know basis without the consent of the child or their caregiver;
- In complex cases involving children, information will be shared within the Best Interest Determination Procedures in order to ensure that all relevant safeguards are in place (see Section 3.3.8 Best Interest Determination (BID) Process for details);
- People may participate in case conferences by invitation only. It should only include actors with permission to receive/share information about a specific survivor. The information shared at this meeting is strictly confidential and will focus on actions taken and actions needed;
- Information sharing must only include relevant information and should not include irrelevant personal or other details about the survivor or the incident;
- All members of this meeting are responsible for ensuring that the dignity and confidentiality of survivors are maintained and that information discussed is only that which is needed to resolve problems and coordinate actions;
- It is the responsibility of the designated case managers for each case discussed to ensure that information sharing has been duly pre-authorized by the survivor. The case manager also keeps the survivor informed of decisions and progress made.

3.2.8 Service evaluation

- Conduct an anonymised satisfaction questionnaire with survivors;
- Participate in case management skill and practice review session(s) with the case supervisor.

3.3 | CHILD PROTECTION CASE MANAGEMENT

Case management for child protection cases is provided by the agencies listed in the table below. Case management for GBV child survivors (which includes sexual violence against children) should be provided by GBV case managers trained in dealing with children (listed above in section 3.2on GBV case management).

In addition to the general skills of case management described in section 3.1, case managers dealing with child protection cases should be able to:

- Apply the guiding principles in working with children (see section 2);
- Be familiar with child development and children's wellbeing;
- Communicate and work with children of various ages and families, including those who have experienced very difficult situations;
- Identify strengths and needs to engage the child and family in a strength-based care and treatment process;
- Understand resources and abilities in children and families, even in difficult circumstances;
- Assess risks, needs and strengths and develop the appropriate response in consultation with the child and/or his caregiver(s);
- Follow informed consent procedures for children (see section3.3.3 on obtaining informed consent/informed assent from children and caregiversand section 3.2.4 on mandatory reporting);
- Be guided by the best interest of the child in all actions at all times.

Agencies involved in child protection case management must ensure that cases are handled confidentially through:

- Ensuring that all staff managing cases are trained in confidentiality principles and procedures;
- Keeping case files in a locked and secure location and restricting access only to relevant, authorized case managers/supervisors;
- Ensuring that staff authorized to access these files do not discuss children's details with non-authorized persons.

All organizations handling child protection cases must have paper and/or electronic system to track and manage cases:

- Case file management (hard copy and electronic) need to be governed by a data protection and information-sharing protocol;
- Electronic case information management are recommended as they help prevent duplication of services and losing track of large numbers of child protection cases currently being supported;

More can be found on GBV information management systems in section 8.1 and on CP information management systems in section 8.2.

Organization	Case Management
IMC	Child protection case management including child survivors of GBV; Mental health case management.
IRC	Child protection including child survivors of GBV
JRF	Child protection including child survivors of GBV
UNHCR	Child protection including child survivors of GBV
TdH	Child protection including child survivors of GBV
NHF	Separated children

3.3.1 Identification of child protection cases by general service providers

There are a number of ways to identify children experiencing or vulnerable to violence, abuse and exploitation that need case management services:

- By child protection agencies during community-based child protection activities, such as CFS, awareness raising activities or psychosocial with children;
- By other general service providers, such as educational staff, police, health workers etc.;
- For refugees, by UNHCR staff, especially registration and help desk staff;
- A child may be identified by community members, including neighbours, and employers as well as through community-based child protection mechanisms such as child protection committees, etc;
- Self-referral: a child has the freedom and the right to inform anyone.

General service providers (including child protection staff not working on case management) should:

- Be aware of the kinds of violence, abuse, neglect and exploitation that children can be exposed to and the signs that a child may have been exposed to violence, abuse, neglect or exploitation;
- Be aware of the child protection case managers available in their geographical areas. When children or their caregivers disclose that a child has suffered violence, abuse, neglect or separation, general service providers should provide basic emotional support to children and their families in line with principles and approaches of psychological first aid (PFA);[40]
- Not ask probing questions, nor conduct in-depth interviews with children who have experienced or are at risk of violence, abuse, neglect and exploitation or who have been separated from their caregivers;
- Service providers should create a safe, supportive, confidential environment that allows children and/or their caregivers to disclose violence should they choose to do so. If a service provider suspects that a child may have experienced violence but the child or their caregiver has not disclosed this information, they should consult a child protection case manager to determine how to proceed (without giving identifying details of the child).
- Maintain confidentiality of the information provided by the child and/or others on the case (see section 2.2);
- Provide honest and complete information to child/caregiver about available services and options including general services and case management services;
- Encourage and support children to seek help; Use the CP Interagency BIA Form (Annex XIII) to document the information the child and/or caregiver choose to disclose to them and consent to share with other service providers when leaving a copy of this referral form with the child or caregivers would not put the child at further risk. For child GBV cases and other cases where using the Inter-Agency Referral form might put the child at risk, the referral should be made by accompanying the survivor, phone or email when child/caregiver consents (referrals made by accompanying the survivor or phone should always be documented by email as well);
- Wherever possible and appropriate, accompany the child to the case manager, with the child's caregiver where appropriate;
- Respect the child's wishes, if the child or caregiver does not wish to be referred to the case manager, except in circumstances it is determined that it is in child's best interest. This includes where the child's safety is at immediate risk (see section 3.2.4 on mandatory reporting).If a general service provider is in doubt as to what is in the child's best interest, they should consult case manager (without providing identifying details of the case);
- If child's caregiver does not access case management services, continue to provide relevant services to the child/caregiver, and refer them to any other basic (non-protection) services they wish to receive (e.g. health, education) using the inter-agency referral form.

40. Psychological First Aid: guide for fieldworkers. WHO. 2011.

3.3.2 Initial assessment by case managers

Children who have experienced violence, abuse, neglect or separation may be referred by other service providers, community members or may make themselves known directly to child protection case managers.

The initial assessment of child protection cases should be conducted as follows:

- Child protection cases should be assessed using the Inter-Agency Referral Best Interest Assessment Form for NGOs (see Annex XIII) or by UNHCR using the UNHCR BIA form;
- In the case of a GBV child survivor, also complete relevant sections of the GBV IMS Psychosocial Intake and Assessment Form (Annex VII);
- The assessment should identify the needs, resources and strengths of the child and family (where present);
- The assessment should be a holistic assessment of the child's needs and resources, including issues that may require referral to other organizations;
- The assessment should include: basic demographic information; current care arrangements; the child's social and family relations; psychosocial wellbeing; access to education and/or vocation training; basic health, nutritional status; access to water, sanitation etchant protection issues (see below);
- The assessment should determine if the child is or has been exposed to or is at risk of violence, abuse, exploitation and/or neglect; the type of violence and if possible, the reasons; and any actions that child, their caregivers or others have taken to protect the child;
- For separated and unaccompanied children, the assessment should also identify if the child needs family tracing and/or alternative care (see UASC SOP for details);
- Identify the priority of the case. High priority cases requiring urgent action include: unaccompanied children, children in detention, children with immediate safety concerns (including self-harm/ suicide),sexual violence that occurred in last 72 hours;
- Consent should be taken from child and/or caregiver (i) for the case management organization to keep the case files and (ii) to share information with other organizations for referral information using the child protection consent form (see Annex VII: CP – Consent for Release of Information);
- The assessment process and outcomes will differ according to the age and situation of each child and depending on the best interest of the child.
- The case manager should use the case prioritisation table in Annex IV to prioritise the urgency of the case. Cases are classified into:
  1. Emergency cases – immediate danger to client or someone else. Initial response by case manager should be immediate or at maximum within 1 day. Case should be reviewed with supervisor.
  2. Urgent cases – risk to client safety or wellbeing. Initial response by case manager should be provided within maximum 3 days. Supervisor should be informed of decision/action.
  3. Moderate risk – client requires services but is not in immediate danger or risk. Initial response by case manager should be undertaken within 1-3 weeks.

During the assessment, case managers should:

- Involve the child in the assessment and decision-making process and seek his/her opinion in an appropriate way that takes into consideration the age and level of maturity of the child;
- Wherever possible, ask to talk to the child separately from the caregivers or peers. If this is not possible in the first interview, arrange another time;
- Avoid methods that could further stigmatize the child;
- Ensure privacy of interviews and ensure they are sensitive to the child's psychosocial needs.

3.3.3 Obtaining informed consent/informed assent from children and caregivers[41]

All actions concerning children should be guided by the best interests of the child. According to the Convention of the Rights of the Child (CRC), "the concept of the child's best interests is complex and its content must be determined on a case-by-case basis. It is through the interpretation and implementation of article 3, paragraph 1, in line with the other provisions of the Convention, that the legislator, judge, administrative, social or educational authority will be able to clarify the concept and make concrete use thereof. Accordingly, the concept of the child's best interests is flexible and adaptable. It should be adjusted and defined on an individual basis, according to the specific situation of the child or children concerned, taking into consideration their personal context, situation and needs. For individual decisions, the child's best interests must be assessed and determined in light of the specific circumstances of the particular child. For collective decisions – such as by the legislator –, the best interests of children in general must be assessed and determined in light of the circumstances of the particular group and/or children in general. In both cases, assessment and determination should be carried out with full respect for the rights contained in the Convention and its Optional Protocols."[42]

Consent for case management with children should be obtained as follows:

- In general, permission to proceed with case management (and other case actions) should be obtained from the child, as well as the caregiver or another suitable adult (see below);
- In Jordan, parent/caregiver (or other responsible adult) consent should always be obtained for children under 16. For children 16 and17 years old, child's consent may be obtained instead of the caregivers if the parent/caregiver is not able or willing to provide consent;[43]
- For children aged 7-18, the informed consent described above should be obtained to proceed with case management services
- For legal services and other services that require legal documents the legal guardian or in some cases the mother may sign. Where the parent or caregiver is deemed unsuitable to sign, then the court will assign a legal guardian.
- For non-legal services in situations where it is not possible or not in the child's best interest to obtain the consent of parent, caregiver or other legal guardian (see below) then consent may be obtained from another trusted adult (for the purposes of these SOPs, a "trusted adult" is a related adult, or adult caregiver nominated by the child, or a behaviour monitor of the MoSD or the FPD). For urgent cases, where no trusted adult is available, the case manager can be the first line for consent, provided that within 24 hours the consent of the behaviour monitor is sought (e.g. cases of UASC);. Cases in which it is not appropriate to obtain parent/caregiver consent include: where the caregiver may be the perpetrator or complicit in the abuse; where informing the parent/caregiver could put the child at further risk; or where unaccompanied children are involved.
- For non-legal services, wherever possible the consent of another trusted adult should always be sought for children under 16. For children above 7, they should participate in identifying this trusted person. Where such a person is not available, the case manager (see above) may have to provide consent for such services if the child is under 16 (this should be documented on the consent form).
- For children 16-17 for non-legal services if consent cannot be safely obtained from the parent/caregiver/legal guardian then consent may be obtained from another trusted adult or if this is not possible or in the child's best interest (e.g. as it would put the child in danger) from the child themselves in line with international guidelines[44] except for cases and services that are within the jurisdiction of the FPD.
- Any decision to take consent from anyone other than the parent, caregiver or legal guardian should be reviewed by qualified person. In the case of case managers, this should be reviewed by their supervisor and in the case of non-case managers this should be discussed and reviewed with the case manager (from their own organization or another case management organization). This process should be documented on the consent form.

41. Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.
42. Convention on the Rights of the Child. General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)*
43. According to Criminal Procedural Law no. 9 for the year 1961 and its amendments, Article 3/2, if the survivor of the crime has not reached 15 years or has mental illness the complaint is made by the caregiver or guardian. If the best interest of the child conflicts with that of his caregiver or that of whoever is representing him or if the child did not have someone to represent him, the public prosecution will assume that role.
44. Caring for Child Survivors of Sexual Abuse. IRC/UNICEF, 2012.

- Children and caregivers should be made aware of any relevant mandatory reporting requirements (see section 3.2.4 on mandatory reporting).

Guidance on how to obtain assent/informed consent from children is described below. These ages are indicative and the child's individual level of development and ability to understand options and take decisions should be taken into account.

Infants and Toddlers (ages 0–6): Informed consent for children in this age range should be sought from the child's caregiver or another trusted adult in the child's life, not from the child. Very young children are not sufficiently capable of making decisions about care and treatment. For children in this age range, informed assent will not be sought. The service provider should still seek to explain to the child all that is happening in very basic and appropriate ways.

Younger Children (ages 7–11): Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to express views or their willingness to participate. The views of children in this age should be taken into consideration before proceeding with services and actions which affect them directly. The child's views can be provided orally and documented as such on the informed consent form. For children in this age range, written parent/caregiver or other responsible adult (either trusted adult) informed consent is required, along with the child's views.

Younger Adolescents (ages 12–15): Children in this age range have growing capacities and more advanced cognitive development, and may be mature enough to make decisions and express willingness for continuing with services. According to standard practice, the case manager should seek the child's views about participating in services, as well as the parent/caregiver's or other responsible adult written informed consent. In the case of provision of services that do not require signature of legal documents, if it is deemed unsafe and/or not in the child's best interest to involve the caregiver, the case manager should try to identify another trusted adult in the child's life to provide informed consent, and take the child's views into consideration. In urgent cases, where it might be difficult to obtain the informed consent of a trusted adult, the case manager will make the decision giving due weight to the child's opinion, provided that within 24 hours the consent of a behaviour monitor of FPD is sought.

Older Adolescents (ages 16–17): Older adolescents, ages 16 years and above, are generally considered mature enough to make decisions. Supportive and non-offending caregivers should also be included in care and treatment decision-making from the outset and provide their informed consent as well. The child should always be consulted as to whether it is safe and in their best interests to involve their parents/caregivers in the decision-making process. For children this age, the child's consent may be obtained for non-legal services instead of the parent/guardian/caregiver if the parent/caregiver is not able or willing to provide consent or if it is not in the child's best interest to take their consent and if another trusted adult is not available to provide this consent except for cases and services that are within the jurisdiction of the FPD. If the adolescent (and where appropriate caregiver) agrees to proceed, the case manager documents their informed consent/assent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

In situations where the case manager or other service providers decides to take a decision without the assent of the child and/or the informed consent of the parent/caregiver it is important that the reasons for this decision are explained to the appropriate persons. This includes when the case manager decides to report the case to FPD or take other measures to ensure the safety of the child. Referrals of asylum-seeker and refugee children to FPD should be done through UNHCR and/or by informing UNHCR.

3.3.4 Initial response and Intervention

If it is decided after initial assessment that a child does require assistance, a case file should be opened and documentation gathered to record and monitor all the services accessed. The case manager or others should provide the child (and where appropriate caregiver) with information about available options for support, so that they can make an informed decision about services. An individual action plan should be developed that should:

- Describe the actions that should be taken to address the primary issues facing the child;
- Be based on the identified needs and strengths/resources of the child and their caregivers and their networks;
- Include an assessment of safety risks and, if required, the development of a safety plan (see section 4.2 on child protection response);
- Be based on the best interest of the child, taking into account the wishes of the child (and the child's caregiver(s) when in the best interest of the child) and taking the age and level of maturity of the child into consideration;
- Include goals, timeframes for implementation, and follow-up mechanisms;
- Include details on who is responsible for what, including referrals to service providers (see below);
- Set out procedures for monitoring and reviewing of the case so that an appropriate assessment can be done at the appropriate time to ascertain whether the child's needs have been met.[45]

For specific procedures regarding case management for separated and unaccompanied children, see UASC SOP and BID SOP.

3.3.5 Referrals

Child protection cases often need referral to services not provided directly by the case manager, such as education services, physical or mental health services, legal/police services, livelihood support (including vocational training or access to better income-generating activities for the whole family) or non-food items. Case managers should facilitate the referral of the child and/or their caregiver to other services as follows:

- Case managers should be familiar with the services offered in their geographical area as outlined in the child protection referral pathways (see Annex XIX);
- Inform the child and/or caregivers of available services that they can access and the pros and cons of each service (including relevant costs if available);
- Take the consent of the child/caregiver to refer the child to specific services. Using the consent form, ask the child/caregiver's consent to share information with the service provider;
- For each service that the caregiver/child consents/assents to, share information with the relevant service provider. Child GBV cases or other sensitive GBV cases should be referred by email using the email referral template (annex IX) and avoid using the interagency referral form
- If the child/caregiver does not consent to share their information with the service provider, the case manager should still provide information to the child/caregiver about relevant services (including contact details);
- In urgent cases, referrals may be done by phone, but should always be followed by relevant documentation (with relevant consents). In such cases, the case manager may accompany the child/caregiver to the service. (Note: this is recommended for GBV child survivors);
- Access by the child to services should be monitored as part of the case follow-up (see below).

45. Case management practice within Save the Children Child Protection Programmes. Save the Children UK. 2011.

3.3.6 Case follow-up and closure

Follow-up is one of the most important activities in CP work and relates to the duty of care that organizations have assumed by taking up the case. Follow-up has the following elements:

- It must be timely and as regular as possible, according to the needs of the child or family;
- It should be carried out, in general, not less than monthly on standard and medium priority cases, and at least weekly on high priority cases. Even if the child is referred to services provided by another agency, staff must still follow-up to ensure the child is progressing;
- It allows for monitoring the general wellbeing of children and for ensuring progress is being made or services have been delivered as planned;[46]
- It ensures that children and adults are kept regularly informed on progress and that both the care received is in place and the social integration of the child is monitored;[47]
- It identifies changes to the child's circumstances, which will then require further assessment;[48]
- It allows for further assessment if interventions are found to be unsuccessful;[49]
- It helps determine the number and frequency of visits based on the specific needs of the individual child and on a case-by-case basis. Continue with this until protection concerns have sufficiently improved.[50]

Case closure is important to ensure that cases are not unnecessarily held open for prolonged periods and dependency is not created.[51] Case closure can take place when all these conditions are met:

- The child's (and caregiver) needs have been met and immediate protection concerns have been resolved;
- The child's safety plan has been reviewed and is in place;
- The child (and caregiver) has been informed he/she can resume services at any time;
- The case supervisor has reviewed the case closure/exit plan.

In other cases, case closure will need to take place when;

- Client requests closure and declines to participate
- Client cannot be reached for 3 consecutive months
- Client dies

Case conferences are convened for all cases that are high priority and those that have additional complexities (see section 3.2.7 on case conferences above). They assess progress and ensure coordination and collation with other service providers.

3.3.7 Service evaluation

Evaluation is undertaken by each agency with the child (and his/her caregiver) to provide feedback on the services received.[52] Case managers may also be involved in evaluation through a final case review and checklist with their supervisor.

The case manager will therefore:

- Conduct a satisfaction questionnaire with the child/caregiver;
- Participate in case management skill and practice review session(s) with their supervisor.

46. Save the Children Case Management Manual - Draft
47. Ibid
48. Ibid
49. Ibid
50. Ibid
51. Ibid
52. Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings. UNICEF/IRC. 2012.

3.3.8 Best Interest Determination (BID) Process

A Best Interest Determination Panel has been established for refugees in Jordan. A best interest determination (BID) describes the formal process with strict procedural safeguards designed to determine the child's best interests for particularly important decisions affecting the child. It should facilitate adequate child participation without discrimination, involve decision-makers with relevant areas of expertise, and balance all relevant factors in order to assess the best option.

The five situations in which UNHCR[53] must make a BID include:

- Temporary care decisions for unaccompanied and separated children in certain exceptional circumstances – for the remainder of 2014 it is recommended that placements of unaccompanied children in alternative care arrangements are reviewed by the BID panel. This arrangement will be reviewed in early 2015 (see UASC section below);
- The identification of the most appropriate durable solution for unaccompanied and separated refugee children (i.e. voluntary repatriation, local integration or resettlement);
- The possible separation of a child from her/his parents/caregivers (or person holding custody rights by law or custom) against their will, if competent authorities are unable or unwilling to take action;
- The identification of durable solutions or decisions on care arrangements, in situations where the custody situation remains unresolved and national authorities are unwilling or unable to adjudicate on the custody;
- In complex cases, prior to family reunification.

For case managers dealing with complex cases such family violence where the case manager is not sure how to determine the child's best interest and to ensure their safety it is recommended that they or their supervisor consult the relevant UNHCR BID supervisor, who can confirm whether a BID panel is required.

A BID panel has been functional since 2007, led by UNHCR with the participation of a local NGO and FPD. Currently BID panels are operational in Amman and Zaatari. Cases assessed by key child protection actors fall within the five situations mentioned above. The membership and frequency of meetings will be monitored to respond to the evolving situation in Jordan. The BID report form is available in Annex XVII.

The BID SOP is currently under revision and will be annexed to the 2015 revision of these SOPs.

53. Field Handbook for the Implementation of UNHCR Best Interest Determination Guidelines, 2010.

CHAPTER 4:

GBV RESPONSE[54]

54. Chapter 4 is adapted from: SGBV Resource Tool: Establishing SGBV Standard Operating Procedures (SOP Guide). IASC Sub-Working Group on Gender & Humanitarian Action,2008.

4.1 | MEDICAL RESPONSE

Medical providers are committed to providing survivors of GBV with medical care as a first priority. Access to health care will be provided in all cases and even before reporting to FPD. Medical providers will:

- Ensure confidential, accessible, compassionate, and appropriate medical care for survivors of GBV;
- Provide the survivor with information about medical procedures;
- Obtain the informed consent of the survivor (see section on informed consent and mandatory reporting);
- Ensure referral to and follow-up with other service providers, as guided by the wishes of the survivor and required by law(see section 3.2.3 on informed consent and 3.2.4 on mandatory reporting);
- Ensure the safety of the survivor and her/his family at all times;
- Collect information in private settings;
- Provide emotional support to the survivor;
- Ensure documentation and follow-up;
- Ensure medical services are accessible for survivors with disabilities and take into account their specific needs.

For sexual violence, healthcare includes at minimum (see Annex XII: CMR Guidelines for Treatment):[55]

- History taken and comprehensive examination completed promptly by a healthcare provider (of the same sex or as preferred by the survivor) trained in the clinical management of GBV including pelvic/genital examination, if the patient consents;
- Within the time window: Treatment of injuries, prevention of disease, including HIV post-exposure prophylaxis within 72 hours, STIs, hepatitis and tetanus;
- Prevention of unwanted pregnancy within 120 hours of the incident;
- Examinations conducted in rooms that ensure privacy, dignity and comfort;
- Information documented thoroughly, maintaining confidentiality and stored securely;
- Follow-up care/secondary referral with full transportation coverage, accompanying survivor whenever possible; emphasizing closed-loop communication;
- Doctors and nurses providing emotional support tailored to the gender, age and circumstances of the survivor. Trainings should be provided to all relevant medical providers;
- Medical facilities should have safe space for children and trained personnel able to adapt the medical exam and treatment for a child;
- If referral is made to FPD (see section 3.2.3 on informed consent and section 3.2.4 on mandatory reporting), the forensic doctor will examine the survivor with his/her consent and will collect forensic evidence to be sent to the laboratory. The forensic doctor provides medico-legal support if the survivor wishes to pursue legal redress;
- If the case is referred to FPD, the forensic examination is carried out at the FPD Forensic Clinic. However if the survivor is hospitalized, the forensic doctor at the hospital does the examination.

Medical providers responding to GBV child survivors must have the knowledge, skills, attitudes and tools to provide specialized medico-legal care for child survivors, including:[56]

- Understanding child development and child sexual abuse concepts;
- Communicating effectively with child survivor;
- Understanding and able to apply clinical care for child survivor;
- Adapting the medical examination and treatment to meet the needs of child survivor;
- Ensuring safe and appropriate referrals and follow-up systems are in place;
- Monitoring activities using established tools.

55. Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and IDPs, WHO, 2004 provides a clear protocol on the health response to survivors and highlights the specific needs of children.
56. Caring for Child Survivor Survivors of Sexual Abuse.IRC/UNICEF. 2012.

The table below indicates the organizations providing medical services for GBV survivors:

Service	Organization
Reproductive health, including clinical care for GBV survivors	IRC, JHAS/UNFPA, IFH/UNFPA, IMC/UNFPA, JWU/UPP/UNFPA, MOH

4.2 | PSYCHOSOCIAL RESPONSE

All actors who interview or have direct contact with survivors should be familiar with the guiding principles and be able to put them into practice (see Chapter 2). They should also be aware of their responsibility to listen carefully and give information, as described in action sheet 8.3 of the IASC GBV guidelines (2005) and provide community-based psychological and social support, including:

- Listen to the survivor and ask only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press her/him for more information than she/he is ready to give;
- If the survivor expresses self-blame, care providers need to gently reassure him/her that sexual violence is always the fault of the perpetrator and never the fault of the survivor;
- Give honest and complete information about services and facilities available;
- Prioritize safety at all times;
- Do not tell the survivor what to do, or what choices to make. Rather, empower him/her by helping him / her to make informed decisions.

Psychosocial supports for survivors of GBV should be holistic. They should target both people and communities (or aspects of both). Psychosocial interventions for survivors of GBV include the following inter-related types of activities:

- Psychosocial support to assist with recovery and healing including psychological first aid, individual and group counseling;
- Support and assistance with social re-integration, including vocational training and women's empowerment, literacy training, school reintegration, child friendly spaces;
- Mental health services. Survivors who require/request specialized metal health support should be referred to the mental health focal point:
  - Individuals who are likely to need more specialized support include those who are unable to take care of daily tasks, cannot maintain good relationships with others or are unable take care of their physical health. Individuals with pre-existing mental health problems are also more likely to need specialized support;
  - Protection actors should counsel those suspected of needing mental health services on available mental health services and, when they consent, refer to a specialized provider.

Psychosocial interventions should be adapted for child survivors and personnel providing support to child survivors should be trained accordingly. Psychosocial interventions for child survivors of GBV include:

- A comprehensive assessment to better understand the child's social and family environment, psychological wellbeing, and strengths to help determine appropriate psychosocial interventions;
- Providing healing education, relaxation training, teaching coping skills and problem solving.[57]

Community-focused psychosocial interventions should seek to enhance survivor wellbeing by improving the overall recovery environment. This includes community awareness actions to reduce stigma and promote access to services for GBV survivors, strengthening of community and family support, including self-help and resilience initiatives.

57. Caring for Child Survivor Survivors of Sexual Abuse.IRC/UNICEF. 2012.

The table below lists organizations providing MHPSS services specifically adapted to GBV survivors:

Service	Organization
MHPSS (specialized for GBV survivors)	IMC, IRC, IFH/UNFPA, UPP/JWU, JRF, Centre for Victims of Torture, Khawla Bint Al Azwar, AWO, MoH

4.3 | SECURITY/SAFETY RESPONSE

The safety of survivors should always be prioritized. Case managers may, upon receiving a case:

- Find strategies that enable the survivor to stay with their family, when appropriate, always prioritizing safety;
- Explore and address any concerns about social stigma for the survivor and/or their family that may prevent the survivor from taking action for their own safety
- Provide phone units so that the survivor may be in contact with the case manager in cases when the survivor is not reachable. This should only be done when providing phone units will not put the survivor more at risk;
- Provide the hotline number to be used in case of emergency;
- Provide interim alternative accommodation, pending long term solutions, providing financial support and transport to the safe location whenever possible. Always assess the security risks related to this option and ensure ongoing monitoring of protection risks;
- Refer a GBV survivor from urban communities and camps to safe houses (shelters) if in imminent danger in coordination with FPD and relevant organisation responsible for the safe house (MOSD, JWU or JRF). The informed consent of the survivor should be obtained (or if child survivor assent of the child and/or consent of the caregiver or if it is determined that it is in child best interest) prior to making any such referrals. Referral to a safe shelter should be the last resort and should be made in a case conference after all other possible alternatives have been explored. Actors need to consider that the decision to refer to a safe shelter could further isolate the survivor.

When the survivor is in imminent danger, shelters can be accessed through FPD/MOSD or JWU and in the case of refugees or asylum-seekers through UNHCR:

- Referrals to shelters will indicate a clear strategy and case management plan leading towards a solution;
- When necessary, the referral agency will ensure follow-up on the case referred;
- When necessary, the referral agency will follow-up on necessary measures and actions including social welfare, medical, and psychosocial services;
- All actors involved in this process will ensure the safety and security of the survivors;
- All actors will ensure that the survivor is treated with dignity and compassion.

MOSD shelters can be accessed through FPD and in the case of children who are refugees and asylum-seekers through UNHCR:

- Dar Al Wifak accepts women and their children(boys up to 9 years old, and girls of all ages), and girls alone if they are 14 (in some exceptional cases 13) years old and above;
- Dar Al Aman shelter provides temporary care for abused or neglected children and is operated by the Jordan River Foundation. It provides services to boys up to 12 years old and girls up to 13 years old;
- There are no specialized shelters for boy survivors above age 12. However, MOSD non-specialized shelters accept boy survivors of GBV.

The JUW shelter is also available:

- Women over 18 can access the shelter with their children directly (girls of all ages, and boys up to 13 years old);
- Girls under 18 can access the shelter in coordination with FPD;
- There is no time limit on residence in the shelters;
- Survivors are provided with comprehensive medical, psychosocial, and legal support;
- Survivors have access to food and NFIs including hygiene products.

Security and safety service providers are listed in the table below:

Service	Organization
Police	FPD
Protection	UNHCR
Shelters	MOSD (Dar Al-Aman and Dar Al-Wifak), JWU

4.4 | LEGAL RESPONSE

Legal responses include providing legal counseling, assistance, and representation for adults and children, when the survivor wants to press charges against the perpetrator or in cases related to personal status (e.g. custody law issues, divorce, alimony, etc.). This includes:

- Information about existing measures that can prevent further harm by the alleged perpetrator;
- Information on court procedures, and any issues pertaining to national justice mechanisms, including foreseen timelines;
- Information on available support in the event that legal proceedings are initiated;
- Information on the pros and cons of all existing legal options which include highlighting the inadequacy of any traditional justice solutions that do not meet international legal standards;
- Legal representation before the court if the survivor wishes to take legal redress;
- Wherever possible, legal actors and others providing support for survivors covering all court-related costs and providing transportation to and from the courthouse when a survivor's case is being heard. The survivors should be informed of any cost implication from the beginning;
- Child survivors and their parents/legal guardians are consulted on the option for legal justice and made aware of the available services and their limitations. The child's needs, wishes and feelings are taken into consideration and every effort is made to enable the child to express himself/herself and to take part in the decision-making process;[58]
- The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing and is provided with legal representation before the court.

The table below indicates key actors providing legal services:

Service	Organization
Legal counselling	UNHCR, ARDD-Legal Aid, JWU, Khawla Bint Al Azwar
Legal representation	UNHCR/Jordanian Bar Association Mizan, ARDD-Legal Aid, JWU

58. Caring for Child Survivor Survivors of Sexual Abuse.IRC/UNICEF. 2012.

4.5 | POLICE PROCEDURES

In Jordan, GBV cases, specifically cases of sexual violence against all survivors and other cases of violence in the family against children and women, can be referred to FPD with survivor consent or following mandatory reporting procedures (see section 3.2.4). For cases involving asylum seekers or refugees, a GBV survivor or their caregiver can report directly to FPD – in this case when the survivor/caregiver consents, FPD will inform UNHCR. When NGOs and CBOs refer cases to FPD, it is recommended that the referrals to FPD be made through UNHCR, when possible and if the survivor consents.

When a complaint is received by FPD, procedures are as follows:

- Priority is given to medical treatment when deemed necessary prior to interviewing the survivor;
- Interviews with the survivor take place in private settings with an officer of the same sex or as preferred by the survivor;
- Cases are handled with extreme confidentiality and FPD has a coding system in place for such purposes;
- Obtain the informed consent of the survivor for relevant procedures.
- In case of children parents will be informed of the case and their consent for relevant procedures will be usually be obtained;
- Ensure spatial and qualitative evidence;
- Document the complaint in the registry;
- Consult with the forensic doctor at all times.
- The forensic doctor will issue a medical report, collect and seal forensic evidence samples and send them to the laboratory;
- The situation may require that the forensic doctor examines other family members who may have been exposed to or at risk of abuse;
- Visit the scene where the abuse took place if/when necessary and gather evidence to be sent to the laboratory;
- Open a case file and process all relevant documents to be sent to the judiciary if/when necessary (see below for details);
- Follow-up on the results of the Judicial Department;
- Provide temporary protection to the survivor or other family members during the period of investigation if/when necessary;
- Follow-up on the wellbeing of the survivor ensuring access to social welfare, medical, forensic and psychological services;
- Hold in demand the perpetrator for the legal period;
- Ensure the safe passage of survivors to and from safe houses.

As the governor has primary responsibility for all security-related matters in their respective governorates, the FPD may refer cases of violence involving matters of broader security such as conflicts between clans or families or honor crimes to the governor.

Specific FPD procedures vary according to both the type of violence, and whether the survivor is an adult or child, as described below.[59] In all cases, the following basic initial steps are conducted:

- A receptionist takes basic information about case including demographic information and information about type of violence;
- Investigators conduct interview with the adult/child, including taking a statement;
- Interviews with children are child-friendly and take into consideration the age and maturity of the child;
- Interviews with children are videotaped to be sent to the judge, where necessary.

59. Interview with FPD staff on 25/3/2013

Physical assault or sexual assault against adults and children (felonies):

- In cases of felonies, the survivor (or their caregiver) can decide whether they wish to file a complaint or not against the alleged perpetrator. If they wish to file a complaint, then the judicial proceeding described below will be followed;
- If they do not wish to file a complaint, FPD will still refer the case to the public prosecutor who will decide whether or not to refer the case to the court proceedings. In this case, their statement can be used by the public prosecutor and they may be called to testify;
- As such, all cases of physical assault against women and children perpetrated by family member and sexual assaults against adults (women and men) and children are referred by FPD to the public prosecutor.

Physical violence against adults perpetrated by a family member that does not constitute physical assault (misdemeanor):

- The investigator counsels the survivor on the following three options: a) Press charges against the alleged perpetrator/file a judicial complaint (court proceedings); b) Refer to a social worker for family mediation; c) Refer to the governor to have the alleged perpetrator sign a pledge not to abuse the survivor again;
- The survivor decides which option she/he wishes to pursue.

Physical violence against children perpetrated by a family member that does not constitute physical assault (misdemeanor):

- In cases of physical violence against children perpetrated by a family member, the child is referred to the forensic doctor for examination;
- If the forensic report indicates that the child suffered violence that resulted in physical bruises or injuries, FPD will refer the case to the public prosecutor;
- If the forensic report finds no evidence of bruises or injuries, then the child or their non-offending parent or legal guardian will be given the option to be a) referred to a social worker for family mediation; b) referred to the governor to have the alleged perpetrator sign a pledge not to abuse the child again; c) press charges against the alleged perpetrator. The views of the child are taken into account in all decisions in this case, and the informed consent will be given by the parent/guardian or the child, if they are considered of a sufficient age and/or developmental level to provide consent. Where children are not able to give informed consent and no parent or legal guardian is available to provide consent, an MOSD social worker can provide consent on behalf of the child.

4.6| JUDICIAL PROCEDURES

In general, cases of physical violence, whether perpetrated by a family member or non-family member, are handled by the court, in accordance with the Criminal Procedures Act. There is no family court to deal with such cases. The survivor can file a regular lawsuit in the regular Criminal Court and/or a divorce lawsuit in the Shariah Court (Personal Status Court).

The judge has discretionary authority to decide whether or not court proceedings can take place in private, and this is done on a case-by-case basis. Service providers should advocate for closed-door trials and sessions for all GBV survivors.

Given the sensitivity of cases of sexual violence, judicial procedures are different from those for physical violence, in that hearings are always conducted in private sessions and chambers in the courtroom. Extra protection and security measures are put in place during the hearing to ensure the safety of the survivor.

Judicial procedures should be child-friendly, particularly in courts:

- According to the new Juvenile Law 2014, interviews with children can be recorded at FPD and used as evidence in court
- Hearings for children take place in private chambers, and privacy is ensured at all times;
- The child will be consulted on the option for legal justice and made aware of the available services and limitations;
- The child's rights, needs, views, and feelings should be taken into consideration and every effort should be made to enable the child to express himself/herself and to take part in the decision-making process.

4.7 | BASIC SUPPORT SERVICES

In a variety of cases, survivors may need basic assistance in order to ensure their immediate wellbeing, safety and security. Material assistance, such as emergency food and non-food items (NFI), shelter and assistance in documentation and registration can be provided through referrals. **Assistance should never stigmatize GBV survivors, by identifying them as survivors in the specific services they receive or at the locations in which services are provided.**

Basic support services are listed in the table below:

Service	Organization[60]
Food & Voucher assistance and Nutrition	WFP, SCI, HRF, IRW, SCJ, Medair, ACTED, JHCO, Caritas, LWF
Non-food Items	UNHCR, IRC, Care International
Cash assistance	UNHCR, IRC, Care International, IH
Life skills, vocational training, income generation	UPP/JWU, Khawla Bint Al Azwar
Education	Ministry of Education, SCI
Non-formal education	Questscope, Khawla Bint Al Azwar

60. Inclusion in this table does not imply that all these service providers have been reviewed and endorsed by the SSGBV Working Group.

4.8 PROCEDURES FOR SPECIFIC GBV ISSUES

4.8.1 Sexual exploitation and abuse (SEA) involving UN and related personnel

Reporting mechanisms and procedures are set down in the UN Secretary General's Bulletin on Sexual Exploitation and Abuse (2003) and are carried out in accordance with national laws. According to the Bulletin "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions."

As SEA reporting is mandatory, for staff of UN organisations or organisations funded by the UN, survivors must be informed that all information that they disclose will be shared through the appropriate mechanisms.

PSEA standards include:

- Sexual exploitation and sexual abuse constitute acts of serious misconduct and are grounds for disciplinary measures, including summary dismissal;
- Sexual activity with children is prohibited. Mistaken belief in the age of a child is not a defence;
- Exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour is prohibited. This includes any exchange of assistance that is due to beneficiaries;
- Sexual relationships between UN staff or humanitarian workers and beneficiaries are based on unequal power dynamics, undermine the credibility and integrity of the work of the agency and are strongly discouraged.

PSEA mechanisms are currently being established in Jordan. Currently incidents of sexual exploitation involving humanitarian workers or refugee workers must be reported to UNHCR. A detailed description of prevention and accountability procedures will be developed and shared soon. National bodies have their own codes of conduct.At the same time, cases of PSEA are dealt with in accordance to national laws.

4.8.2 Early marriage

In Jordan, the legal age of marriage is set at 18 years. Shariah judges may authorize marriage for those who are 15 to 17 years, provided that the groom is capable of paying the alimony and dowry, the bride agrees to the marriage, the child guardian's consents and that judge determines that the marriage is in her best interest. If the groom is under 18, they must agree to the marriage, their guardian must consent and the judge must determine it is in their interest.[61]

According to Jordanian law, marriage for those below 15 years of age is not allowed, except in very exceptional cases after thorough assessment of the case by the court.[62] Discussions among relevant authorities and humanitarian actors on how to address the legal protection needs of pregnant or child parents under 15 are currently taking place.Upon receiving clients at risk of early marriage, service providers should apply the same case management procedures in accordance with other GBV cases (see Chapter 3). Furthermore responsible agencies will:

Upon receiving clients at risk of early marriage, service providers should apply the same case management procedures in accordance with other GBV cases (see Chapter 3). Furthermore responsible agencies will:Legal assistance and representation in obtaining birth registration, marriage certification and when appropriate in family law matters;

- Counsel the client on legal, social and health consequences of early marriage;
- If the client consents, always giving priority to her/his safety, provide counselling to relevant family members to prevent the early marriage;
- In cases involving refugees/asylum seekers refer to UNHCR;
- Ensure other referrals as guided by the wishes of the client.

Upon receiving cases of early marriage that have already occurred, the following services will be available:

- Legal assistance and representation in obtaining birth registration, marriage certification and when appropriate in family law matters;
- Provision of reproductive health counselling and services, including family planning;
- Access to educational and vocational training and referral;
- Advice and information regarding available psychosocial services including women's spaces, counselling and couple counselling and refer, if the person consents.

In cases where violence or other protection concerns are disclosed, follow the same procedures as for other GBV cases.

61. Personal status law, number 36, 2010, Article 10, paragraph b "If there is a marriage under 18 it should be approved by the Chief of Shariah Judges and according to special instructions issued by him". The text of the Special Instructions is below:
Special Instructions to Grant Marriage Permission for Those Who are Below 18 Years of Age. Based on article (10) in the Provisional Personal Status Law no (36) for the Year 2010.Effective From Date It Was Issued in the National Gazette on January 16, 2011
The judge, and based on approval from the Department of the Chief Justice (Qadai Al Qadah) is permitted to grant authorization to marry for those who are 15 years of age and for whom the marriage is deemed necessary in accordance with the following:
1. The Fiancé must be fit to marry the Fiancée in accordance to the elements of capability stipulate in article (21) paragraph (2) of the Personal Status Law (Note: this includes: is it required for marriage that the man is "equal or equivalent to the woman in religion and wealth. Wealth capacity means that the man has the capability to pay the "dowry" and to financially provide for his spouse)
2. The Judge must verify and assess the agreement and consent of all along with the freedom of choice and overall satisfaction;
3. The Court must ascertain whether the marriage is in their interest (note: understood to be interest of the engaged couple) be it economic, social or security and leads to reaping the benefits or warding off evils. This is done by any means or measures the courts finds suitable to check and to ultimately confirm that there is a real need or necessity for the marriage
4. The court has to take into consideration – to the extent possible – and in accordance to the details of each case that there is a an apparent benefit from the marriage, that any age difference between the applicants is deemed suitable, that the marriage is not repeated, nor is it a reason for discontinuing school education.
5. Guardian must provide consent for the marriage in accordance to articles (17), (18) and (20) of the Personal Status Law
6. The Court must provide proper documentation of the recommendation justifying the authorization to marry. Application and supporting
documentation is then submitted to the Department of the Chief Justice (Qudi Al Qudah) for review and approval.

62. Convention on the Rights of the Child: Jordan Fourth and Fifth Report, Child Rights Committee, 2011. Article 35/c of the Personal Status Law #36, 2010 states: "Case of incorrect marriage for minority shall not be heard if the wife gives birth, if she is pregnant or if both parties meet the eligibility conditions at instituting the case".

CHAPTER 5:

CHILD PROTECTION RESPONSE

5.1 | CHILD PROTECTION SERVICES

This section outlines the services provided by child protection and broader protection actors. This includes child friendly spaces (CFSs) and community-based psychosocial services, specialized psychosocial services, legal and safety services for child survivors of violence, juvenile justice services and birth registration. These services should be available for all children, regardless of their age, gender or circumstances.

Case management services for child protection cases are covered in Chapter 3.

5.1.1 Community-based child protection, psychosocial support, and mental health services

This section covers three main forms of community-based child protection and psychosocial services. Community-based child protection and psychosocial services aim to mobilize and support community members, especially refugee community members, to better protect and support children affected by the refugee crisis.

These types of services should be available to all children affected by the crisis. However, children who are direct survivors of violence, abuse, exploitation or separation particularly benefit from these activities. They should be integrated into activities with other children who are affected by the crisis more generally to avoid stigmatization and promote social integration. These activities should be implemented in a coordinated manner by child protection organizations to ensure coverage and equitable access to these services for refugee and host population children, avoid duplication of services and ensure a harmonised approach among different organizations that meets international standards and is culturally/contextually appropriate.

5.1.1.1. Community-based child protection mechanisms

Community-based child protection mechanisms - often termed 'child protection committees' - are "networks or groups of individuals at the community level who work in coordinated way towards child protection goals" which "include local structures and traditional or informal processes for promoting or supporting the wellbeing of children".[63] These committees are responsible for:

- Working on prevention of abuse, violence and exploitation of children (see section 5.2 on prevention) including community mobilisation, awareness raising and advocacy;
- Raising awareness and acceptance of existing child protection and other services for children in communities
- Identification of key child protection issues, mobilising communities and advocating with relevant actors to address these issues
- Identification of child protection cases, mobilisation of community resources and referral to formal service providers including child protection case managers or other relevant service providers. Child protection committees should be trained in how to identify and refer cases as per the CP referral pathways (see Annex XIX).

These committees/mechanisms should be implemented in line with Standard 16: Community-Based Mechanisms of the Minimum Standards for Child Protection in Humanitarian Action and inter-agency TOR for child protection committees in Jordan.

63. Minimum Standards for Child Protection in Humanitarian Action.CPWG.2012, p.143.

5.1.1.2. Child friendly spaces (CFS)

Child friendly spaces are "safe spaces where communities create nurturing environments in which children can access free and structured play, recreation, leisure and learning activities and are an important child protection response to restore sense of normalcy for children who have experienced violence and displacement". CFSs should be implemented in line with the Guidelines for Child Friendly Spaces in Emergencies[64] and Standard 17: Child Friendly Spaces from the CPiE Minimum Standards[65] including:

- Be available for all children who have been affected by the crisis including those children who have directly experienced violence and/or are living in camps or the community;
- Provide age and gender appropriate activities for younger children (6-12), as well adolescents (13-18);
- Ensure children and community participation and ownership, including engaging family members in supporting their children;
- Provide a range of services including psychosocial activities, non-formal education, recreational activities and life skills sessions for children as well as awareness-raising activities for parents/caregivers and family members on supporting and caring for their children in difficult situations;
- Provide safe, supportive and stimulating environments for children;
- Child friendly spaces should be inclusive for all children, including children with disabilities, and ensure integrated activities;
- Include older persons and persons with disabilities as volunteers in CFSs;
- Identify and, where appropriate, refer child protection cases (see Annex XIX: CP Referral Pathways).

5.1.1.3. Other community-based psychosocial activities

All child protection actors should ensure timely and appropriate psychosocial support to children, including children with disabilities, is integrated into their child protection response as follows:

- Coordinate mental health and psychosocial support services according to the IASC intervention pyramid, from actions that benefit all members of affected communities to more specialized mental health services with other sectors such as education and health;[66]
- Train child protection staff on the effects of violence and displacement on children's and adults' psychosocial wellbeing;
- Provide child protection services in a way that promotes self-healing;
- Provide basic, non-intrusive emotional support to children and families through approaches such as psychological first aid (PFA);[67]
- Respect basic 'do no harm' principles by avoiding pressing children and parents/caregivers to share their personal experiences beyond what they would naturally share, and avoiding using clinical terminology to describe children's normal reactions (for instance, 'trauma') etc;
- Involve the affected community in the planning and carrying out of child protection and psychosocial activities;[68]
- Identify children and families experiencing severe distress which impairs their functioning and/or mental illness and refer to mental health services (see section 4.2.2 on health).

64. Guidelines for Child Friendly Spaces in Emergencies, Global Protection Cluster, Global Education Cluster, INEE, IASC Reference Group on MHPSS. 2011.
65. Minimum Standards for Child Protection in Humanitarian Action. CPWG. 2012.
66. Ibid
67. IASC Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Managers Know? IASC. 2010.
68. Ibid

In addition, child protection actors and psychosocial actors together should ensure that children affected by violence and displacement have access to structured psychosocial activities implemented in and by the community to support children's psychosocial wellbeing and recovery.[69] This includes:

- Structured sessions on child resiliency and life skills to help build children's coping skills;
- Awareness-raising for parents/caregivers and other caregivers to support parents/caregivers and community members to better support and care for their children;
- Conducting peer-to-peer activities and youth mentorship programmes;
- Supporting recreational, sports, cultural and civic engagement activities for children;[70]
- Community-based social support activities for parents/caregivers (for instance, women's groups, reestablishment of religious activities) to promote parent/caregiver wellbeing which has a direct positive impact on children's protection and wellbeing;
- Integrating these activities within child protection programmes and activities rather than creating stand-alone psychosocial services.[71]

5.1.1.4. Specialized, non-focused psychosocial services

Children, who have experienced violence, abuse and exploitation, as well as separation from their family, are more at risk of psychosocial problems. While most children will recover with the support of their family and friends, some children and/or families will have emotional, behaviour or social problems that require professional services such as counselling or case management. Child protection services should either include these types of services in their programme or establish referral pathways to them. These services include:

- Case management services (see Chapter 3);
- Individual counselling, couple and family counselling;
- Group counselling;
- Support groups.

These services should be provided in a way that maintains confidentiality and enables children and their parents/caregivers to exercise control and choice in shaping the support they receive. They should be integrated into wider systems so as to reach more people, increase sustainability, reduce stigma and be consistent with the principles outlined in the IASC MHPSS Guidelines. They should provide services to all children in need, including those who are direct victims of violence, abuse and exploitation.

5.1.1.5. Mental health services

Children experiencing mental illness or levels of distress that lead to impaired functioning should be referred to mental health services. Any general child protection service provider who is unsure if a child requires mental health services can refer him/her first to child protection case managers and/or counselling services who will conduct an assessment and determine the type of psychosocial/mental health service required.

69. See pyramid 'Level 2 Community and Family Supports' in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, IASC, 2007.
70. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007.
71. Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Managers Know? IASC, 2010.

The table below lists service providers in community-based child protection, psychosocial support and mental health:

Service	Organization
Child protection committees	SCI, UNICEF, Tdh-L, Mercy Corps,
CFS and community-based psychosocial/ child-protection services for children[72]	SCI, SCJ, Tdh, IMC, ICS, JWU, JRF, JRC, Mercy Corps, Family Guidance and Awareness Center, NHF, Zenid/JOHUD, Care International, Princes Salma Centre, UPP, INTERSOS, IMC, Mercy Corps
Counselling/support group services[73]	IRC, Family Guidance and Awareness Center, JRF, JCR, NHF, CVT, FPD, Zenid, JRS, IMC, HI, Mercy Corps
Clinical mental health services	IMC, CVT, MOH/WHO

5.1.2 Security, legal, police and judicial services for child survivors of violence and neglect

This section describes the services for child survivors of violence and neglect to ensure their safety and access to justice (see also GBV response above). This includes police, legal, judicial and social services, as well as shelters for child survivor of violence and/or neglect. Services are available to all children at risk of or experiencing violence. Police, legal and judicial services are available for children who have experienced violence or neglect by family members (as defined by Family Protection Law and Juvenile Law, see Chapter 1) or sexual violence or physical assault (as defined under the Penal Code, see Chapter 1).

5.1.2.1. Security for child protection cases

Humanitarian and security actors should take steps to respond to security threats towards children in general. They should also ensure that individual children who are at risk of experiencing further violence are provided with services to ensure their safety. Key actors involved in security include the Police Security Department (PSD) for camp settings, border police, FPD and governors.

Actions to respond to security threats against children in general include:

- Maintain adequate security presence in camps and community areas with high concentrations of refugees; ensure police patrols in areas where children are particularly at risk;
- Ensure security staff including border patrols and security in camps are adequately trained in refugee and child protection issues;
- Raise awareness of children and refugee and host communities on how to report violence against children to police and/or UNHCR;
- Involve FPD and other security actors in monitoring of violence, abuse and exploitation of children, and work with security actors to develop responses to common forms of violence;
- Establish links at local level between community-based child protection mechanisms, child protection service providers and police/FPD to monitor common security threats against children in specific locations and develop common responses to these threats;

72. This corresponds to level 2 of the IASC psychosocial pyramid in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.
73. This corresponds to level 3 of the IASC psychosocial pyramid in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.

- Ensure that personnel working in shelters have adequate information and training on child protection issues, including unaccompanied and separated children, sexual exploitation and abuse, and exploitative labour, and have signed up to and have been trained in a code of conduct or other policy which covers child safeguarding.[74]

Actions in relation to children who are survivors of or at risk of violence include:

- General service providers who identify children who are survivors of violence and/or at risk of violence should provide children and their caregivers with information about child protection case managers and FPD;
- Child protection case managers dealing with cases of violence against children should make a safety assessment and, in cases where there are risks for the child's safety, develop a safety plan for the child in consultation with the child and, where appropriate, their caregivers;
- A safety plan can include: actions that can be taken by the child and/or their caregiver; working with other persons known to the family/child to ensure their safety; involving child protection committees/ networks; reporting to FPD (see details on FPD procedures below); reporting to the general police (in case of physical assault of a child by non-family member); moving the child to another family or location; temporarily placing the child in a shelter;
- In Za'atri camp, cases involving security issues related to children (not family or sexual violence) can be reported to the Gendarmerie who is responsible for camp security.

Removal of children from their families for neglect and/or security reasons can only be done by FPD. In the case of asylum-seekers and refugees these cases should follow Best Interest Determination procedures (see below). Where a child is removed from their families for their safety, they should be placed with another family member, if safe, supportive care can be provided. FPD is authorised to remove a child and place them with another family member or in a shelter, on the basis of a court order from Juvenile Judge. In some cases, FPD and UNHCR may also place children with family members or in shelters on the basis of a BID Panel recommendation. The child's views are taken into account in accordance with their age and developmental level in deciding on a placement of the child with family members. If a child needs to be removed from their current care arrangements and placed in a shelter or formal foster family, this must be approved by the Juvenile judge. Formalized standby foster parents/caregivers may also be able to provide safe accommodation in the future as long as additional training is provided. Further details can be found in the UASC Sops. Placing children in shelters should be a last resort and a temporary measure. For asylum seekers and refugee children the referral should be done through UNHCR /FPD and the case will require the implementation of BID procedures (see section 3.3.8 Best Interest Determination (BID) Process).

- Dar Al Aman shelter provides temporary care for abused or neglected children and is operated by Jordan River Foundation. It provides services for male children up to 12 years old and female children up to 13 years old. Children can be admitted to Dar Al Amanor MOSD shelter through FPD pending a decision from the Juvenile Judge and based on the Behaviour Observer's report;Abused or neglected adolescent girls from 14 to 17 can be referred to Dar Al Wafaq shelter. This shelter is run by MOSD but referrals should go through FPD in cooperation with MOSD;
- Abused or neglected adolescent girls from 14 to 17 can be referred to Dar Al Wafaq shelter. This shelter is run by MOSD but referrals should go through FPD in cooperation with MOSD;
- MOSD has two care centres for boys; one in Amman for boys of ages 12-15 years and one in Shafa Badran for boys of ages 16-18 years. MOSD non-specialized shelters accept boy survivors of GBV. Referrals can be made through FPD pending a decision from the Juvenile Judge and based on the Behaviour Observer's report;
- Shelters provide integrated services for children, including education, psychological support, and medical services. They also, where possible, facilitate visits from family members;

74. Minimum Standards for Child Protection in Humanitarian Action, CPWG, 2012.

- Governors have primary responsibility for all security-related matters in their respective governorates. As such, cases of violence against children involving matters of broader security – such as conflicts between clans/families, or honour crimes – may be referred to the governor. In addition, in some cases, caregivers/children may choose to refer the case to the governor by FPD (see below).

5.1.2.2. Police procedures for child protection cases

The Family Protection Department (FPD) handles cases of family violence, neglect and sexual abuse against children that have occurred in Jordan. FPD has units throughout Jordan, in the north, south and in Amman (see Annex XIX: CP Referral Pathways).Family violence, neglect and sexual abuse can be referred to FPD when the child/caregiver consents or when it is considered in the best Interest of the child (see section 3.2.4). For cases involving asylum seekers or refugees, a child or their caregiver can report directly to FPD – in this case when the survivor/caregiver consents, FPD will inform UNHCR. When NGOs and CBOs refer cases to FPD, it is recommended that the referrals to FPD should be made through UNHCR, when possible and if the survivor consents. The regular police force handles cases of physical assault against children by non-family members.

The FPD provides integrated medical, legal, psychosocial services to child survivors of violence and their families as follows (see also section 4.1.5 above):

- A receptionist takes basic information about the case including demographic information and information about type of violence;
- Children in need of immediate medical treatment are referred for medical treatment prior to being interviewed;
- FPD conducts an investigation including interviewing, as appropriate, the child, family members, other witnesses and the alleged perpetrator. Procedures are child-friendly and take into consideration the age and maturity of the child. Interviews with child survivors of violence are videotaped as appropriate;
- All cases are handled confidentially and the informed consent of the child's caretaker is taken, when in the best interest of the child;
- Children, and where necessary, the alleged perpetrator are referred to forensic medicine for evidence collection;
- Social workers do family visits/case studies and can provide psychological and social services and family mediation for the child and the family when appropriate for specific cases;
- FPD can refer the case to the governor to have the alleged perpetrator sign a pledge to not harm the child;
- Where required for the safety of the child, as described above, FPD can remove the child from the family and place them in alternative care. This should be done by court order by Juvenile Judge but is sometimes done on the advice of a social worker;
- FPD liaises with the relevant police directorate to detain for questioning or arrest alleged perpetrators;
- FPD can refer the case to the judiciary when appropriate (when and how cases are referred to judiciary or not are described below);
- For children under 15, it is the child's parent/caregiver/legal guardian who decides whether they wish to press charges against an alleged perpetrator. Children over 15 can also choose to press charges against an alleged perpetrator under the Penal Code (that is, for cases of sexual violence and/or physical assault);
- FPD will follow-up on the wellbeing of the child ensuring access to social welfare, medical, forensic and psychological services.

Physical assault or sexual assault (felonies) against children:

- In cases of felonies, the survivor (or their caregiver) can decide whether they wish to file a complaint against the alleged perpetrator. If they file a complaint, the judicial proceedings described below will be followed;
- If they do not wish to file a complaint, FPD will still refer the case to the public prosecutor who will decide whether to refer the case to court proceedings. Their statement/recorded interview can be used by the public prosecutor in the case;

- As such, all cases of physical assault against children perpetrated by a family member and sexual assaults against children are referred by FPD to the public prosecutor.

Physical violence against children perpetrated by a family member that is classified as a misdemeanour:

- If the forensic report indicates that the child suffered violence resulting in bruises or injuries, FPD will refer the case to the public prosecutor, irrespective of the wishes of the child/caregiver;
- If the forensic report finds no evidence of bruises or injuries, then the child or their non-offending parent or legal guardian will be given the option to: a) be referred to a social worker for family mediation; b) be referred to the governor to have the alleged perpetrator sign a pledge not to abuse the child again; c) press charges against the alleged perpetrator. The views of the child are taken into account in all decisions in this case, and the informed consent will be given by the parent/guardian or the child if they are considered of a sufficient age and/or developmental level to provide consent. Where children are not able to give informed consent and no parent or legal guardian is available to provide consent, an MOSD social worker can provide consent on behalf of the child.

5.1.2.3. Judicial procedures for child protection cases

Cases of violence against children are referred to the specialisedCriminal Court. Cases of violence against children are referred to the specialized court convened as a Juvenile Court where special procedures for juveniles in line with the Juvenile Law are applied.
This includes children who need to be removed from their families due to violence, abuse, neglect or children who need to be placed in alternative care other than their own extended families (either in shelters or with foster families).

Special child-friendly procedures include:

- Interviews with children maybe recorded at FPD and used as evidence in court;
- Hearings for children take place in private chambers, and privacy is ensured at all times;
- The child is consulted about the option for legal justice and made aware of the available services and limitations;
- The child's rights, needs, views, and feelings are taken into consideration and every effort made to enable the child to express himself/herself and to take part in making the decision-making process.

The Shariah court is responsible for all personal status law related to child protection cases including custody, divorce, inheritance and legal guardianship. The Shariah court is also responsible for providing guardianship to foster families or family members caring for separated children.

5.1.2.4. Legal aid for child protection cases

Legal aid is available for child protection cases where: the child/caregiver wants to press charges against the perpetrator or the case is taken to the court by the public prosecutor; in cases related to personal status (e.g. child custody, divorce, etc.); or in case of foster families or family members caring for separated children wishing to be granted legal custody of children separated from their parents/caregivers/legal guardian.

Legal aid should ensure that:

- Child survivors and, where appropriate, caregivers are provided information and consulted on the legal and court proceedings and made aware of the available services and their benefits/limitations;
- The child's needs, wishes and feelings are taken into consideration and every effort is made to enable the child to express himself/herself and to take part in making the decision;
- The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing;
- Legal representation is provided in court;

- Wherever possible, legal actors and others providing support for child protection cases should cover court-related costs and provide transportation to and from the courthouse when a child's case is being heard. The child/caregiver should be informed of any cost implication from the beginning.

Legal actors for CP cases include UNHCR, ARDD Legal Aid, Mizan and the Jordan Bar Association Lawyers (JBAL). Refugee children requiring legal aid should be first referred to UNHCR, who will then refer to their partner, ARDD Legal Aid, which provides free legal aid or Jordanian Bar Association Lawyers who provide legal representation. ARDD Legal Aid, Mizan and Jordan Bar Association Lawyers also provide legal aid for non-registered refugees and Jordanian children including legal counselling, mediation and legal representation.

5.1.3 Children in conflict with the law

Children from refugees and Jordanian host communities can be in conflict with the Jordanian law for a range of reasons. While numbers of refugee children in conflict with the law have been limited, there are increasing numbers of Syrian refugee children – particularly adolescent boys - being brought before the Juvenile Court for a range of offences. The Convention on the Rights of the Child[75] and the Jordanian Juvenile Law both require special legal proceedings for children in conflict with the law. The Jordanian Juvenile Law is currently under review to bring it into closer alignment with international standards.

Minimum age: The minimum age of criminal responsibility in Jordan is 7[76]. However, children age 7 to 12 cannot be sentenced..

Arrest and investigation: Children in conflict with the law are usually arrested by regular police officers. In Za'atri and North Amman, these cases should be referred to the Juvenile Police Department which specializes in dealing with children in conflict with the law. . During the interrogation of a child, a parent/caregiver/guardian, lawyer, or another trusted person must be present. If none of these is available, a probation officer must be in attendance.[77] The presence of a trusted person is important to safeguard the child's rights during interrogations, especially the right not to be pressured to confess.[78]

Anyone who is aware of children who have been arrested or detained should immediately inform the Juvenile Justice Police Department if they exist in their area. In cases of arrest or detention of refugee children, UNHCR should also be immediately informed for protection and legal representation of the child. See Child Protection Referral pathways for contacts. JPD will inform UNICEF of detention/arrest of refugee children.

Diversion: The Juvenile Police Department promotes diversion of children in conflict with the law from the formal justice system in Jordan. The Convention on the Rights of the Child (CRC) as well as other international standards promotes diversion.[79] Jordanian Law does not allow police, prosecutor or courts to refrain from investigating, prosecuting or adjudicating offences for reasons of pettiness of the crime or in the best interest of the child. However in cases where the offences require a complaint to be filed by the injured party (including misdemeanours such as milder forms of assault [80]), the Juvenile Police Department encourages and supports mediation by a third party between victim and offender families. Where this mediation is successful, clemency regulations are used to close the case and divert children from formal judicial proceedings.

75. UN Convention on the Rights of the Child.
76. Penal Code, law No. 52 of 2002
77. Juvenile Code, Article 15.
78. Ibid, Article 208.
79. Convention on the Rights of the Child, 1989, Art. 40.3.b.
80. Penal Code, Article 333-334

Police custody: According to the Juvenile Law, only the Judiciary have the authority to detain children [81].However in practice, children who are arrested will usually remain in police custody for up to 24 hours, before being presented to the public prosecutor or being released. In the first 24 hours after the arrest, children in conflict with the law are most vulnerable and most in need of protection. Children have to be held separated from adults when in custody and should only be handcuffed when this is necessary for security reasons.

Legal representation: Suspects, including children, have the right be to be represented by a lawyer throughout an investigation.[82] However, the investigation phase is initiated by the public prosecutor. Defense attorneys are permitted in the investigation and trial stages but they are not mandatory. Free legal assistance is provided by the following organizations:

- Asylum-seeker and Refugee children in conflict with the law can receive free legal aid including legal representation through UNHCR/Jordanian Bar Association (see section 4.2.1.3 for details). All refugee children in conflict with the law should be first referred to UNHCR who will ensure legal representation;
- For non-refugee children, Al Mizan offers legal aid and assistance to children in conflict with the law.

Informal justice system: Dispute resolution through informal justice mechanisms are sometimes used by children in conflict with the law and their caretakers. According to Jordanian law these procedures should go through the formal justice system, and are not valid unless approved by a court. These mechanisms usually aim to restore social peace and prevent revenge rather than fairly assessing the facts or sanctioning behaviour of individuals. Children are usually not part of these proceedings, but are regularly also not directly affected by the outcomes of the process, which are frequently compensation payments between affected families. For unaccompanied children, access to the informal system is especially difficult, since they lack representation and support by their family. In cases of GBV and 'moral crimes', informal justice outcomes are often incompatible with child rights. In certain situations, especially if the safety of the child is in danger due to possible acts of revenge or 'honour crimes', it can be advisable for the child suspect or victim to hand himself/herself over to authorities for protection rather than go through informal justice mechanisms.

Bail: Every child that is suspected of having committed a misdemeanour should be released from pre-trial detention if he/she provides a bail bond.[83] In case of an alleged felony (for instance, physical or sexual assault), this is only possible if special circumstances are found in the case. Usually, authorities demand that the caretaker acts as guarantor for the child, provides the bail and receives the child from the place of detention. In some cases, bail is only granted if there is a settlement with the complainant, which creates pressure on the suspect to make use of informal justice mechanisms. Often, short-term detentions could be avoided, if caretakers were willing and able to receive their children immediately from the police or the detention centre. In some cases, children remain in detention because they have no other place to stay or cannot or should not return to their caretakers.

Pre-sentence detention: If bail is not granted, child suspects will be held in pre-sentence detention upon decision by the public prosecutor. There are three detention centres for juveniles in Jordan, two for boys (in Irbid and Amman - Tabarbour) and one for girls in Amman. Children under the age of 12 cannot be detained before trial. The same applies to children who are suspected of an administrative offence. Children suspected of a misdemeanour can be detained for up to two months by order of the public prosecutor[84]and in addition, for up to another two months by order of the court.[85] Children suspected of felonies can be detained for up to 6 months by order of the public prosecutor[86] and for up to two months by order of the court[87] and after indictment until the end of the trial, by order of the Attorney General.[88]

81. Juvenile Law no. 32 for the year 2014, Article 8
82. Criminal Procedural Law no. 9 for the year 1961, Article 63.
83. Money deposit as guarantee for appearance if summoned. Juveniles Law, Article 16.
84. Criminal Procedures Code, No. 9 1961, Article 114.3.
85. Ibid, Article 114.1
86. Ibid, Article 114.13
87. Ibid, Article 114.1
88. Ibid, Article134.2

Trial/sentencing: Jordanian Law provides less severe punishment for children than for adults. The maximum prison sentence that can be inflicted on children age 15 and older is 12 years. For those aged 12 to 14, the maximum custodial sentence is 10 years.[89] In misdemeanours and less severe felonies, non-custodial measures are available, such as suspended sentences, supervision orders and fines.[90] Children aged 7 to 11 cannot receive custodial punishment; only placement with a parent/caregiver, guardian, or care institution, or supervision by a probation officer can be ordered.[91] Defense attorneys enjoy basic defense rights, such as the right to cross-examine witnesses, to call witnesses for the defense[92] and to make copies of the case file.[93]

Execution of custodial sentences: Children deprived of their liberty can be visited by their caretakers and relatives on a regular basis. Children in detention enjoy basic rights, such as the right to education. Art. 27.1 Juvenile Law provides the possibility for an early release of children after one third of their sentence is served and other conditions are fulfilled.

Key responsibilities of police and prosecution are to:

- Inform parents/caregivers or other caretakers of the child immediately after the arrest. In case of child refugees, inform UNHCR;
- Hand over the case to specialized police departments (JPD) whenever possible, and as early as possible;
- Ensure that parents/caregivers, caretakers, lawyers or probation officers are able to attend interrogations.

Key responsibilities of general humanitarian actors are to:

- Immediately inform Juvenile Protection Department (where they exist) of any child arrested or detained, and inform UNHCR of any refugee child arrested or detained;
- Seek the assistance of a lawyer or an organization specialized in juvenile justice before undertaking or suggesting any actions that might have legal implications;
- Respect relevant laws, ensure the child's and parents/caregivers' consent for any procedures, and the best interest of the child;
- Be especially aware of risks for the safety of the child due to acts of revenge or honour crimes;
- Encourage persons trusted by the child, in particular parents/caregivers, to attend interrogations, visit children in detention, and to support their reintegration after release;
- Child protection case managers can act in lieu of the person of trust if no-one else is available;
- Provide medical, psycho-social or other services needed by children in conflict with the law;
- Report child rights violations against refugees to the UNHCR focal point.

Responsibilities of legal aid organizations are to:

- Provide legal representation, legal assistance and legal aid as early and as comprehensively as possible;
- Obtain appropriate written consent from child/caregiver to represent them in legal proceedings;
- Wherever possible and appropriate, inform and involve child's caregiver in process and supporting the child;
- Ensure child/caregiver is informed of legal proceedings, options, costs, timeframes, benefits and disadvantages of various legal options and their view is taken into account in line with the child's best interest;
- Inform the UNHCR focal point immediately in cases of child refugees in conflict with the law, when taking over a case or providing other services;
- Refer cases to humanitarian actors specialized in medical, psycho-social or other services when needed;
- Report child rights violations against refugee children in conflict with the law to the UNHCR focal point.

89. Juvenile Law, Article 18,19.
90. Ibid, Article 18,19.
91. Ibid, Article 21.
92. Ibid, Article,175.2.
93. Criminal Procedural Law, Article 175/2

The table below lists actors providing safety and security, legal, police and judicial services:

Service	Organization
Protection Hotlines	UNHCR, FPD
Legal aid	ARDD-Legal Aid (refugees) Mizen (non-refugees)
Legal representation	UNHCR/Jordanian Bar Association – Legal Aid for refugees (referral must first go to UNHCR) Mizen
Police and multi-sectoral services for family violence and sexual violence	FPD
Police for children in conflict with the law	Juvenile Police Department (North Amman and Za'atri) Regular Police (other locations)
Shelters	Dar Al Aman / JRF (for children under 13; admission through FPD) MOSD (for adolescent girls and women)
Judicial proceedings	Criminal Court (criminal cases) Juvenile Court/judge (children in conflict with the law and in need of special protection) Shariah court (custody, divorce, guardianship etc.)

5.1.4 Birth registration

All children have the right to a legally registered name, officially recognised by the government according to Article 7 of the CRC (registration, name, nationality, care). Most Syrian arrivals do not have documents with them (family booklet, ID, marriage certificate, etc.). They therefore face constraints and possible legal challenges in having birth certificates issued for their children. The main concern of the Civil Status Department is to be able to prove the marriage relation to avoid lineage mixing. UNHCR has reached consensus with the Department regarding the minimum documentation requirements, which are as follows:

- The availability of a family booklet or marriage certificate is required;
- In the event that the father does not have any ID, the Department will rely on the family booklet only;
- If the wife is alone and has a family booklet, she, with two witnesses or relatives, can register the baby at the Department, even if the wife's photo is not available in the family booklet;
- If the father or the mother has a family booklet in addition to a receipt of proof that their ID is retained with the authorities, the receipt will be considered evidence for their identity and will be reliable as long as it is stamped by the authorities;
- If the family only has a UNHCR certificate with photos of the wife and husband, then the Department will accept this document, even if there were no other supporting documents;
- Where there are no documents, the parents/caregivers can file a lawsuit under the Shariah Court titled "fixing marriage";
- Birth notifications from hospitals should always be obtained;
- The Department will second one of its employees bi-weekly to Zaatari camp to liaise with UNHCR in order to collect birth applications, review documents, guide concerned families on the procedures, and then issue birth certificates and deliver them the next week to avoid delay or fines; Refugees living in host communities can approach the Civil Status Department branches in their respective locations.

Key actors for birth registration are listed in the table below:

Service	Organization
Information about services	UNHCR
Issuance of birth certificates	Personal Status Department

5.1.5 Other basic services

Child protection cases may need basic services, such as health, education and material assistance in order to ensure their immediate wellbeing, safety and security. This section will provide information on services provided by other sectors that are important when responding to child protection cases. For example, in cases where a child is involved in child labour, providing families with alternative livelihood support can be essential in helping the child return to school.

5.1.5.1. Health

Primary, secondary and some tertiary health care services are available to all registered Syrians free of charge at Public Health Centres and Governmental Hospitals (referral from public health centres is necessary, except for emergencies).

Discussions on provision of services to asylum-seekers and refugees not-registered with UNHCR in the urban settings are on-going.

In relation to **emergencies** for non-registered Syrians, Iraqis and other nationalities, if the patient or someone on behalf of the patient reports to Caritas or JHAS within a maximum period of 48 hours, the treatment cost for stabilization could be covered by UNHCR (if it is deemed a genuine emergency).

Vaccination services, antenatal care, postnatal care are provided free of charge at government public health services regardless of registration status.

Basic medical services for child protection cases include:

- Access to primary health care services;
- Treatment of injuries;
- Access to MHPSS services;
- Referrals to other relevant and specialized services;
- Life-saving interventions for injured/wounded children and surgeries;
- Vaccination and treatment of communicable diseases;
- Medical documentation;
- Follow-up care.

Healthcare programme managers should ensure that health care is available for children who are particularly at risk of abuse, violence, neglect and exploitation. This may include those in alternative care, children who have lost one or more caregivers, child caregivers and child heads of households, and children with disabilities. Health managers should:

- Identify and tackle the different barriers preventing girls and boys from accessing services and design outreach services for children;

- Strengthen, adapt or develop child-friendly and disability-inclusive procedures for admitting, treating and discharging unaccompanied children;
- Ensure health workers are trained in basic child protection as relevant to their work, including prevention of separation (including ensuring there are procedures in place so that caregivers can stay with children in case of medical evacuation and hospital admission);
- Ensure access to sexual and reproductive health services for older children;
- Train clinical health staff on clinical care of children, and train auxiliary non-clinical staff on the confidentiality and protection elements of work related to sexual violence;
- Ensure that those providing health services (including community health workers) have signed up to and been trained in a code of conduct or other policy which covers child safeguarding.

Health care providers should:

- Be attentive to the signs of child abuse and sensitively identify children experiencing or at risk of abuse. They should also be able to identify other child protection issues, including child labor, early marriage and separated/ unaccompanied children;
- Provide child-friendly, safe, respectful and confidential health services to survivors of violence, abuse, exploitation and neglect (including GBV);
- Provide basic emotional support to child protection cases and their families, such as psychological first aid;
- Provide children and their caregivers information on other available services for child protection cases, according to the child protection referral pathways described in Annex XIX and refer when child/ caregiver consents;
- Report cases of family violence against children and/or sexual violence to FPD in line with the mandatory reporting requirements (described in section 3.2.4above).

Health/medical service providers are listed in the table below:

Service	Organization
Primary health care	IRC, JHAS, MOH, JWU, Caritas/UNHCR, Kitab Al Sunna, UAE Red Crescent, Islamic Charitable Society, Jordan Relief Association
Medical care adapted to children	IRC, MoH, Al Farouk Charitable Society
Treatment of injuries	MOH
Health examination	IFH
Referrals to hospitals/secondary health services	JHAS, Islamic Charitable Society, Caritas/ UNHCR,MoH
Secondary health care	JHAS, MOH, UAE Red Crescent
Rehabilitation services for persons with disability	HI, NHF
Provision of mobility aids and prostheses	HI, NHF
Assessment of need for type of wheel chair	JHAS, HI
Rehabilitation services for persons with injuries	HI
Detection and diagnosis of disabilities	NHF, HI

Specialized mental health services:

It is estimated that 10-20% of children who have experienced profound stress due to violent conflict and displacement could suffer mild to moderate mental disorders requiring focused psychosocial activities such as psychological first aid or case management. Two to four per cent of children, however, could suffer severe mental disorders and require access to clinical mental health services.

Protection actors should counsel those children that might be in need of mental health services on the available mental health services. If they (and their parents/caregivers) give their consent, they maybe referred to a specialized provider.

IMC provides primary mental health services for children in Jordan. For complicated cases where further intervention is needed, children are referred to MOH facilities.

Service	Organization
Mental health services	JHAS, IMC, MOH
PSS services	HI

5.1.5.2. Education

Since the beginning of the crisis, Education Sector Working Group partners have been providing emergency formal, informal and non-formal education assistance to vulnerable Syrian children. For formal education with Ministry of Education with the support of UNICEF and other partners has ensured that Syrian children benefit from free access to public schools across the country, regardless of their status and documentation. Syrian refugee children have free access to public schools (from 1-12grade) provided that they have a valid UNHCR asylum seeker certificate and a Ministry of Interior (MOI) service card that reflects their place of residence. UNHCR also supports access to scholarships for tertiary education in coordination with the relevant governments.

Formal education:[94]

- Access to free primary formal education in Jordanian schools in the host community (1-12 grade);
- Provision of formal education (grade 1-2 grade) for Syrian children in camps;
- Catch-up/remedial classes are available in host communities (Mafraq, Ramtha, Irbid, Amman) and camps;
- School supplies and basic clothing are provided to the most vulnerable Syrian children in host communities.

Informal education[95] (IFE) services in host communities and camps:

- Provision of life skills, recreational activities, and basic learning classes in community-based centres and camps;
- Provision of post-basic education/technical skills, self-reliance opportunities;
- There are some vocational training centres in Jordan which will accept refugee children. However, as places are limited, these should be reserved for youths who are in critical need of self-reliance opportunities.
- There are some vocational training centers in Jordan, which will accept refugee children. However, as places are limited, these should be reserved for youths who are in critical need of livelihood options.

94. **Formal education:** Certified education services provided by the Ministry of Educations public schools (grade 1-12).
95. **Informal education:** Educational activities that range from recreational activities to literacy numeracy, and life skills sessions. These educational activities are not certifiable by the Ministry of Education and not specifically bound to certain age or target group. The main categories are: 1. Basic learning; 2. Technical skills/Post Basic education; 3. Recreational activities

Non-formal education[96] (NFE) services in host communities:

- Drop out education programme: MOE certified non-formal education (NFE) for those who have dropped out and out-of-school youth interested in re-entering the formal education system or working towards an alternative 10th grade equivalency diploma (includes referral option for VTC);
- Other programmes include the **Adult education programme** (open for persons 15 and above), **the Homes study programme** (open for persons12 and above), the Evening study programme (open for persons 12 and above) and **the summer study programme** (open to all school age students).

All children, including children with disabilities, have a fundamental right to education. Article 24 of the CPRD holds that State Parties must ensure that:

- Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education or from secondary education on the basis of disability;
- Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
- Reasonable accommodation of the individual's requirements is provided;
- Persons with disabilities receive the support required within the general education system to facilitate their effective education;
- Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

96. **Non-Formal Education:** Certified education services following MOE's NFE curricula (2 year course). The eligibility of students to NFE includes those who have missed at least 1 year of school or have never been enrolled in formal education in Jordan. When completed 2 years of NFE, the learner will receive a certificate which equals to a public school 10th grade completion (drop-outs educating programme). Learners who are willing to go on with their education reaching up to Tawjihi can enrol in the home-schooling programme as shown below:
Students who completed the drop out educating programme requirements and have obtained their certificate can continue studying with home-schooling programme based on their age as described below:
14.5-16 y.o. will do the 7th grade placement test and study 8th grade as home schoolers;
16-17 y.o. will do the 8th grade placement test and study 9th grade as home schoolers;
17+ y.o. will do the 9th grade placement test and study 10th grade as home schoolers.
After the completion of 1 year as home schoolers, learners can go back to Formal school if their age allows them (3 years age difference).

HOME SCHOOLING PROGRAMME
Students who don't hold any certificate and are 12years old and above can do a 6th Grade placement test and study 7th grade as home schooler.
Students who have 6th grade certificate and above and are 18 years old and above can do a 9th grade placement test and study 10th grade as home schoolers.

EVENING STUDIES PROGRAMME
Educational services provided by the Ministry of Education in its schools (after school) for people who wish to pursue education that could not be achieved through formal education. Learners have to pay 60JDs a year and buy text books.

SUMMER STUDIES PROGRAMME
This program aims to organize summer study centers in order to strengthen or expand students' abilities and develop their aptitudes, skills, arts and culture. Summer studies plan includes all subjects and educational activities that the student chooses receive more strengthening or deepening or expansion

ADULT EDUCATION AND LITERACY PROGRAM
This program is divided in terms of educational level into two stages:
a) stage of novices: it lasts for 16 months (or two years); the graduate is given a certificate equivalent to that of fourth (4th) grade.
b) stage of followers: it lasts for 16 months; the graduate is given a certificate equivalent to that of the sixth (6th) grade.

Education service providers are listed in the table below:

Service	Organization
Hotline for information on education and protection services in schools	Save the Children Jordan
Formal education	Ministry of Education, UNICEF
Non-formal education (only in host communities, not in camps)	Ministry of Education, Questscope, JOHUD, Islamic Center, UNICEF, UNESCO
Informal education (for out-of-school youth, and youth not eligible for the formal system) and mentoring, including literacy/numeracy classes, life skills, and recreational activities	IRC, Questscope, NRC, Finn Church Aid, Al-Farouk Society , IMC, Save the Children International, Family and Childhood Protection Society, Family Guidance & Awareness Centre, Khawla Bint Al Azwar, UPP/ Jordan Women Union, Caritas, AVSI, Jesuit Refugee Service (JRS), East Amman Charity Center, Yarmouq Baqa Center, Madrasati Initiative, UNICEF, INTERSOS, ICS, JOHUD,
Pre-primary education	Save the Children International, Jesuit Refugee Service
Mentoring	Questscope, Mercy Corps
Vocational training	Caritas, Save the Children International, CARE

5.1.5.3 Non-food items (NFIs)

- Non-food items are provided to all refugees upon arrival at Al Za'atri camp. These can be taken with refugees as they leave the camp;[97]
- There are various ad hoc NFI provisions in the host community offered by a variety of organizations but there is no NFI provision by UNHCR outside the camps;[98]
- Refugees do not need to be registered with UNHCR to receive NFI items from other organizations;
- These items are not given specifically to child survivors of violence or separation to avoid stigmatizing these children and/or creating further separation of children from their families;
- Unaccompanied children should receive these items from partners. However, organizations should verify with UNHCR that these children are indeed unaccompanied before distributing items;
- An initial 'placement package' for unaccompanied or separated children placed in kinship or foster care or being supported to live independently should be included with provisions for children in the household (including the mentor's household) if required. The items given should be based on the needs of individual households, where possible, rather than as a generic kit, to prevent secondary separation:[99]
- Non-food items should be accessible and appropriate for persons with disabilities.

97. UASC SOPs, UNICEF. 2013.
98. Ibid
99. Ibid

5.1.5.4. Shelter

- Refugees have access to shelter including tents and caravans through UNHCR and partners in the camps;
- A number of NGOs and CBOs provide rental assistance to refugees in host communities. In the host community, a number of Islamic charities have apartment buildings in various locations available to vulnerable families on referral;
- Refugees with disabilities have access to appropriate and accessible shelter.

5.1.5.5. Self-reliance opportunities and cash assistance

- As poverty is one of the root causes of many child protection problems, cash assistance and livelihood programmes can be important in responding to various child protection cases, in particular child labour, early marriage, families caring for separated children, unaccompanied children or those who have dropped out of school;
- A 'cash for work' scheme is available in the camp, which currently targets adults. People are employed on a rotational basis to ensure access for all. Some small scale 'cash for work' is available in the community;[100]
- Employment in host community is restricted, as Syrians are required to apply for work permits;[101]
- UNHCR and other partners provide cash assistance to vulnerable families to cover rent, grants and small business enterprises, winterization, education, tuition fees, and other basic needs. This is based on a household assessment.This can be extended if required on the basis of the child's BIA;[102]
- Cash for work programmes should be accessible for persons with disabilities, and persons with disabilities actively included in participation of cash for work schemes;
- UNHCR and partners provide emergency cash assistance (one time) to newly registered refugees;
- Cash assistance for refugees from UNHCR and some partners require refugees to register with UNHCR. They will then be assessed against criteria to determine if they are eligible for cash assistance;
- Some partners (see below) provide cash assistance to non-registered refugees and vulnerable Jordanian host communities. Case assistance is also available for vulnerable Jordanians, especially orphans from the Zakat Fund and other CBOs;
- Child protection cases can be eligible for cash assistance from UNHCR and other partners, if they meet the criteria;
- Cash should only be provided to child protection cases as part of a broader programme to ensure that these cases meet standard criteria and receive assistance comparable to other vulnerable persons. Programmes that provide cash or shelter assistance specifically for child protection cases (e.g. unaccompanied children) should not be established. This avoids stigmatisation and encouraging children or parents/caregivers to claim their children are separated or have experienced violence;
- Specific issues related to livelihood for caregivers for unaccompanied and separated children are included in the UASC SOP.

100. Ibid
101. Ibid
102. UASC SOPs, UNICEF, 2013; Syria Regional Response Plan 2013, UNHCR, 2012.

5.1.5.6. Food assistance, nutrition, fuel and water

- WFP and cooperating partners provide food assistance to refugees in both the camp and host community settings. All refugees residing in camps and registered refugees residing in the community are entitled to a two times a month food voucher (either in the form of paper vouchers or electronic cards) which allows them to purchase food items worth 24 JOD per person per month.
- Fuel for cooking and heating and water are provided to refugees living in the camps;
- In the host community, such services are not currently provided by UNHCR. Some partners provide seasonal assistance;[103]
- Appropriate food items for persons with disabilities according to their needs should be ensured.

Service providers are listed in the table below:

Service	Organization
Self-reliance opportunities	IRC, UPP, JWU, SCI, Al Shua'a for Woman & Child Development (host communities)
Cash assistance	IRC, SCI, , Family Guidance and Awareness, Care International, UNHCR, JRC, Medair, ADRA, ICS, UNICEF ***Note:*** *Cash assistance for refugees from UNHCR implementing partners must go through UNHCR*
Food, Vouchers and Nutrition	WFP, SCI, HRF, IRW, SCJ, Medair, ACTED, JHCO, Caritas, LWF
NFI	ICMC, Christian & Missionary Alliance Church/Mercy Corps, Care International, Family Guidance and Awareness Center, UNHCR, ICS, Kitab Al Sunna, Family and Childhood Protection Society, JRS, Questscope, Al Sanabel

5.2 | CHILD PROTECTION PROCEDURES

This section describes particular forms of violence, abuse and exploitation against refugee children in affected host communities. For each section, it provides a brief background on this issue, some key programming responses, as well as procedures to respond to children who have experienced this type of child protection issue.

5.2.1 Physical violence

Physical violence takes a number of forms, occurring either separately or together with psychological and/or sexual violence. Physical violence includes hitting a child with the hand or with an object (such as a cane, belt, whip, shoe and so on); kicking, shaking, or throwing a child, pinching or pulling their hair; forcing a child to stay in an uncomfortable or undignified position, or to take excessive physical exercise; burning or scarring a child. It can occur in schools, homes or in the community and can range in severity from mild to severe.

103. UASC SOPs, UNICEF, 2013; Syria Regional Response Plan 2013, UNHCR, 2012.

Physical violence in the family:

- Parents/caregivers who use physical violence against their children should be supported with appropriate guidance, mentoring or counselling to prevent the violence including: positive parent/caregiver skills including positive discipline; anger management; counselling to address causes of the violence; and/or family mediation;
- Child protection committees and child protection staff can help identify children at risk of or experiencing violence and help them access appropriate services;
- Children who experience physical violence should be provided with health, psychosocial, and educational services;
- Children six and above who are at risk or who experience physical violence should be offered information and services to help them protect themselves (such as the "Safe You/Safe Me" booklet and awareness-raising sessions);
- General service providers who identify children experiencing physical violence by family members should be referred to a qualified child protection case manager or the FPD with the child/caregiver's consent. If the child/caregiver does not consent, the general service provider can refer to their case manager, if they believe the child's safety is at risk. If unsure, general service providers should consult with a child protection case manager without providing identifying details of the case.
- For case managers handling cases of family violence where the case manager is not sure about how to determine the child's best interest and to ensure their safety it is recommended that they or their supervisor consult the relevant UNHCR BID supervisor, who can confirm whether a BID panel is required

Physical violence in the community:

- Child victims of violence by other children – such as bullying – should be offered information and services to help them protect themselves, as well as psychosocial services, if necessary;
- Parents/caregivers of child victims of violence should also be offered awareness-raising sessions on child protection issues to help protect their children;
- Child perpetrators of violence against other children should be offered information and services on child rights and life skills (including managing emotions) as well as psychosocial support to deal with underlying causes of this violence, if required. Parents/caregivers of these children should also be involved in any psychosocial services for these children;
- Children who are victims of physical assault, as defined under the Penal Code, perpetrated either by adult non-family members or children, can report this to the police who will conduct an investigation. For children under 15, the complaint must be made by the child's parent/caregiver/guardian, while children 15 and above can make the complaint themselves. Articles 333, 334 and 335 of the Penal Code define physical assault as follows: "Anyone who deliberately harms someone else including beating or injuring that person through acts of violence which result in sickness or an inability to work for more than 20 days will be imprisoned from 3 months to 3 years";
- Child perpetrators of physical assault (and other crimes) should be treated in line with relevant Juvenile Justice standards (see section 4.2.1.4 above).If arrested or in detention, asylum-seeker and refugee children should be referred to UNHCR. These children may also require a BID Panel.

Actions following referral of physical violence to case managers:

- UNHCR/NGO child protection case managers who receive cases of physical violence against children by a family members should complete the Inter-Agency Best Interest Assessment (BIA) Form (see Annex VII), including identifying any safety concerns. FPD will complete their own assessment form;
- The case manager should develop a plan to respond to this violence. Where it would not further endanger the child, they should also consult with the child's caregiver (not the perpetrator of the violence);
- Children exposed to severe or recurrent violence should be offered counselling or life skills to help them address the effects of this violence. Family members may also need this service depending on the type of violence;
- Where possible, they should get the consent of the caregiver and/or child to refer to other services. Children and caregivers should be counseled on the services of FPD;

- Cases can be referred by case managers to FPD without the consent of the child or caregiver where they believe it is in the child's best interest – for instance, in cases where there are imminent safety threats to the child. For asylum-seekers and refugees, it is advisable that case managers consult the relevant UNHCR BID supervisor, who can confirm whether a BID panel is required

5.2.2. Violence in schools

The use of physical punishment by educational staff, including teachers and school management, is prohibited in the schools of the Ministry of Education under the Civil Service regulations.[104] To reduce the prevalence of violence in schools, the Ministry of Education in cooperation with UNICEF and other partners developed the Ma'an (Together) Towards a Safe School Campaign. This plan aims to promote positive disciplinary methods by teachers towards students in Ministry of Education and UNRWA schools. It aims to change teachers' behavior by equipping them with educational methods to manage and guide students' behavior rather than using violence. Violence between students is prohibited under the School Discipline Regulation (see Annex II: National Laws and International Conventions).

The campaign promotes new disciplinary methods in schools, advocates the end of societal tolerance of violence in schools and supports media coverage to spread the message nationwide. It works to make teachers aware of their rights and responsibilities and hold them accountable for their actions and guarantee a better future for our future generation.[105]

Penalties for corporal punishment are imposed according to Jordanian law (see Annex IX: National Laws and International Conventions for relevant articles).

- The Civil Service Bureau stipulates punitive measures against anyone who inflicts corporal punishments on children;
- Employees of educational establishments must refrain from using any kind of physical punishment against the students as per the Civil Service Regulations.[106] Violators will be held accountable for any breach of the regulation.

The MOE Protection and Counselling Unit monitors, refers and follows up on protection cases of violence in schools. SCJ's role is to conduct awareness-raising about children rights to education, including updating students on disciplinary guidelines and on services available at the help desks for children and their families and where relevant to support MOE on managing individual cases.

Current procedures related to cases of violence in schools include:

- Cases are reported to MOE school counsellors and to SCJ through their help desk, by educational staff, the child's family, the child themselves or other service providers;
- MOE counsellors or SCJ social workers conduct an assessment and submit a short report with recommendations for review/approval to their relevant focal points (for school counsellors, it is the District Head of Counselling unit; for SCJ it is to the MOE Protection Unit);
- MOE counsellors may deal with some less serious cases of violence among children through mediation directly among the children, and where appropriate involve parents. More serious cases of violence are dealt with by forming committees to investigate/verify the complaint through the Ministry of Education Directorate that the school reports to. If the violence is confirmed, a detailed report will be written. When the abuser is a staff member they will be disciplined in accordance with the Regulations of the Civil Service 2013. The case may be referred to family protection department (for instance, in cases of sexual violence). .

104. Civil Service Regulations 2013, Article 82.
105. Jordan Ma'an Campaign: Together Towards Safe Schools. UNICEF.2012.
106. Civil Service Regulations 2013, Article 82.

- MOE counsellors and SCJ social workers will follow up the case in cooperation with the Ministry of Education, and if the child requires other services, they can refer the case to the relevant service providers (including FPD and JPD); For asylum-seekers and refugees, in cases where relocation of the child or separation from their parents or caregivers might be needed, BID procedures should be followed
- The case is closed once necessary action is taken by the Protection Unit or SCJ (depending on interventions needed).

Service providers are listed in the table below:

Service	Organization
Hotline for information on protection and educational services	SCJ: 077 6702426, 080022766, 080000111 MOE Protection Department hotline: 0800 22775 (free from landline) or 06 568 0081

5.2.3 GBV including sexual violence against girls and boys

Children in both refugee and host communities are vulnerable to the various forms of gender-based violence outlined in 4.1 above. Sexual violence affects both girls and boys but is significantly underreported. Early marriage is particularly prevalent among Syrian adolescent girls, most of whom were married before arriving in Jordan. Procedures for cases of gender-based violence against children are outlined in section 4.1above. Girls and boys with disabilities are especially vulnerable to sexual violence due to entrenched social and structural discrimination against them.[107]

5.2.4 Child labor

Child labor is a widespread problem among Syrian refugees especially adolescent boys, as well as among Jordanian host communities, especially in economically disadvantaged areas. Child labor is unacceptable because the children involved are too young and should be in school. Child labor also encompasses work done by children who may have reached the minimum working age, but the work done is harmful to the emotional, developmental and physical wellbeing.

Jordan has ratified the ILO's Child Labor Conventions[108] and the UN Convention on the Rights of the Child and has subsequently introduced policies and legislation to prevent child labor. In Jordan, the minimum age of employment is 16, and education is compulsory education is up to 10th grade or16-years-old. It is therefore illegal for children under the age of 16 to be employed.

No child under the age of 18 is allowed to be employed in dangerous or "hazardous work". A revised list of hazardous occupations was issued by the MOL in June 2011 that include: Bodily hazards; physical, psychological, moral and social hazards, for example, moral hazards; chemical, hazards; physical hazards; biological, and microbial hazards (e.g. viruses, bacteria, parasites and others) and; ergonomic hazards (e.g. relating to human harmony with use of machines and work tools), etc.; and other hazards.

Children aged 16-17 also have the following conditions on their employment:

- They cannot work more than six hours per day and must be given a break of at least one hour after every four working hours;
- They are not allowed to work between 8:00 pm and 6:00 am or on religious feasts, public holidays and weekends;

107. Handicap International & Save the Children. Out from the Shadows; Sexual Violence Against Children with Disabilities. 2011.
108. ILO Convention No.138 on Minimum Age of Employment (1973) and No.182 on the Worst Forms of Child Labour (1999).

- The employer must request the following from the child's guardian: birth certificate; child's certificate of health for the required work issued by a doctor and approved by MOH and written approval of the child's guardian for the child to work in the establishment;
- The employer must keep these documents in a special file for the child, with information on the his/her place of residence, date of employment, the work for which he/she was employed, wages and leave.

In August 2011, the government endorsed the National Framework to Combat Child Labour (NFCL) which sets out a mechanism to address child labour by the MOL, MOE and MOSD. The mechanism involves the following stages: 1) Identification and reporting; 2) Initial assessment which includes educational and family assessment and referral to services; 3) Implementation stage; and referral (to appropriate services); 4) follow-up and evaluation. It is not yet fully operational but is being pilot-tested. Other partners are being integrated, including CSOs, police, religious leaders, etc., and their how they can be best integrated in the various stages of the above frame is being considered as they can support all components of the referral mechanism. A national monitoring system (framework stages) has been electronically designed by ILO and MOL to form a new national database for child labour to assist in data collection, analysis and monitoring.

Employing children between the ages of 16 and 18 is legal under certain circumstances and certain working conditions. It is illegal to employ children under the age of 18 in hazardous work or work that may cause physical harm.

Refugee children of legal working age (and adults) need to apply to the Ministry of Labour for a work permit. A Residence permit is required in order to apply for a work permit.

Employers who fail to respect the above conditions are in violation of the labour legislation and subject to fines of between 300 and 500 JD (which can increase in case of repeat violations). In addition, employers who employ persons illegally (for instance, without a work permit) face a fine of between 500 to 1000JD (double in the case of repeated offenders).

Key actions on child labor for refugee and host communities include:

- Child Protection actors conducting awareness-raising for the community on the hazards of child labour and the importance of education;
- UNICEF, ILO, MOL, SAVE, MOE and MOSD conducting capacity building with implementing partners on the issue of child labor, including child labor among refugee populations;
- Child protection actors involving refugee parents/caregivers and children in their community awareness raising programmes with sessions on prevention and response to child labor;
- Child protection organizations reporting regularly to the Ministry of Labor details of employers who are engaging in child labour;
- Strengthening linkages between the referral mechanism of the NFCL and the case management system of the humanitarian response.
- UNHCR providing legal protection to refugee children involved in child labour, particularly in cases of arrest, relocation to a refugee camp or risk of refoulement

The following support should be offered to the child/family by qualified child protection case management agencies, such as UNHCR, IMC, or JRF:

- Assessment of the situation of the child and family by qualified child protection case managers;
- Counselling to the child and families regarding the risks of child labor and relevant Jordanian law in relation to child labour;
- Provision of information to child and families about education and vocational training options, and referral to these services as appropriate;
- Assessment of the eligibility of the family for cash assistance through UNHCR. The assistance is provided after an assessment of the family's situation. For a family to be eligible for cash assistance, the child needs to be enrolled in school;
- Provision of other economic support, such as rent, food packages and employment opportunities linked to educational opportunities through UNICEF supported programmes;

- Participation of children and/or families in psychosocial services including child and youth friendly spaces;
- Follow-up and monitoring of the child and family to ensure access to services and reduce risk of continuation or return of child to child labor.

The table below lists service providers involved in the prevention of and response to child labor in Jordan:

Service	Organization
Monitoring and protection	MOL, MOE and MOSD
Case management	IMC, IRC, JRF, UNHCR, MOSD, NCFA (For coordination and standards)

5.2.5 Separated and unaccompanied children including alternative care

Information on procedures for prevention and response to unaccompanied and separated children is included in separate SOPs. UASC identified by case management agencies or other humanitarian actors should be referred to UNHCR for registration and provision of appropriate protection and assistance services. UNHCR will then refer to partners when needed.

Procedures for placing unaccompanied asylum-seekers and refugee children in Alternative care arrangements have been agreed between the Ministry of Social Development, UNHCR, UNICEF and relevant NGOs.

The three main alternative care arrangements envisaged for unaccompanied children are:

1. Temporary hosting for unaccompanied children with families for period of up to 3 weeks
2. Formal foster families; and
3. Supervised group living where unaccompanied adolescent boys aged 15 or above live in groups of up to 3 adolescents supported by mentor living close by.

In brief the process for placing unaccompanied children in alternative care is as follows:

- Case management organisations working with unaccompanied children conduct screening of potential foster families or mentors among the asylum seekers and refugees
- Case management conducts assessment of the wishes and needs for alternative care for unaccompanied children and matches the child with foster family or mentor for placement
- Emergency temporary hosting for unaccompanied children in foster families or mentorship arrangements can be made on the basis of recommendation by case worker
- Other placements should be reviewed by Ministry of Social Development (MOSD)Behaviour Monitor and then presented to BID panel
- BID panel recommendation will be presented by MOSD Behavioural Monitor to the Juvenile Judge/ Court for approval.

Monitoring of the placement will be done by the case manager, under the supervision of the Ministry of Social Development Behaviour Monitors.

The table below lists service providers involved in the prevention of and response to UASC in Jordan:

Service	Organization
Monitoring and protection	MOSD
Case management	IMC, IRC, JRF, UNHCR, MOSD, FPD, UNICEF

5.2.6 Children associated with armed forces and armed groups (CAAFAG)

The listing of Syrian government forces in the Secretary General's Annual Report on Children and Armed Conflict (S/2012/261) in June 2012 in relation to the killing and maiming of children, as well as attacks against schools and hospitals, officially triggered the establishment of a monitoring and reporting mechanism (MRM) on children and armed conflict (CAAC) for Syria. The Secretary General's Annual Reports have also indicated that Syrian government forces were also responsible for committing rape and other forms of sexual violence against children. The Free Syrian Army (FSA) was also reported in relation to recruitment and use of children.

The UN has verified that the FSA is recruiting and using children in hostilities in Syria. However, currently there is no verified information of recruitment or use of children in hostilities by government forces. Syria has ratified the Optional Protocol (OP) on the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict. Ratification of this OP means that under international law it is illegal for Syrian government forces and armed groups to recruit or otherwise allow any children under 18 to participate in hostilities in any way, either as combatants or in support roles (such as drivers, spies etc.).

Given the challenging situation in Syria, including security and access issues, and the massive influx of refugees in neighbouring countries (Jordan, Iraq, Lebanon and Turkey), a regional approach is envisaged at first to support the work of the task force in Syria. The MRM on children and armed conflict for Syria was established in Jordan in March 2013 to monitor all six grave violations.

The MRM on children and armed conflict for Syria was established in June 2012 to monitor all six grave violations, including killing and maiming of children, attacks against schools and hospitals and child recruitment in Syria. A regional monitoring mechanism has been established to monitor these six grave violations in Jordan, Iraq, Lebanon and Turkey and to advocate with the parties to the conflict (both government and opposition forces) to prevent these violations.

Key actions to prevent and address children associated with armed forces or armed groups:

- If children are identified as having being recruited or used in the hostilities by government forces or by armed groups in Syria, they should be referred to child protection case managers (UNHCR and other case managers) for further follow-up;
- Case managers will provide support to children associated with armed groups and forces. They will explain to them the MRM mechanism and when the child and/or caregiver consents refer them to UNICEF MRM mechanisms (see details below)
- Provide sustainable solutions (including counselling, vocational training, ensuring formal and non-formal education) for boys and girls at risk of returning to Syria for the purposes of participating in the conflict, or who may be at risk of recruitment by armed forces or armed groups if they return to Syria;
- Conduct sensitization/awareness raising activities to youths, parents/caregivers and other community members on children's rights, including the risk to and impact for children inbeing involved with armed

forces or armed groups;
- Monitor and report on possible recruitment or use of girls and boys by armed forces or armed groups.

Please note that due to safety and security issues of children associated with armed forces or armed groups and their families, ONLY key child protection agencies are involved in the coordination and planning of prevention and response activities.

5.2.7 Child Trafficking

The Anti-Human Trafficking Law (2008) prohibits all forms of trafficking and prescribes penalties of six months to 10 years' imprisonment for forced prostitution, child trafficking, and trafficking of women and girls. The National Committee (consisting of the Ministries of Interior, Justice, Labor, and the police) launched in March 2010 a National Strategy and Action Plan to Combat Human Trafficking for the period 2010-2012.

The anti-trafficking law contains a provision for the opening of shelters. However Jordan has no shelter services for victims of trafficking. There is no government shelter available for male victims of trafficking, although the police and the Ministry of Labour sometimes pay for male victims involved in labour disputes, some of whom may be trafficking victims, to reside at a hotel. It is not known how many trafficking victims received this type of assistance in 2011. There is no report to date of children being involved in trafficking.[109]

Protecting trafficked children requires timely victim identification, placing them in a safe environment, providing them with social services, health care, psychosocial support, and reintegration with family and community, if it is proven to be in their best interest.

Documenting children from birth through birth certificates and registration (with UNHCR if refugees) can serve to prevent trafficking. Accurate documentation of care arrangements for separated and unaccompanied minors are also paramount.

Key activities when a child has been identified as a victim of trafficking include:

- Cases to be referred to child protection organizations for assessment and development of a case plan, including direct support and referral for services;
- Reports of child trafficking should be reported immediately to the Anti-Trafficking Unit;
- Children missing should be reported as missing by their parents/caregivers.

109. United States Department of State, Trafficking in Persons Report – Jordan. 19 June 2012.

CHAPTER 6:

PREVENTION

Although prevention and response are divided in this SOP into two separate sections, they are inter-related activities. Many elements of GBV and CP response are also preventive measures. Prevention entails working at different levels of society to achieve social change and implement targeted interventions with specific groups. Prevention also includes more generalized approaches for the population at large (e.g. campaigns, mass media messaging and other awareness-raising initiatives).

In setting prevention strategies, it is important to target not only affected individuals (whether adults or children) but also the broader community, since the broader community is influential in creating a culture of non-tolerance for GBV and CP related issues. The impact of GBV and CP affects various systems, including physical and mental health, law enforcement, judicial and public social services and non-profit organizations, as they respond to the incident and support children and/or survivors. Without a strong prevention component, service delivery alone will not change the attitudes and behaviours that cause GBV and CP and allow them to continue within the community.

6.1 | GBV PREVENTION

All parties to these SOPs will:

- Provide or participate in training about GBV, the IASC GBV Guidelines, UNHCR GBV Guidelines, these SOPs, and other relevant materials, adapted to the sector of intervention;
- Adopt codes of conduct for all staff that focus on preventing sexual exploitation and abuse. Actions include: providing training to all staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow-up on reports;
- Actively seek equal participation of women, girls, boys and men in the design and delivery of services and facilities in the setting, and meeting regularly with women and girls to learn about accessibility, safety, and security related to services and facilities;
- Ensure services are inclusive and accessible for persons with disabilities;
- In collaboration with the SGBV sub-working group, carefully coordinate, develop and implement GBV awareness-raising activities within the community and advocacy among other humanitarian actors and government authorities;
- Organize economic empowerment activities to reduce vulnerabilities;
- Strengthen the protective environment, by assessing security and safety and addressing protection issues. When designing projects and implementing interventions, always consider intended and unintended consequences of activities and review strategies to ensure survivor's protection and according to the best interests of the survivor(s);
- Foster community mobilisation and outreach information campaigns to prevent further incidence of the identified violence and stigmatization of survivors. Agencies should work with different formal and informal refugee community based networks to:
    - Maintain awareness of GBV risks and issues in the setting, and communicate these to security actors and the GBV sub-working group;
    - Engage in problem-solving discussions to continuously strengthen prevention strategies;
    - Actively promote respect for human rights and women's rights, and support the role of women and youths as equal decision makers;
    - Promote male role models and positive masculine norms and behaviours that are non-violent.

- Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described in these SOPs and the IASC GBV Guidelines (2005) including:
    - **Health:** Implement the Minimum Initial Service Package for reproductive health in emergency situations (MISP); Ensure health services are accessible to women and children; Integrate GBV awareness-raising and behaviour change activities into community health activities.

- **Social services/psychosocial services:** Influence changes in socio-cultural norms; promote respect for human rights and women rights; encourage survivors to seek assistance; provide family counselling; promote community acceptance and social re-integration of GBV survivors/victims.
- **Security:** Maintain adequate security presence; through formal and informal networks, maintain awareness of protection and security issues related to GBV; provide information to the GBV sub-working group about protection and security issues; develop and strengthen specific prevention strategies to address evolving security issues.
- **Legal justice:** Raise awareness in the community and among the refugee population on national laws and available legal aid services; promote respect for the survivor by the Criminal Justice System to encourage them come forward to report violence;[110] apply relevant laws and policies, and adjudicate GBV cases affectively.

All actors involved in prevention must coordinate with each other and plan activities in a collaborative manner. Public information messages, awareness-raising campaigns and behaviour change strategies must be coherent, consistent, and connected to services and organizations to avoid confusion in the community.

6.2 | PREVENTION OF VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF CHILDREN

All humanitarian actors are responsible for preventing violence, neglect, abuse and exploitation of children – not only the parties to this SOP.

All parties to this SOP will:

- Provide or participate in training about child protection, the Minimum Standards on Child Protection in Humanitarian Settings, this SOP, and other relevant materials, adapted to the sector of intervention;
- Adopt codes of conduct for all staff that focus on preventing sexual exploitation and abuse. Actions include: providing training to all staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow-up on reports;
- Actively seek equal participation of girls and boys in the design and delivery of services and facilities and meeting regularly with girls and boys to learn about accessibility, safety, and security related to services and facilities as to strengthen the protective environment for children, by assessing and addressing protection issues;
- Ensure services are inclusive and accessible for children with disabilities and caregivers with disabilities;
- In collaboration with the CP sub-working group, carefully coordinate, develop and implement CP awareness-raising activities within the community and advocacy among other humanitarian actors and government authorities;
- Agencies should work with different formal and informal community based networks from the refugee population and the broader community (e.g. child protection committees) to:
  - Maintain awareness of CP risks and issues in the setting, and communicate these to protection actors and the CP and GBV working group;
  - Engage in problem-solving discussions to continuously strengthen prevention strategies;
  - Actively promote respect for human rights and children's rights, and support the role of children and youths as equal decision makers.
- Reinforce and activate the role of schools in the implementation of extra-curricular activities;
- Reinforce the role of parents/caregivers councils in schools;
- Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described in this SOP.

110. The National Framework for Family Protection from Violence, NCFA, 2006.

6.3 COMMUNITY MOBILISATION FOR PREVENTION

Child protection and GBV actors conduct a range of activities to mobilize communities GBV and children as follows:

- Conduct capacity-building for CBOs;
- Establishing CFS, youths and women's centres that provide multi-sectoral services for women and children;
- Establishing protection committees, child protection committees and parent/caregiver-teachers associations;
- Conducting awareness-raising activities/life skills to children and parents/caregivers on protection of children;
- Conducting awareness-raising activities with women, men and children on GBV;
- Mobilising religious leaders to speak out on protection of women, men and children;
- Mobilising men and boys to prevent violence;
- Using arts, social media and mass media to raise awareness and stimulate dialogue on prevention of violence;
- Actively search for and engage the participation of men, women, boys and girls with disabilities.

CHAPTER 7:

INFORMATION DISSEMINATION

This section provides a quick overview of key considerations and principles for how information may disseminated to the community as well as service providers. The section provides an overview of frequently used methods for information dissemination and suggested guidance on where referral cards can be disseminated.

7.1 INFORMING THE COMMUNITY

- Ensure a coordinated approach and consistency of messages with other stakeholders carrying out information dissemination prior to conducting outreach activities related to protection;
- Messages should be contextualized and adapted to the target audience, and tested prior to being disseminated. Messages may require different methodologies to be used and will further vary according to the target group. This means that while the key elements of the information shared will remain the same, the way in which that information will be relayed will vary according to age, sex, community, etc.
- Special considerations should be given to illiterate or disabled audiences and appropriate messaging should be considered to ensure their equal access to information
- When messaging on child protection and GBV, benefits based and dialogue approaches are preferred and have been consistently proven to contribute towards longer term prevention and behaviour change outcomes. This implies highlighting the positive gains of actions or services rather than focusing on the negative consequences of actions (e.g. it is more acceptable and preferable to highlight the benefits girls and their family enjoy when marriage is delayed as opposed to focusing only on the negative health and other consequences they risk if she is married early)
- Develop an action plan between governmental, non-governmental and UN organisations with prioritization of messages, timeline, scope and specific responsibilities;
- Prioritize informing communities about existing services and how they can access them for GBV related services the messages should focus in particular on safe and confidential access to assistance and on emergency medical responses. Share back experience and lessons learned with other service providers so as to regularly revise information dissemination strategies so as to maximize reach.

Information dissemination methods include but are not limited to:

- Distribution of referral cards with relevant information on service locations, hours and focal point contacts
- Distribution of posters with key slogans and images or information regarding access to services;
- Radio / television information programmes facilitated by service providers on available services and their importance;
- Hotline; providing automated or over the phone information and support to callers on how to access services;
- Community based information dissemination or awareness-raising activities which allow service providers to interact with groups of individuals at a given time and discuss services or protection concerns as it relates to them.

Referral cards can be distributed to the following outreach initiatives:

- Medical mobile teams;
- Registration centers;
- Refugee focal points and host communities focal points;
- Islamic charities and clinics;
- Community centers;
- Women's centers;
- NFI distribution centres.

The interagency AMANI campaign is one of the key prevention actions undertaken by members of the child protection and SGBV Sub-Working Groups. The "Amani" campaign (which means "my safety" in Arabic) overall campaign message is "Our sense of safety is everyone's responsibility. The objective of the campaign is to raise awareness in refugee and Jordanian communities on how to stay safe, and what to do if you or someone you know experiences violence, abuse or exploitation. The campaign is based on key inter-agency messages for communities, children and parents, on how to better protect children and adults from harm and different kinds of violence. These messages were developed by the Child Protection and SGBV Sub-Working groups, in collaboration with women, girls, boys and men in Zaatari camp and in urban settings, while drawing from best practices and examples from other contexts.

The key protection issues addressed in the Amani campaign are:

1. Prevent violence and stay safe
2. Response for survivors of violence
3. Early Marriage
4. Psychosocial support
5. Disabilities
6. Child Labour
7. Birth registration
8. Separation
9. Humanitarian aid is free
10. Respect for diversity/discrimination

The Amani campaign consists of a series of images for each key message featuring a family of five – mother, father, 2 sisters and a brother, including an adolescent girl called Amani. Campaign products and tools (including animated videos) have been produced and orientations and trainings for members of the Child Protection and SGBV Sub-Working Groups are ongoing. An interagency plan has been developed for and members of the CP and GBV sub-working groups are using these tools in their activities with community members in urban areas and camps to facilitate discussion, debate and action to better protect boys, girls, women and men from violence and other kinds of harm. Organisations are displaying these posters in their community, conducting individual and group discussions and community meetings around the key issues, screening the films and distribute the campaign products during their activities.

7.2 INFORMING SERVICE PROVIDERS

In addition to ensuring that communities are regularly informed about services, it is equally as important to ensure that service providers are also aware and informed of available services.

While many of the messages and tools used for the community are applicable to inform service providers, messages for service providers contain additional information and awareness raising tools as it relates to the linkage between protection concerns, services and their own,.

Methodologies generally used for information sharing with Service providers include but is not limited to:

- Presentations to senior management of participating organizations and formal endorsement and signature;
- Specific trainings to introduce or refresh knowledge of SOPs and Referral Pathways to child protection and GBV governmental, UN and NGO actors and the continuum of care and protection that links them;
- Trainings to introduce or refresh knowledge of SOPs and Referral Pathways to non-protection related governmental, UN and NGO actors from other sectors
- Coordination meetings within and amongst, governmental, NGOS and UN agencies. Inter-agency case management trainings and other related capacity building initiatives

CHAPTER 8:

DOCUMENTATION, DATA, AND MONITORING

A number of organizations have existing electronic case management systems. ProGres is the UNHCR global asylum-seeker and refugee registration and case management data base. UNHCR Refugee Assistance Information System is used for service provision for UNHCR and other partners and contains two isolated modules of GBVIMS and CPIMS. Both systems (the GBV IMS and CP IMS) are currently being rolled out in Jordan. The roll out of the two information management systems will be supported by continuous trainings for the respective agency focal points to ensure they are familiar with the tools and procedures.

8.1 | GBV INFORMATION MANAGEMENT SYSTEM

Inter-Agency GBVIMS: As of July 2014, The GBVIMS is being piloted in a number of locations in Jordan. The Gender-Based Violence Information Management System (GBVIMS) is a data management system that enables those providing services to GBV survivors to effectively and safely collect, store, analyse, and share data related to the reported incidents of GBV. In Jordan, The GBVIMS module in RAIS (Refugee Assistance Information System) was created by UNHCR in June 2013 in consultation with the GBVIMS Task Force and with guidance from the GBVIMS Steering Committee.

A GBVIMS Information-Sharing Protocol (ISP) has been developed and endorsed amongst data gathering and coordinating agencies to guide the safe, confidential and ethical collection, analysis and utilization of GBVIMS data (non-identifying statistical data). Currently UNHCR, UNFPA, UNICEF, IRC, IMC, JRF, and IFH/NHF are signatories of the ISP. The GBVIMS is not a case management tool but rather a database which allows agencies to jointly analyse trends in GBV incidents being reported to case management agencies and the trends in referral services provided so that agencies can inform response priorities and strategies at an inter-agency level in Jordan.

Referrals and information sharing for service provision: Case management agencies are responsible for documenting GBV cases. This SOP includes intake and consent forms to be used by the lead agencies when a GBV case is reported (see Annexes VII, and X). Medical personnel may use the GBV IMS Medical Intake and Assessment form attached in Annex VIII, though this has not yet been rolled out by the inter agency GBV IMS initiative at this time. These forms are only to be used by specialized agencies.

Agency staff charged with collecting the Initial Intake information from the survivor should be appropriately trained on how to fill out the forms and how to act in accordance with the guiding principles. Training on the proper completion of intake forms will include determining the appropriate case definition for each reported incident of GBV.

Intake forms contain extremely confidential and sensitive information and this information may only be shared with others under certain circumstances (see section on consent and information sharing). Forms must always be kept in locked files and should never be shared directly.

8.2 | CHILD PROTECTION INFORMATION MANAGEMENT SYSTEM

The CP IMS is a global standard inter-agency child protection information management system (IA CP IMS) for the child protection sector. This information management system is a practical, field-level tool that supports effective and safe case management. It is comprised of database software and accompanying 'tools', including standardized case management forms and data protection protocols. Designed and launched globally in 2005 by the IRC, Save the Children International, and UNICEF, the IA CP IMS is being rolled out in Jordan by UNICEF, UNHCR, IMC and the IRC specifically to assist in the child protection caseload.

The CP IMS has built-in safeguards that protect children's information and promote best practices in confidentiality. Encrypted/partial data can be shared across agencies for transfers, referrals or reporting, depending on the information-sharing protocol agreed upon by the agencies. Information regarding GBV incidences involving children will be entered into a specific form, so that non-identifying information can be extracted and entered into the GBV IMS.

The CPIMS module in RAIS (Refugee Assistance Information System) was created by UNHCR in June 2014 in consultation with the CP IMS Task Force and is currently being piloted by UNHCR and other CP case management agencies.

Referrals and information sharing for service provision: Case management agencies have agreed on an Inter-Agency Best Interest Assessment (BIA) Form to be used when a CP case is being identified (see Annex XIII).

For asylum-seekers and refugee children care arrangements, changes in family size and places of residence among other data are systematically recorded in ProGres to ensure access to protection and assistance services. Efforts are being made at global and local level to link the CPIMS and ProGres.

NCFA has developed an electronic system to respond to cases of domestic violence to be used by all institutions that provide services to cases of violence. This system is designed to follow-up on procedures relating to necessary services provided by relevant institutions for domestic violence cases and violence against children. The system also ensures that the case are dealt with and the necessary services are provided as fast as possible and in line with the response systems outlined in the National Framework for the Family Protection and the procedures of all concerned institutions. The system also helps to ensure the provision of holistic and high quality services based on a participatory approach and facilitates referral and information sharing of cases between institutions. It provides periodic reports on the response of institutions that provide services to cases of violence that help to identify gaps and provide or suggest solutions to stakeholders or concerned duty bearers to take appropriate action.

8.3 | GBV AND CP INDICATORS

The members of the CP and GBV sector group report regularly (every month) on the indicators agreed in the Regional Response Plan (RRP) by recording their input in Activity Info.

The outcomes and achievements are reflected on the monthly dashboard of the Protection Sector which is generated from the information collected in Activity Info. The reports on the indicators guide gaps analysis and review of protection strategies

CHAPTER 9:
COORDINATION

9.1 | COORDINATION MECHANISMS

Effective prevention and response to CP and GBV require multi-sectoral coordinated action among, at a minimum, health and social services actors, legal, human rights, and security sectors and the community. Non-protection agencies with a strong field presence also play a key role in reporting issues that come to their attention while undertaking non-protection specific activities.

In Jordan, the UNHCR Representative coordinates the response to the Syrian refugee crisis. There are eight national sectors within this coordination structure. Sub-national sectors and working groups are also operating in different geographical areas in the country. The Child Protection and Sexual and Gender-Based Violence are sub working groups of the Protection Sector (CP and SGBV SWGs). They are coordinating bodies with the objective to strengthen child protection and GBV prevention and response for Syrian refugees and asylum-seekers in camps and urban settings as well as other populations affected by the crisis, including host communities as appropriate. The CP and SGBVSWGs ensure alignment with the national sector-wide coordination related to CP and GBV.

The Protection Sector is co-chaired by UNHCR and IRD. The CP SWG is co-chaired by UNHCR and UNICEF while the SGBV Sub-WG is co-chaired by UNHCR and UNFPA. Members of the Sub-Working Groups include UN agencies, international and national NGOs and institutions working in these sectors.

The national level Sub-Working Groups meet every two weeks. Extraordinary meetings and Ad-hoc task forces are created by the chairs and at the request of members of the sub-working groups, when this is considered necessary to address an issue of urgent matter. In Zaatari refugee camp there are Field CP and SGBV Sub-Working Groups, each with specific tasks and responsibilities outlined in terms of reference. These field or sub-national SWGs meet every two weeks as well. In other locations, CP and GBV related issues are addressed through the general coordination and protection meetings.
Information is shared at least monthly among and between sub-working groups through dissemination of meeting minutes. The appropriate sector takes action and provides follow up information. The CP and SGBV Sub-Working Groups also regularly report to the Protection Sector, both at the national level and at the field level. Specific Taskforces (TF) are also established under the CP and GBV Sub-Working Groups, including Early and Forced Marriage TF, Case Management TF, GBVIMS TF and UASC TF.

9.2 | Referral Pathways

The Gender-based Violence (GBV) and Child Protection (CP) referral pathways will be updated on a regular and ad hoc basis by the GBV and CP Standard Operating Procedures (the SOP) Steering Committee in coordination with the GBV and CP SWGs.

Organizations wishing to include their services in the SOP referral pathways should submit their request to the coordinators of the SGBV and/or CP SWG who will present the application to the SOP Steering Committee for inclusion. The decision of the SOP Committee will be notified to the organization by the coordinators of the SWGs. Inclusion of new services in the referral pathways will only be considered by the SOP Steering Committee if the requesting organization has endorsed the SOPs and the service approved by the relevant SWG.

SIGNATORY PAGE FOR PARTICIPATING ACTORS

The following organizations endorse these Standard Operating Procedures:

1. Alianza por la Solidaridad
2. ARDD Legal-Aid
3. AVSI
4. Arab Women's organization (AWO)
5. CARE
6. Centre for Victims of Torture (CVT)
7. Danish Refugee Council (DRC)
8. Family Protection Department (FPD)
9. Fundación Promoción Social de la Cultura (FPSC)
10. Global Communities
11. International labour Organization (ILO)
12. International Medical Corps (IMC)
13. Intersos
14. International Rescue Committee (IRC)
15. International Relief and Development (IRD)
16. Jordan River Foundation (JRF)
17. KnK (Children without Borders) Japan
18. Ministry of Health (MOH)
19. Mercy Corps
20. National Council for Family Affairs (NCFA)
21. Near East Foundation USA
22. Noor Al Hussein Foundation / Institute for Family Health (NHF/IFH)
23. Nippon International Cooperation for Community Development (NICCOD)
24. Norwegian Refugee Council (NRC)
25. PU-AMI
26. QUESTSCOPE
27. Relief International
28. Save the Children International
29. Save the Children Jordan
30. Terres des Hommes Italy
31. Terres des Hommes Lausanne
32. Triangle GH
33. UN Women
34. UNHCR
35. UNICEF
36. UNFPA
37. UNRWA
38. Un Ponte Per (UPP)
39. World Food Programme (WFP)
40. World Vision International

We, the undersigned, as representatives of our respective organizations, agree and commit to:

- Abiding by the procedures and guidelines contained in this document;
- Fulfilling our roles and responsibilities to prevent and respond to GBV and CP;
- Providing copies of this document to all incoming staff in our organizations with responsibilities for action to address GBV and CP, so that these procedures will continue beyond the contract term of any individual staff member.

Signature page

NCFA Representative
Date:

UNHCR Representative
Date:

Family Protection Department
Date:

UNICEF Representative
Date:

Save the Children International
Date:

UNFPA Representative
Date:

Legal-Aid-ARRD
Date:

Institute for Family Health/Noor Al Hussein Foundation
Date:

Triangle GH
Date:

INTERSOS
Date:

AVSI Foundation
Date:

Un Ponte Per
Date:

International Rescue Committee
Date:

Center for Victims of Torture
Date:

Signature page

Organisation: International medical Corps
Date:

Organisation: Mercy Corps
Date:

Organisation: Save the Children Jordan
Date:

Organisation:
Date:

World Vision International
Date:

Terre des Hommes-Lausanne

Signature :

Organisation Name :Alianza por la Solidaridad

Representative Name :Lidia Hernandez Alonso

Date :1st December 2014

Signature :

Organization : Arab Women Organization

Representative : Layla Naffa, Director of Projects

Date : June 29, 2014

Signature :

Organisation Name : CARE International in Jordan

Representative Name : Salam Kanadan

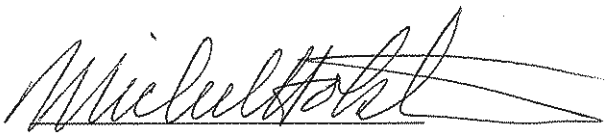
Date : 8 December 2014

Signature :

Organisation Name : Fundación Promoción Social de la Cultura (FPSC)

Representative Name : Sofia Sainz de Aja (Head of Mission FPSC Jordan)

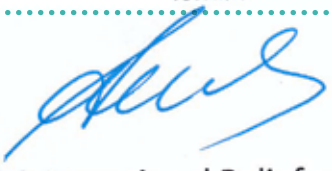
Date : 27/11/2014

Signature : 

Organization : Global Communities

Representative : Michel Holsten, Sr. Vice President

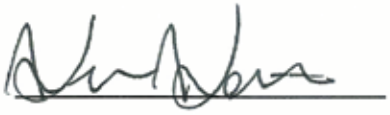
Date : May 7, 2014

Signature : 

Organisation Name : IRD, International Relief and Development

Representative Name : Dr. Uma Kandalayeva, Country Director, Jordan

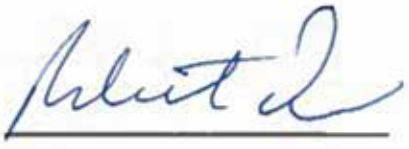
Date : December 3, 2014

Signature : 

Organisation : KnK (Children without Borders) Japan

Representative : Koko Kato

Date : 30th August 2014

Signature : 

Organisation : NRC

Representative : COUNTRY DIRECTOR, ROBERT BEER

Date : 08 May 2014

Signature : 久保 祐

Organisation Name : Nippon International Cooperation for Community Development (NICCOD)

Representative Name : Yu KUBO

Date : 7th December, 2014

Signature :

Organisation Name : PU- AMI

Representative Name : LAVIGNE FRANK

Date : 07-12-2014

Signature :

Organisation Name : Questscope

Representative Name : Mulhanna Khiesat

Date : 4- Dec - 2014

Signature :

Organisation : RELIEF INTERNATIONAL

Representative : REGIONAL COUNTRY DIRECTOR PHILIPPE CECHC

Date : 14 APRIL 2014

Signature :

Organisation Name : UN Women

Representative Name : Giuseppe Belsito

Date : 4 December 2014

Signature :

Organisation Name : WFP Syrian Refugee Response

Representative Name : Imelda Campbell

Date : 4.12.14

صفحة التواقيع للأطراف المشاركة 2014

إجراءات العمل الموحدة المشتركة بين الوكالات للوقاية من والتصدي للعنف المبني على النوع الاجتماعي والعنف والاستغلال والإساءة ضد الأطفال

نحن الموقعون أدناه، بصفتنا ممثلين عن منظماتنا، نوافق ونلتزم بما يلي:

- التقيد بالإجراءات والمبادئ التوجيهية الواردة في هذه الوثيقة؛
- الوفاء بأدوارنا ومسئولياتنا في الوقاية من والتصدي للعنف المبني على النوع الاجتماعي والعنف والاستغلال والإساءة ضد الأطفال؛
- تزويد كافة الموظفين الجدد في منظماتنا بنسخ من هذه الوثيقة مع تحديد مسئوليات العمل للتعامل مع حالات العنف المبني على النوع الاجتماعي والعنف والاستغلال والإساءة ضد الأطفال كي تستمر هذه الإجراءات إلى ما بعد مدة تعاقد أيّ منهم.

اسم المنظمة :..... إدارة عامة لإسرة .

الاسم الموقع : ..... عبيد دكتور / حمدة أحمد القيام

التاريخ: .....٨/١٢/٢٠١٤.....

التوقيع : .....

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- **الوفاء بأدوارنا ومسئولياتنا في الوقاية من والتصدي للعنف المبني على النوع الاجتماعي والعنف والاستغلال والإساءة ضد الأطفال؛**
- **تزويد كافة الموظفين الجدد في منظماتنا بنسخ من هذه الوثيقة مع تحديد مسئوليات العمل للتعامل مع حالات العنف المبني على النوع الاجتماعي والعنف والاستغلال والإساءة ضد الأطفال كي تستمر هذه الإجراءات إلى ما بعد مدة تعاقد أيّ منهم.**

اسم المنظمة :.....

الاسم الموقع : .....

التاريخ: .....

التوقيع : .....

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اسم المنظمة : وزارة الصحة

الاسم الموقع : .....

التاريخ: ٣١/١٢/٢٠١٤

التوقيع : الدكتور علي حمد [illegible]

ACRONYMS

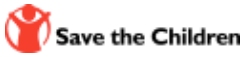
ADRA	Adventist Development and Relief Agency
AVSI	Association of Volunteers in International Service
BID SOP	Best Interest Determination Standard Operating Procedures
CAAFAG	Children associated with armed groups or forces
CBCPC	Community-based child protection committees
CBO	Community-based organization
CFS	Child-friendly spaces
CP	Child protection
CP IMS	Child Protection Information Management System
CP Sub-WG	Child Protection Sub-Working Group
CPRD	Convention on the Rights of Persons with Disabilities
CPWG	Child Protection Working Group
CRC	Convention on the Rights of the Child
CSO	Civil society organization
CVT	Centre for Victims of Torture
FGM/FGC	Female genital mutilation/female genital cutting
FPD	Family Protection Department
FSA	The Free Syrian Army
GBV	Gender-based violence
GBV IMS	Gender-based Violence Information Management System
GBV Sub-WG	Gender-based Violence Sub-Working Group
HI	Handicap International
IASC	Inter-Agency Standing Committee
ICS	International Charitable Society
IFE	Informal education services
IFH	Institute for Family Health
ILO	International Labor Organization
IMC	International Medical Corps
IRC	International Rescue Committee
IRD	International Relief and Development
JHAS	Jordan Health Aid Society
JRC	Jordan Red Crescent Society
JRF	Jordan River Foundation
JRS	Jesuit Refugee Service
JWU	Jordanian Women's Union
MHPSS	Mental health and psychosocial support
MISP	Minimum Initial Service Package
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Interior
MOL	Ministry of Labor

MOSD	Ministry of Social Development
MRM	Monitoring and reporting mechanism
NCFA	National Council for Family Affairs
NFCL	National Framework to combat Child Labor
NFE	Non-formal education services
NFI	Non-food items
NGO	Non-governmental organization
NHF	Noor Al-Hussein Foundation
OP	Optional Protocol (of the CRC)
PFA	Psychological first aid
PSD	Police Security Department
PSEA	Protection against sexual exploitation and abuse
RFP	Referral focal point
RRP	Regional Response Plan
SCI	Save the Children International
SCJ	Save the Children Jordan
SEA	Sexual exploitation and abuse
SOP	Standard operating procedures
TdH	Terre des hommes
UAE Red Crescent	United Arab Emirates Red Crescent
UASC	Unaccompanied and separated children
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UPP	Un ponte per
VCT	Vocational training centre
WHO	World Health Organization

This project is co-funded by
the European Union

UNFPA
United Nations Population Fund
Jordan Office

UNHCR
The UN
Refugee Agency

unicef

Save the Children

Child Protection
Sub-Working Group

SGBV
Sub-Working Group

Aliança
per la
Solidaritat

ARDD
LEGAL AID

AVSI
www.avsi.org

AWO

care

The
CENTER for
VICTIMS of
TORTURE

DRC
DANISH
REFUGEE
COUNCIL

Global
Communities
Partners for Good

International
Labour
Organization

INTERSOS

IRD

KnK JAPAN

MercyCorps

NEAR EAST
FOUNDATION

NICCOD

NRC
NORWEGIAN
REFUGEE COUNCIL

questscope

RELIEF
INTERNATIONAL

Save the Children

Terre des hommes

triangle

UN
WOMEN

unrwa

un ponts per

World Food Programme

World Vision