المجلس الوطني لشؤون الأسرة
NATIONAL COUNCIL FOR FAMILY AFFAIRS

In partnership with

Standard Operating Procedures (SOPs) for Prevention and Response to Violence in Jordan

"Gender-Based Violence, Family Violence and Child Protection"

Standard Operating Procedures (SOPs) for Prevention and Response to Violence in Jordan

"Gender-Based Violence, Family Violence and Child Protection"

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Policies and Guiding Principles for the Prevention of and Response to Violence in Jordan

(Gender-Based Violence, Family Violence and Child Protection)

2018

the Standard Operating Procedures (SOPs) for Prevention of and Response to Violence in Jordan
(Gender-Based Violence , Family Violence and Child Protection)

Table of contents

[PREFACE]

To strengthen the National Protection System and to complement national programs, projects and plans to stand against all types of violence in Jordan, especially GBV and Child protectionfrom violence, exploitation , neglect and abuse on the legislative, institutional, service and awareness levels, based on the role of the National Council for Family Affairs set out in Article 4 of Law No. 27 of 2001, Under the guidance of Her Majesty Queen Rania Al-Abdullah' (chairman of the board of Trustees of the National Council for family affairs) in the development of policies relating to the family and follow up their implementation, and to support the efforts of governmental and non-governmental institutions and their coordination and integration to ensure that work on protection against violence is institutionalized, furthermore institutionalizing professional practices that regulate work procedures for all institutions operating on the territory of the Hashemite Kingdom of Jordan in dealing with issues of gender-based violence, family violence and Child Protection.

The National Council for family affairs in collaboration with United Nations organizations in Jordan (the United Nations Children's fund (UNICEF) /Jordan office, UNFPA / Jordan office, UNHCR / Jordan office), under the supervision of theNational Team For Family Protection , which includes in its membership representatives from national institutions, governmental and non-governmental, and in partnership with sub-working groups (GBV, child protection), , have developed the document « The National Standard Operating Procedures to respond and prevent Family, Gender-Based Violence and Child Protection

", with a view to standardizing terms of reference for the work of all institutions, official, private, and international related to the system of protection from violence in dealing with cases of violence from the Jordanian community and all those living on the land of the Hashemite Kingdom of Jordan, including refugees.

The guide includes in its first part a description of policies, guidelines, procedures and responsibilities related to the prevention and response to cases of violence in Jordan, this part is considered to be a basis, a starting point and a reference for the construction of the second part in its various sections which includes procedural evidence of each type of violence, including but not limited to each type of violence (Domestic violence, child labor, Juvenile) which emphasizes the sequential detailed procedures, which reflects the methodology of the work with the cases based on the rights, the wishes and needs of the survivors, and in a way that will specify the responsibilities and roles of all partners within a participatory approach based on cooperation and coordination between all the partners involved.

And to ensure that these national references and procedures are translated into reality, it requires ,from all official institutions private international, the adoption of these references as a key reference in dealing with cases of violence and represent it in the internal procedural evidence in dealing with cases of violence, to ensure the standardization of operating procedures and methods at the national level. Also those procedures will be reviewed periodically and updated according to feedback and the best national and international practices related to raising the quality of services to all cases of violence in Jordan.

In conclusion, we reaffirm our pride in our partnership with all, and the council is committed (as a coordinating umbrella for all institutions concerned in the family affairs and its members) to work with all stakeholders to promote participatory action to support and promote the family protection system and its members at the national level, nor can we fail to give our sincere thanks and gratitude to everyone who contributed in the development of these procedures from the National Team for family protection from violence, partner United Nations organizations in Jordan, civil society organizations and international actors, stressing the importance of continued partnership work between all institutions in order to strengthen the family protection systems to prevent and respond to GBV and child protection from violence, exploitation, neglect and abuse, calling Almighty that our efforts to provide decent livelihood to the children of our beloved country under the leadership of His Majesty the Hashemite King Abdullah II Ibn al-Hussein.

Secretary General

D. Mohammad Fakhri Miqdadi

[Introduction]

The Hashemite Kingdom of Jordan started to focus on issues of GBV , Family violence and the protection of children from violence, exploitation, neglect and abuse on the national level at early stages, many of the national achievements were carried out by national institutions-governmental and non-governmental organizations and international organizations, these achievements have resulted in numerous programs and projects that have contributed to the development of the legislative, institutional and service environment for protection. In the area of the legislative environment, the family protection law ,the Jordanian juvenile law the national family protection team by laws and regulation was developed and at the procedural level, "the national framework for the family protection " was developed in 2016, in addition to that, the «standards for accreditation and quality assurance of the services provided to cases of domestic violence» was prepared in 2014, and in 2011 «standard operating procedures of the inter-agency prevention of and response to GBV, exploitation, neglect and abuse against children in Jordan» was developed which targets refugees present on the territory of the Hashemite Kingdom of Jordan, and has been reviewed and updated periodically until 2014.

In order to consolidate the national vision in strengthening the protection system at the national level and unify the efforts of national institutions, governmental and non-governmental organizations, UN and international organizations working in this field, and in order to establish the work in this field within the institutions, efforts has been poured into the development of The National Standard Operating Procedures to respond and prevent Family, Gender-Based Violence and Child Protection

The procedures are considered a national reference that contributes to enhancing the effectiveness of the national and practical policies in the field of protection from violence, identifying mechanisms for participatory action based on the needs and desires of the survivors , and to define roles and responsibilities for all institutions concerned in accordance with one unified operating procedure methodology to be used with the case and its needs, and in line with its actual and legal roles, in a way that enhances the effectiveness of their response to cases, and provide services that meet their needs with high quality and efficiency and ensures respect for the rights and desires of the survivors

This document was prepared with a participatory approach with all national governmental and non-governmental institutions and in partnership with the United Nations organizations (United Nations Children's fund/ UNICEF, the United Nations High Commissioner for refugees/UNHCR, the United Nations Population Fund/UNFPA), National institutions, governmental and non-governmental organizations, international organizations and sub-working groups (GBV, child protection), based on that technical committees were established representated by by all stakeholders

to contribute in the identification and revision of general frameworks developed from this document, which was developed based on best practices of both international and national levels, and in accordance with the legislative and institutional references of reference at the national level in order to achieve national vision of the advancement of the protection system at the national level. Also there has been several focused workshops conducted with broad participation by representatives of all the institutions concerned to discuss the drafts of the various and the final document, this has contributed to a comprehensive understanding among all the institutions and sectors working in this field in the Hashemite Kingdom of Jordan, the purpose of this document, its importance and the requirements of the actual application as a reference document binding to all institutions, and the requirements for the practical implementation of the working methodologywith the cases at the institutional and national levels.

This document is intended to be a reference for all national and international institutions working within the Hashemite Kingdom of Jordan, who's concerned in providing prevention programs and response services to cases of GBV, domestic violence and child protection from violence, exploitation and neglect, and aims to the following:

- Development of the general framework for the policies and programs for the protection and prevention of GBV, domestic violence, and the cases of violence, exploitation, neglect and abuse against children "Child Protection" which is constructed on the multi-sector institutional approach based on the needs of those who are at risk.
- Unification and solidification of the foundations of the coordination between all partners to provide integrated and comprehensive services in accordance with documented procedures which Define roles and responsibilities and ensure a holistic and participatory reaction to provide inclusive, comprehensive and quality programs and services for cases of GBV , family violence and child protection, within a systematic process of supervision and follow-up based on the operating procedures with the cases that is based on desires and needs of the survivors taking into consideration their best interests.
- Find a common language and establish a common understanding between all the specialists and workers in the field of protection of GBV, family violence and the protection of the child and to consolidate understanding to ensure the consistency of the programs and activities of all the working participants in this field.

The National Standard Operating Procedures to respond and prevent Family, Gender-Based Violence and Child Protection

Includes two interdependent and complementary parts, as follows:

- Part one: Policies and guidelines for the prevention and response to violence in Jordan (GBV, family violence and Child Protection), which describes the general policies, guidelines and programs in the field of prevention of and response to GBV, domestic violence and child pro-

tection in Jordan, which includes the minimum procedures for prevention and response to GBV, domestic violence , violence against children and exploitation, , it also contains a comprehensive explanation of the the procedures and methods for working with the cases in terms of concepts, principles, tools and stages of intervention, within a framework, that defines the roles of institutions and organizations responsible for implementing procedures in the five key response sectors: Health sector, psychosocial support sector, legal/ justice sector, security sector and education sector.

- Part two: Procedural evidence of each type of violence within several sections, including but not limited to the following (Domestic violence, child labor, juvenile, child marriage…) this procedural manual details a sequence of actions to work with cases of violence with an approach based on the rights, wishes and needs of thesurvivors , and define responsibilities and roles for all the partners involved, within the framework of cooperation and coordination and intensive ongoing follow-up for all cases within the stages of interference between receiving the case and closing its files, which will contribute to ensuring the timely delivery of quality services by the relevant authority and the highest quality of competence, as there are a guideline for procedures prepared for dealing with cases of domestic violence, and is currently working on the development of each of the guidelines to procedures dealing with cases of child labor, and guideline to procedures to deal with juveniles.

And to strengthen the response of the protection systems to cases of GBV, family violence and child protection at the national level, it takes a commitment by all parties, governmental institutions, non-governmental and international organizations to this document to consider it as a reference for the organization and institution which work in preventing and responding to cases of violence, and to ensure that their internal procedures are taken into account with the policies, principles and roles set out in the national standard operating Procedures to prevent and response to cases of violence in Jordan (GBV, domestic violence, child protection).

The national Standard operating Proceuders to respond and prevent family violence in jordan will be reviewed periodically to ensure the updated of the information and to reflect the best national and international practices related to raising the quality of services provided for all cases of violence in Jordan.

Chapter One:
Definitions and Terms

Definitions specific to Family and Gender-Based Violence

Gender[1]	The relations, social roles and the values set by the society for both sexes (men and women). These roles, relations and values change according to time and place as they intertwine with the other social relations such as; religion, social class, race …etc.
Gender-Based Violence (GBV)[2]	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.
Family Violence[3] **(FV)**	Any act or refraining of doing an act by one of the family members upon any other member inside the same family that leads to a physical or moral damage.
Sexual Violence [4]	The violence resulting from a sexual act or practice, including sexual harassments, comments or enticement, or coercion. This also 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 or encouraging the child to watch pornography or to take part in producing, marketing or disseminating them, or encouraging the child to act in an inappropriate sexual manner.
Rape[5]	Intercourse with a female other than the wife of the alleged offender, and without her consent, whether under coercion, threat or deception.
Indecent Assault[6]	Any act that includes violation to a particular body part of the victim, which is considered indecent and offends decency. Sexual contact with a female in a manner that is against nature, sodomy, and any assault regarding honor in particular and extends to touching private parts of the victim whether male or female are deemed as indecent assaults.
Physical Violence[7]	The use of physical force or threatening to use it, which might result in a physical injury or harm; such as hitting, cutting, punching, biting, or burning with incinerating or caustic substances and any other acts that might lead to a physical harm to the body.
Psychological Violence [8]	The violence resulting in mental disorder or psychological or emotional pain, such as: insult, humiliation, degradation, isolation from family and friends, sarcasm, intimidation and impossible demands, or arbitrary deprivation of rights and freedoms.
Child Marriage	Any marriage under the age of 18 years

Note: All the aforementioned definitions and terms apply to children and adults.

(1) Adapted from Inter-Agency Standing Committee (IASC)
(2) Ibid.
(3) The National Framework for Family Protection against Violence 2016
(4) Ibid.
(5) Penal Code, Articles 292, 293, 294, 295, 300, 301.
(6) The Jordanian Cassation Court, decision no. 181952/ (Five member bench), 1 January, 1953
(7) The National Framework for Family Protection against Violence 2016
(8) Ibid.

Definitions Specific to Child Protection

Child[9]	Every human being who is below the age of 18 years, unless reaches her/his majority earlier in accordance to the applicable law.
Juvenile[10]	Every child who has not completed eighteen years of age, including the juvenile delinquents and the juveniles in need of care and protection.
Child Protection	Protecting children from harm and violence. Harm includes: violence, abuse, exploitation and neglect. CP programmes aim at promoting, protecting and achieving children's rights of protection against abuse, neglect, exploitation and violence as contained in the United Nations Convention on the Rights of the Child and all other human rights conventions in addition to the national laws in force.
Best interests of the child	Putting the child best interest above all considerations and at paramount priority in all circumstances, regardless of the interests of the other parties and giving the child the right to determine and express her/his interest. It broadly describes the child's welfare which is determined by a variety of individual circumstances, such as age, maturity level, presence or absence of parents/ caregivers, or the environment of the child and her/his experiences.
Orphan	A child whose father or mother has died.
Children without parent/caregiver care	All children who are not living with and are not cared by at least one of the parents for whatever reason or under whatever circumstances.
Alternative care	Care given when the child's natural family is unable - even with the proper support- to provide the appropriate care for the child, or when the family abandons or gives up their child. The care could take a formal or an informal form which includes the care of relatives, or the custody of the child, or any other form of family care, or childcare places similar to the family such as institutional care, or arrangements of independent living under supervision.
The Custodian	A person chosen by the father or paternal grandfather or a guardian chosen by the paternal grandfather or- in the event that they are not available- the Judge, to manage the affairs of the minor and care for his interests.

The Guardian	The guardian of a minor is his or her father, followed by the father's designated agent, the grandfather, the grandfather's designated agent, and then the court or the person designated by the court.
Care giver	A person entrusted with the care of the child; it is first given to the mother during marriage and after separation, then the custody is given to the maternal grandmother, the paternal grandmother, then the father; and then, the court, based on the evidence in the best interests of the minor, has the right to grant custody to the most eligible relative.
Child Abuse	The deliberate abuse or neglect that affects the child's safety, welfare, dignity and growth which might cause a probable harm. This includes all sorts of physical, sexual, psychological, or emotional abuse which causes harm. Harm could take many forms, such as: impacts on the physical, emotional and behavioral growth of the children, their general health, family and social relations, self-esteem, academic attainment and their future aspirations.

(9) Convention on the Rights of the Child (CRC) Article 1, 1989.
(10) Juvenile Law 2014

Child Survivor	Any person under the age of 18 who has been subjected to any sort of violence, especially GBV.
Neglect	Failing to provide or secure the basic physical, developmental or psychological needs for the child, whether deliberately or due to carelessness or negligence. Neglect is sometimes called the 'passive' form of abuse, as it relates to the failure to meet some key aspects of care and protection resulting in the impairment of the child's health or development. It may also include unresponsiveness to meet the child's most basic emotional needs. Neglect does not include situations of poverty, where a person entrusted with the care of the child cannot afford to provide the basic needs of the child but is trying to do so.
Legal age of Consent	The age of legal maturity in Jordan is 18[11]; hence, any official documents related to the children less than 18 years of age should be signed by one of the parents or custodians according to law[12].
Informed Assent (Children's willingness to participate)	The expressed willingness to participate in the services. The «younger children's assent», who are by definition too young to give their informed consent, but can understand and approve taking part in receiving the services is sought. Informed assent is the willingness expressed by the child to take part in receiving services.
Unaccompanied children	Any child who has been separated from both parents/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 neighbor, another child under the age of 18 years, or a stranger.
Separated children	Any child separated from both parents/care-giver designated by law or custom, but not necessary from other relatives.
Children Associated with Armed Forces and Armed Groups (CAAFAG)	Any person below eighteen years of age who is or who has been recruited or used by an armed force (government military or other security forces) or armed (opposition) groups in any capacity, including 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 with members of armed groups (e.g. through participation in demonstrations, throwing stones or writing slogans on walls).
Child labor	Any work performed by a child which is detrimental to her/his health, education, physical, mental, spiritual, moral, physical or social development.
The Worst Forms of Child labor [13]	Includes slavery, prostitution, pornography, illicit activities, work that will likely harm the child's health, safety or morals, as specified in the International Labor Organization Convention (No. 182) which prohibits the worst forms of child labor for all children under the age of 18, even those who have reached the legal working age set at 16 years[14]. The 2011 decision on work that is onerous and unhealthy for minors included types of work that the Jordanian law prohibits minors to perform.

(11) Civil Law No. 432/, Article 43 indicates that «the age of maturity is 18 years»

(12) Personal Status Law No. 36 for the year 2010, Article 210

(13) Convention on the Prevention of the Worst Forms of Child Labor and Immediate Procedures to Eliminate them, 1999 (no. 182)

(14) The Jordanian Labor Law No. 8 for the year 1996

Human trafficking[15]	a. The recruitment, transportation, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Or the recruitment, transportation, harboring or receipt of persons under the age of 18 for purposes of exploitation even if not accompanied with threat or use of force or other forms contained in article (1) of this paragraph. b. For the purposes of paragraph (a) of this article, the term (exploitation) means: The exploitation of persons for servitude, forced labor, slavery or practices similar to slavery, the removal of organs, prostitution or any other form of sexual exploitation. c. Crime is deemed (cross-national) in any of the following cases: 1. If committed in more than one country. 2. If committed in a country and prepared for, planned or supervised in another country. 3. If committed in any country via an organized criminal group that carries out criminal acts in more than one country. 4. If committed in a country and spread to another.

Definitions Specific to Case Management1

Survivor	The person subjected to any form of violence.
Perpetrator	Any person who commits the act of violence in any of its forms against another person.
Case Management	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.
Case Coordinator	The specialized employee who possesses the required skills, expertise and qualifications to deal with the survivor in the relevant institution. The case coordinator assumes the responsibility of the case management starting from the assessment of safety risks until case closure through supervision of and communication with the case management team that is responsible for following up on the case, whether inside the relevant institution or with the partnering institutions in addition to the coordination of the meetings concerning the survivor.

(15) Human Trafficking Code 2009, no. 9 for the year 2009

Supervisor of Case Coordinators	The specialized employee who possesses supervisory skills. S/he assumes a supervisory position inside the institution. S/he is responsible for assigning cases to the case coordinators in the institution, following up on these cases, providing technical and administrative (logistic) support to the case coordinators and ensuring that quality service is provided in accordance with the work plan of the survivor
Service Provider	The employee at the institution who deals directly with the survivor through providing specialized service to him/her by the competent people in the following domains: social work, psychology, counseling, sociology, child rearing, medicine, nursing, law or any other domains relevant to humanities.
Informed Consent	The voluntary consent of a person, who has full capacity to give consent/approval to receipt of services, which is based on full, clear and readily comprehensible information. To acquire consent, the person needs to possess the capacity and maturity to realize the available services and understand them. Parents/caretakers or the custodian are usually responsible for giving the consent on behalf of the child with regard to the receipt of services until the s/he reaches the age of eighteen, taking into account the national laws and legislations in force.

Other Relevant Definitions and Terms

Specialized Service Providers[16]	Individuals, organizations, and institutions involved in preventing and responding to gender-based violence, family violence and/or child protection.
General Service Providers	Refers to all actors, including UN, NGO and governmental actors, providing services that are not specialized in child protection and/or GBV and FV.
A Person with a Disability[17]	Any person with a consistent partial or total sensory, physical, psychological or mental impairment that may reduce his/her ability to learn, be qualified or work whereby s/he is unable to meet his/her normal day-to-day requirements as those of non-disabled peers.
Competent Person[18]	Any person who has reached the age of 18 Gregorian years and who is in possession of his mental faculties and has not been declared legally incompetent.
Incompetent Person[19]	Any person who lacks discretion by reason of youth, imbecility or insanity
Person of Defective Capacity[20]	Any person who has reached the age of discretion but has not reached the age of majority and any person who has reached the age of majority but is an idiot or of unsound mind.
Psychosocial Support[21]	Support that aims to protect and promote psychological and social wellbeing and/or prevent or treat behavioral disorder.
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 a secret location and locked files.

(16) According to the National Framework for Family Protection against Violence 2016
(17) IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings. IASC. 2005.
(18) Law on the Rights of Persons with Disabilities No 31/ 2007
Article 43 (civil law)
(19) Article 44 (civil law)
(20) Article 45 (civil law)
(21) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007.

Mandatory Reporting	State laws which mandate certain agencies and/or persons in some professions (health, education, and social service providers, etc.) to report cases of GBV and FV and violence against children (e.g., physical, sexual, emotional and psychological abuse and neglect).
Felonies[22]	Crimes that are punishable by the death penalty, or life or temporary imprisonment with hard labor, or life or temporary detention such as: murder and rape crimes, indecent assault, or aggravated assault.
Misdemeanors[23]	Crimes that are punishable by a term of imprisonment or a fine such as: slander, vilification, simple harm or commission of indecent acts in public.
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[24].
Arrest, Threat of Refoulment or Need for Bailing	Any case 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.
Torture[25]	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) Jordanian Penal Code

(23) Ibid.

(24) United Nations Refugee Convention, Article 1, 1951.

(25) UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,1984.

Chapter Two:
Guiding Principles

All actors working in the area of case management and service-delivery to GBV, FV and CP cases are mandated to adhere to the following set of guiding principles:

Guiding Principles for all Procedures[27]

1. Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV, Family Violence and CP. This includes sharing information to avoid duplication, and to maximize a shared understanding of the intervention programmes.
2. Develop and sustain multi-sectoral interventions to prevent and respond to violence.
3. Engage the community fully in understanding and promoting gender equality and power relations that protect and respect the rights of women and girls and marginalized groups.
4. Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing and monitoring programmes through the systematic use of participatory methods.
5. Integrate and mainstream GBV, Family Violence and CP interventions into all programmes and all sectors.
6. Ensure accountability at all levels.
7. Understand and ensure adherence to the code of conduct of all workers concerned with GBV, Family Violence and CP cases.
8. It is possible to work with the survivor's family if it does not contradict with the survivor's best interest.

Guiding Principles for Working with Children [28]

1. **Avoid exposing children to further harm due to intervention:**
   a. Identify mechanisms to manage and assess CP cases prior to adopting any new interventions.
   b. Plan interventions based on research and understanding of behaviors and social norms.
   c. 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.
   d. Avoid restricting services and benefits to specific categories of children or families, but apply an inclusive case management approach for all children at risk.
   e. Guarantee confidentiality and informed consent/assent when dealing with sensitive issues, and ensure that interventions are carefully planned to respect privacy.

   It is important to note that the primary condition to getting the informed consent is for the person to possess the legal capacity to grant it; hence, the parents / the caregivers are responsible for giving consent on behalf of the child in order to receive service.
2. **Implement and adhere to protocols for protection of children, including the reporting procedures of violence and abuse cases.**
3. **All children should have access to assistance by:**

(27) Adapted from: GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide), Guiding Principles for Standard Operating Procedures 2008, IASC Sub Working Group on Gender & Humanitarian Action.
(28) Minimum Standards for Child Protection in Humanitarian Action.CPWG.2012.

a. Ensuring that assistance is provided without discrimination and is not withheld from children in need or their families and caregivers, and that access for services is provided in compliance with the standards.
b. Using innovative and creative ways of child protection interventions to reach the children who are often in most need of protection.
c. Ensuring the prompt response of child protection workers when patterns or cases of discrimination or exclusion are identified.

4. **Protect children from physical and psychological abuse arising from violence and coercion:**
   All concerned child protection interventions should seek to make children more secure, facilitate children's and families' efforts to stay safe, and reduce children's exposure to risks.
5. **Assist children to claim their rights, access available remedies and recover from the effects of abuse/violence:**
   a. Assist children and their caregivers in claiming their rights through the provision of information and documents, and help them access solutions.
   b. Ensure provision of appropriate and adequate support for children to recover from physical, psychological and social impacts of violence and other violations.
6. **Promote CP systems:**
   a. Identify and build on the existing effective programmes and local capacities.
   b. Avoid the creation of parallel protection systems, such as protection and response services provided by the local community institutions and others.
   c. Build the capacities of national and state-level authorities as well as civil society.
   d. Ensure and systematize representative participation of the community, including meaningful participation of children during analysis, planning, and assessment exercises.
   e. Establish links and coordinate with other entities working on child protection and related issues.
7. **Promote resilience skills of children:**
   a. Ensure that child protection programming strengthens protective factors that reinforce children's positive resilience skills, and address elements that expose children to risks.
   b. Ensure that programmes are accessible to all children and that they reinforce the skills and strengths of the children.
   c. Ensure that programmes involve those close to children, and reinforce supportive relationships between children, their parents/caregivers, peers and other important people.
   d. Ensure child protection programmes and services in communities take into account the social and legal norms that influence children's lives and conditions.

Guiding Principles for Working with Survivors

1. Ensure the safety of the survivor(s) at all times.
2. Respect the confidentiality of the survivors at all times.
   a. 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, in compliance with laws and regulations in force such as mandatory reporting.
   b. Do not discuss any Information regarding the incident or the provided services with the survivor or the perpetrator in the presence of any other person who is not involved in the case.
   c. Keep all written information about the survivor in secure and locked files.
3. Respect the wishes, choices, rights, and dignity of the survivors.
   a. Consult the survivors on where they wish to seek help and respect their wishes. Do not pressure the survivors and do not suggest or otherwise guide them in any specific direction.
   b. Conduct interviews in private settings that ensure their privacy. For example, prepare interview rooms for survivors which are fully equipped with the basic requirements to make the child feel safe and comfortable, taking into account psychological status of the child.
   c. Ensure that interviews and examinations are conducted by staff of the same sex as the survivor or as preferred by him/her, including all service providers.
   d. Be explicit regarding your role and what you can and cannot provide.
   e. Be respectful at all times, and maintain a non-judgmental manner. Do not laugh or show any disrespect to the individual or her/his culture, family, or situation.
   f. Be patient; do not press for more information if the survivor is not ready to speak about her/his experience.
   g. Show empathy, understanding and willingness to listen.
   h. Ask only relevant questions that are required to assess the violence case.
   i. Avoid having the survivor to repeat his/her story in multiple interviews.
4. Ensure non-discrimination towards the survivors in all procedures and the provision of services in a manner that respects their dignity, irrespective of their sex, nationality, race, religion and background.

Guiding Principles for Working with Child Survivors

1. **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 and mental safety—in other words, the child's wellbeing— throughout their care and treatment. Service providers must assess the positive and negative consequences of actions while ensuring participation of the child and her/his caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure that the child's rights to safety and ongoing development are never compromised. (For ways to determine the best interest of the child, see the UNHCR Guidelines on Determining the Best Interests of the Child, 2008).
2. **Ensure the safety of the child**: Ensuring the physical and emotional and mental 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.
3. **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 the following:
   - Confidential collection of information during interviews;
   - Sharing of information in line with local laws and policies and on a need-to-know basis; and case information is stored securely.

   In Jordan service providers are required under local law to report child abuse to the concerned local authorities. Consequently, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery.
4. **Involve the child in decision-making**: Children have the right to participate in decisions that impact 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. When service providers are unable to follow the child's wishes (based on best interest considerations), they should always explain the reasons to the child.
5. **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 status, caregivers' status, cultural background, financial situation, or disabilities, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.
6. **Strengthen the children's resilience skills**: Each child has unique capacities and strengths and possesses the capacity to heal. Factors which promote children's resilience skills should be identified and built upon during service provision. Children who have caring relationships, opportunities for meaningful participation in family and community life and unconditional respect and acceptance regardless of the nature of their problem or abuse are more likely to recover and heal from abuse.

Guiding Principles for Working with Survivors with Disabilities

1. Respect dignity and individuality, including; freedom of making decisions and the independence of the persons with disabilities.
2. Ensure full and effective involvement in the community without exclusion.
3. Ensure non-discrimination, respect of differences and acceptance of disabled persons as inseparable from the human diversity and humanity.
4. Ensure equality of opportunities and accessibility to services.
5. Equality between men and women.
6. Respect the evolving capacities of the disabled children and their right in preserving their identity.

Chapter three:
Case Management Methodology, Reporting and Referral Mechanisms

Overview of Case Management Process and Responsibilities

Case management methodology is a collaborative multidisciplinary process promoting quality and effective outcomes through communication and the provision of appropriate resources to meet an individual's needs. This process includes assessment, monitoring and evaluation of options and services, planning, implementation and coordination[32] This methodology was adopted at the national level in managing GBV, Family Violence and CP cases in Jordan.

Case management methodology aims at empowering the survivors, their families, and caregivers –where appropriate- by increasing their awareness about the available options to deal with the problem, and helping them make informed decisions to manage their situation.

Case management ensures the involvement of survivors-and their families- in all aspects of the planning and service delivery.

A case management methodology is useful for persons with complex and multiple needs who seek access to services from a range of service providers, organizations and groups. It also ensures service quality control by harmonizing of procedures and work forms among partners and reducing time spent on searching for other services.

Basic Principles Underpinning Case Management

1. Ensuring the survivor is the main focus in case management.
2. Empowering survivors and their families, and ensuring their involvement in all aspects of the planning and service delivery.
3. Respecting the wishes, the rights, dignity and capacity of the survivor/child.
4. Providing emotional support by demonstrating a caring attitude towards child survivors.
5. Providing explicit information to child survivors to enable them to make informed choices regarding the requested services.
6. Listening and establishing rapport and a trusting relationship, which creates a supportive environment in which the child survivor can begin with the recovery process.
7. Ensuring confidentiality which is critical to protecting the safety and security of child survivors and to prevent misuse of information.
8. Ensuring non-discrimination by treating every child survivor in a dignified manner regardless of her/his sex, background, race, ethnicity or circumstances of the incident(s).
9. Obtaining informed consent from the child survivor prior to sharing any information.

(32) GBV Emergency Response and Preparedness. Participant Handbook. International Rescue Committee IRC.

Work Regulations among Partners under the Case Management Methodology [33]

The institution responsible of case management should abide by the following regulations:

1. Assigning coordination task to the case coordinator, and calling on the involved parties to take part in the case management meetings of the survivor.
2. Involving the institution concerned with the identification and detection of violence cases and child protection which reported the case in the membership of the case management team through following up on the case, providing services, participating in the case management conference meetings and taking decisions.
3. All participating institutions in the case management team should send a person who is technically qualified and authorized to take decisions on the necessary interventions for the survivor.
4. Assessing the risk factors for the survivor through the assessment of the degree of personal security and self-safety risks; assessing the degree of physical and psychological risk; and organizing an immediate response meeting jointly with of all concerned service providing partners.
5. The case coordinator should periodically brief the case management team with the developments regarding the survivor.
6. The case coordinator should collect and secure all necessary information and follow-up on all procedures and services required by the survivor, which are taken by the service providers of the case, and should also ensure that the implementation of the procedures and any relevant information exchange are not delayed by the case management team.
7. Engaging the survivor or his/her representative in all stages through briefing him/her on the available options and the outcomes of each, in addition to the sought plan.
8. Taking the decisions regarding the survivor collaboratively among the case management team.
9. Taking the decisions of file closure consensually among the partners on the basis of the assessment of the risk factors outcomes, and releasing the final decision according to the majority of votes among the case management team members.
10. The entity responsible for the case management should establish partnerships and memoranda of understanding with the concerned institutions to provide specialized services.

Case coordinators should possess the required skills to manage cases in line with the above principles. They should also be aware of their roles and responsibilities and have the ability to handle difficult situations professionally and with cultural sensitivity.

(33) National Framework for Family Protection against Violence 2016

Case Management Pathways [34]

Two case management pathways have been adopted among institutions involved in handling of GBV, FV and CP cases as prescribed in the mandatory reporting requirements in conformity with the laws, regulations and special instructions that regulate the roles and procedures of institutions while handling such cases. It has also been stressed that the case management entities should fulfil their commitment to establish partnerships and memoranda of understanding with all service delivery institutions (medical, psychological, social, legal, educational …) in a manner that ensures the harmonization of their inter-agency relations to provide services to cases.

1. Case management pathway among partners in cases that require reporting to the legally competent authority. This is determined based on the nature of the case and the group at risk (and whether the perpetrated act constitutes a felony or misdemeanor according to national legislation, laws and regulations in force). All institutions shall commit to reporting to the legally competent authority, provided that they take part in the case management team. In such cases, the reporting institution shall manage and follow-up on the case by calling all meetings relevant to the survivor, following up on decisions emanating from such meetings and coordinating among partners regarding the procedures and services that should be provided by all the partnering institutions to the survivor, taking into account examining the conditions, needs, wishes.
2. Case management pathway among partners in cases where no reporting to the legally competent authority is required (and where the act does not constitute a felony or misdemeanor according to the national laws and regulations in force). In this instance, the institution that received or detected the case shall deal and manage it according to the case management methodology, and henceforth shall commit to pursuing all stages of the case management process including assessment, coordination, planning, referral and follow up till the case file is closed.

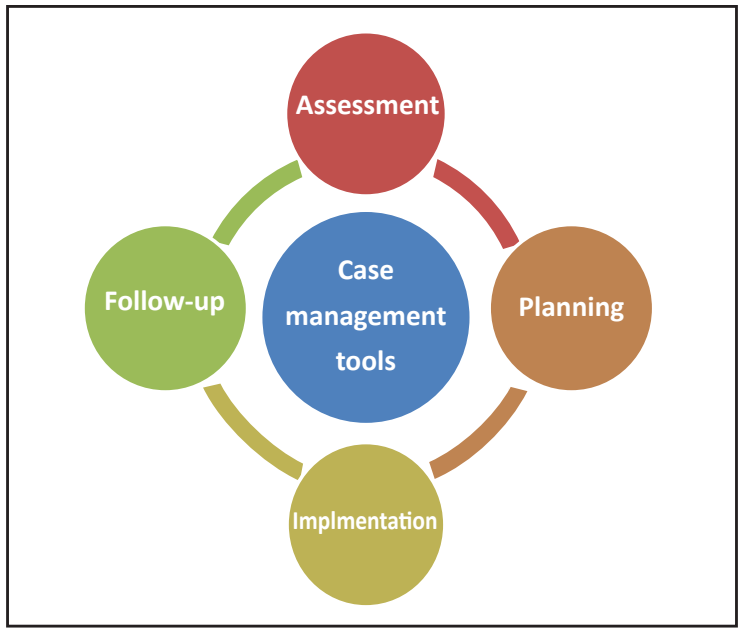
Stages and Tools of the Case Management Process

The case management process is based on coordinated and flexible steps, whereby transition to another stage is possible according to the follow up of the survivor case.
The case coordinator shall be responsible for following up on the case management process and shall be supported by the multi-disciplinary case management team.

(34) Ibid

Case Management Tools

1. **Case Assessment:** Is an on-going dynamic process to collect and analyze the information relevant to the survivor to determine the appropriate support services.
2. **Case Planning and Preparation of Intervention Plans:** Based on the outcomes of the planning, the procedures that need to be followed with the survivor should be determined. This interactive process is conducted by the case management team jointly with all concerned institutions to provide services to the survivor under the leadership of the case coordinator concerned with the management of the case.
3. **Case Implementation:** Is commencement of the intervention plan and the provision of services to the survivor. The implementation may include the provision of direct services or referral to other institutions.
4. **Case Follow-up:** Is an on-going process to review the progress that has been achieved in the implementation of the plan, identify challenges/difficulties that could hinder or change the course of the intervention plan, and make any required adjustments, for the protection and security of the survivor in a timely, effective and efficient manner.



Response Phases

The process of response to GBV, Family Violence and CP is essentially concerned with providing services to the survivor, ensuring that protection and security are provided to him/her and then to families and perpetrators, and preventing the recurrence of violence and abuse in the future.

The response process is based on specific phases through which the main objectives of the response process and the roles and responsibilities of all parties concerned with their implementation are determined.

Phases of Response to Violence Cases:

Phase One: Identification and Reporting Phase:

1. Case management begins with case identification. Case identification mechanisms can be strengthened through field work, public awareness and effective inter-agency referral mechanisms.
2. National laws may require some institutions and/or people working in the educational, social, health sector services to report violence cases, such as abuses against children and incompetent persons, sexual abuse, or in cases of suspected presence of danger on the life of the survivors.

Phase Two: Immediate Response Phase:

1. The aim of this phase is to ensure security and personal safety of the survivor through the assessment of the preliminary risk factors and the urgent needs that pose a direct threat on her/his life.
2. An immediate response meeting is held with the concerned partners, which results in a detailed immediate response plan for the case, which includes steps to be taken for the provision of the services, in addition to determining roles and responsibilities of the concerned partners and the implementation timeframe.

Phase Three: Comprehensive Intervention Phase:

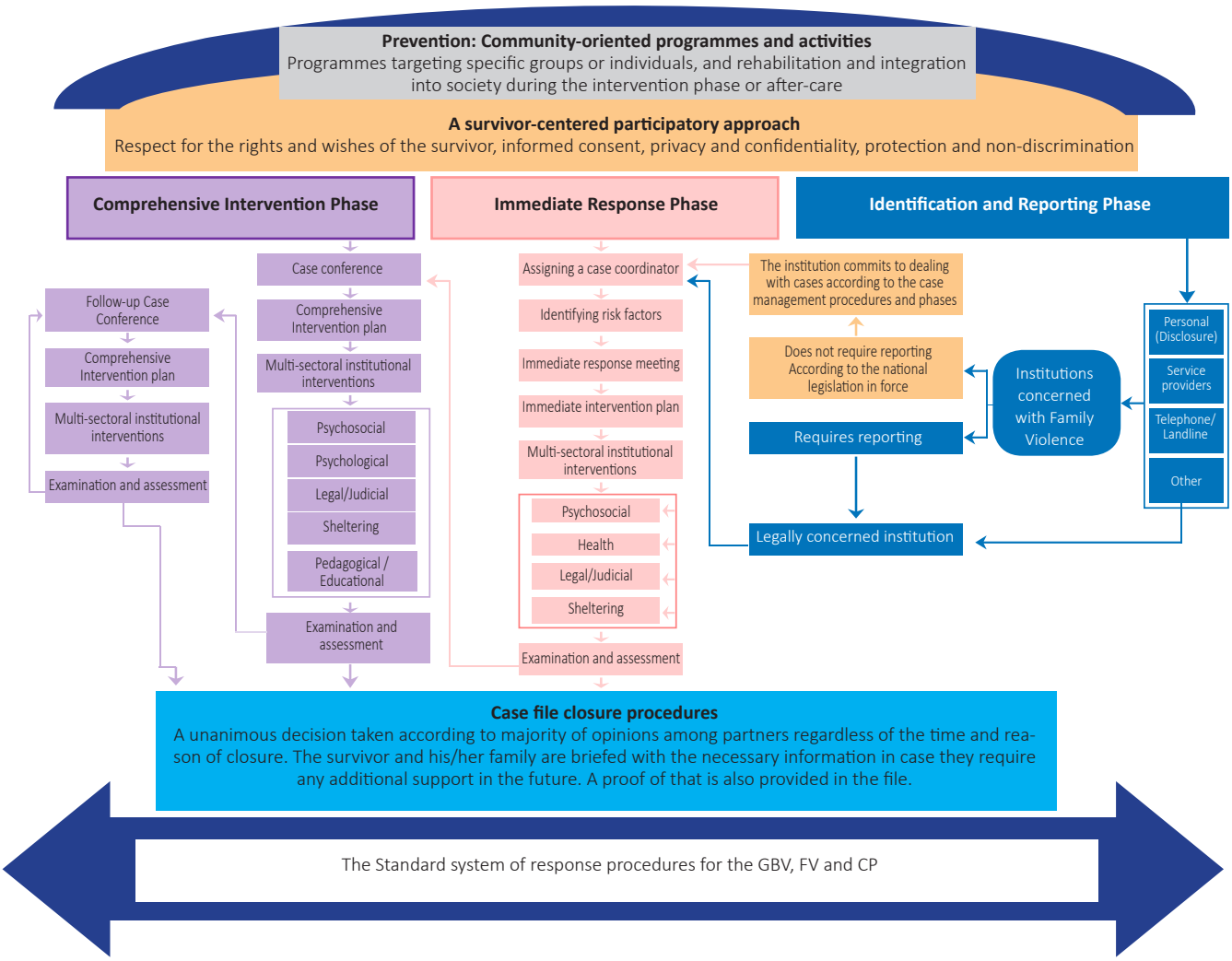
A comprehensive multi-disciplinary intervention plan is prepared and implemented based on a thorough assessment of the case needs. This plan aims at empowering the survivors and their families and preventing the recurrence of violence.

Case File Closure Procedures

1. This is a step in the case management process. The case file is closed after conducting a review of the case, ensuring that the life-threatening risk factors have been eliminated and implementing the immediate response and intervention plans.

   The mechanism of implementation for these phases will be detailed later in this document[35].

(35) For more details refer to Detailed Procedures of the National Framework for Family Protection against Violence


Prevention: Community-oriented programmes and activities
Programmes targeting specific groups or individuals, and rehabilitation and integration into society during the intervention phase or after-care
A survivor-centered participatory approach
Respect for the rights and wishes of the survivor, informed consent, privacy and confidentiality, protection and non-discrimination
Comprehensive Intervention Phase
Immediate Response Phase
Identification and Reporting Phase
Case conference
Comprehensive Intervention plan
Multi-sectoral institutional interventions
Psychosocial
Psychological
Legal/Judicial
Sheltering
Pedagogical / Educational
Examination and assessment
Follow-up Case Conference
Comprehensive Intervention plan
Multi-sectoral institutional interventions
Examination and assessment
Assigning a case coordinator
Identifying risk factors
Immediate response meeting
Immediate intervention plan
Multi-sectoral institutional interventions
Psychosocial
Health
Legal/Judicial
Sheltering
Examination and assessment
The institution commits to dealing with cases according to the case management procedures and phases
Does not require reporting According to the national legislation in force
Requires reporting
Institutions concerned with Family Violence
Personal (Disclosure)
Service providers
Telephone/ Landline
Other
Legally concerned institution
Case file closure procedures
A unanimous decision taken according to majority of opinions among partners regardless of the time and reason of closure. The survivor and his/her family are briefed with the necessary information in case they require any additional support in the future. A proof of that is also provided in the file.
The Standard system of response procedures for the GBV, FV and CP

Management of Gender-Based Violence (GBV), Family Violence (FV) and Child Protection (CP) Cases [36]

The case management methodology has been adopted nationally for the handling of all GBV, Family Violence and CP cases to ensure coordination between all sectors and determine the roles and responsibilities among them.

Annex (1) presents a detailed flow chart of the case management procedures according to the response stages, with a detailed identification of work regulations and chain of procedures.

The commentary below presents detailed implementation of the case management methodology mechanism for GBV and Family Violence cases in general.

Management of Gender-Based and Family Violence Cases

The goal of case management for GBV and Family Violence cases is to empower survivors by raising their awareness of the available options, providing them with support to enable them to take informed decisions and informing them of the available services. Case management of the survivor focuses primarily on ensuring the provision of safety and security and meeting the survivor's health, psychosocial, social and legal needs following the incident.

Several national and international institutions in Jordan manage GBV and Family Violence cases. These agencies assess any case they receive to provide support, including GBV and Family Violence cases involving children. Various tools are used to assess the GBV and Family Violence cases such as interviews and the risk factors assessments regarding protection.

Detection and Disclosure [37] of GBV and Family Violence

Survivors have the freedom and the right to disclose an incident to anyone; they may disclose their experiences to a trusted family member or a friend. They may also seek help from an individual or an acting organization in the local community. They have the right to disclose what they believe is suitable information regarding what has happened to them and choose the time to disclose that information.

Any service provider contacted by a survivor and informed of an incident of violence has a responsibility to give **factual and accurate** information about services available; give a reasonable amount of time during which services can be expected; and explain the consequences (pros and cons) of accessing a particular service, including the mandatory reporting of some cases to the official institutions.

(36) (37) the National Framework for Family Protection against Violence

First: Non-Specialized General Service Providers

1. Service providers should create a safe, supportive, confidential environment that allows the survivor to disclose information on the violence they were subjected to, should they choose to do so. Building trust with the survivors to disclose such information takes time. General service-providers should not attempt to identify or detect the cases of GBV and Family Violence or child protection cases as this can lead to stigmatization of the survivor and can place them –and the staff/volunteers- at risk[38].
2. All actors coming into contact with the survivor should be aware of the GBV and Family Violence referral pathways, and the forms of assistance available.
3. Non-specialized actors should not interview the survivors or initiate a direct intervention.
4. The wishes of the survivors must always be respected as to where or from whom they wish to seek assistance. They should not be urged into a particular course of procedures.
5. Non-specialized actors should ask for the survivors' consent to connect them with a primary focal point officer at the institutions concerned with GBV and FV cases and facilitate the communication between them and the service provider. Once the survivor consents to sharing his/her information, the referral should be carried through either by physically accompanying the survivor, or over the phone or email, all of which should be documented in the forms.
6. All information should be kept confidential, except among those directly responsible for the case, even if a family or a community member requests any information on the type of support provided.
7. All legislation relevant to the standards adopted by institutions concerned with GBV and Family Violence cases with regard to the reporting of such cases to the relevant official authorities should be observed.

When general service providers identify violence and abuse cases and refer them to the case coordinator:

1. Responsibility for managing the case is transferred to that organization.
2. The service providers' responsibility is to ensure that the case coordinator has received the case and is capable of providing the relevant service.
3. The referring institution should provide the case coordinator with all available information and personal details.
4. Case management organizations should acknowledge reception of the case and confirm when they will be able to meet the case. If they cannot provide services to the case for any reason, they should inform the referring organization and, if appropriate, inform them with the reason (e.g. the case does not fit within their mandate, the service provider cannot accept new cases etc.)
5. If the referring organization continues to provide services, and needs to coordinate with the lead case coordinator, they can request a case management meeting (Case Conference).

(38) Questions about whether people have experienced GBV or child protection issues should only be asked during individual, confidential interviews by qualified child protection or GBV cases coordinators or protection staff.

6. Case coordinators can provide referring organizations information on a need-to-know basis only. If an organization is unable to continue provision of services to the case, the only information the case coordinator needs to provide is whether or not they can provide the required services, or provide a time frame when they can initiate provision of services.

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

1. Accompany Case: This is recommended for emergency or urgent CP, GBV and Family Violence cases. The referral should be documented in the referral form.
2. Referral by phone: This is recommended for emergency or urgent cases if accompanying the case is not possible, or is not in the best interest of the violence survivor. The referral should be documented in the referral form (look below).
3. Referral by email: Email referrals are the preferred way to document all GBV, Family Violence cases and child protection cases. In emergency cases, referral is directly conducted via phone or personal accompaniment of the case, taking into account the documentation of the referral via email.

   For low risk cases, the referral can be via email only. Such cases are recommended to be assimilated and referred on a regular basis (i.e. every week) to ease the follow-up process among acting organizations.

   When using email for referrals, it should only be sent to the relevant focal points in the referred institution, and should not be shared with any other people.
4. Referral by interagency referral form: The interagency referral form is recommended for child protection cases that are comparatively less risky, such as child labor or bullying, where leaving a copy of this form with the child or their caregiver would not present a risk to the child. The benefit of this form in these cases is that it provides important information to the child/caretaker 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 case.

   For GBV and Family Violence cases, the confidentiality in the referral should be ensured and its information should only be provided to the concerned parties.
5. Referral by a database system: Some organizations have online systems that allow the referral of cases. These systems should only be used in CP, GBV and Family Violence cases within the same organization or between organizations who share the data exchange protocols that respect standards of confidentiality.

   For example, there are some institutions who use the RAIS (a special database to some UN institutions in the humanitarian aid domains and its partners) which does not possess sufficient protection of information confidentiality and is used for the referral of different cases to other services (such as financial aid). Accordingly, any information regarding protection issues on such cases should not be installed into this system.

Second: Specialized Service Providers (Initial Assessment)

Specialized actors include medical, psychosocial services or institutions concerned with handling GBV and Family Violence cases such as the Family Protection Department.

Specialized actors can receive cases either through disclosure by the survivor or through referral from other non-specialized institutions. All specialized service providers should ensure the following:

1. Adherence to legislation related to the reporting standards of GBV and Family Violence cases adopted by the official institutions concerned with these cases.
2. Access to basic services that are safe, private and confidential. Survivors are more likely to come forward to seek help and report a GBV and Family Violence incident should the following conditions be available:
   a. Availability of trained male and female personnel to deal with such cases.
   b. Interaction and provision of services to survivors should be done in a respectful and non-judgmental manner throughout the entire process.
   c. Ensure that survivors feel safe and comfortable while accessing services.
3. Assignment of a case coordinator who is qualified and trained to handle GBV and FV cases and who initiates the case management procedures in the following manner:
   a. Provides initial emotional support and information about the support options to the survivors (protection, security, health care, and psychosocial and legal …). Expected benefits and consequences of such support should be discussed. Survivors should give their permission before contacting any institution for support.
   b. Once the survivor feels comfortable and has given her/his informed consent, determines the immediate needs jointly with the survivor. For example, explains the importance of the survivor receiving medical attention as soon as possible after an incident of sexual violence to prevent sexually transmitted diseases, HIV/AIDS and unwanted pregnancy.
   c. Determines case priorities. During the assessment, GBV and Family Violence cases should be prioritized. The initial assessment form, the risk factors assessment and identification of special requirements helps case coordinators and other service providers to prioritize cases and ensure the provision of timely support to cases.
   d. Prepares a comprehensive safety plan for social support and needed services in cooperation with the survivors, to meet their needs. If the survivors are in imminent danger, action must be taken to develop a safety plan that takes into account their best interest to ensure maximum safety.

Accordingly, the cases are classified into[39]:

1. High priority cases – Includes life-threatening cases. Immediate response procedures should be initiated immediately, and service-delivery should be coordinated promptly.
2. Low priority cases – Indicate the case that needs multiple services, but there is no imminent or immediate danger. Immediate response procedures should be initiated and service-delivery should be coordinated as soon as possible.

(39) Detailed Procedures of the National Framework for Family Protection against Violence

High priority cases
Examples of high priority cases:
1. Cases of severe physical injuries which require immediate medical care. 2. The use of weapons or sharp tools or attempted strangulation during the assault. 3. Sexual assault within the last 72 hours to receive preventive care after being subjected to sexual violence (emergency contraceptives, avoiding sexually transmitted diseases and transmission of AIDS). 4. The threat to kill the survivor by the perpetrator or one of the family members (threat of an honor crime). 5. The survivor suffers from one of the symptoms of psychological instability: severe crying spells, aggressive tendencies, confusion, distortion, disorientation, failing to concentrate and to pay attention, fear, shivering and anxiety. 6. Suicide attempts, planning for it or threatening to hurt others.

Informed Consent and Information Exchange

Sharing any information about GBV and Family Violence cases can have serious and potentially life-threatening consequences for the survivors and those helping them. Utmost care is therefore required while managing information.

1. After disclosing information, survivors have the right to control how information about their case is shared with other institutions or individuals.
2. Survivors must be made aware of any risks or implications of sharing information about their situation.
3. Survivors have the right to place limitations on the type(s) of information to be shared, and to specify which institutions can and cannot be given the information. Survivors must also understand and consent to the exchange of non-identifying data about their identity for data collection and security monitoring purposes.
4. If survivors agree or request referral, they must give informed consent before any information is exchanged with others. Before an institution exchanges any information about the case, or makes any referral, survivors should be given factual and sufficient information about possible referrals and their implications. This will enable survivors to make informed decisions with regard to the way or possibility of exchanging information.
5. Confidentiality and obtaining informed consent should always be prioritized except in highly exceptional circumstances (that require mandatory reporting)[40].
6. Informed consent of the survivors should be taken to provide them with services, refer them to other services and to share their information. To ensure consent is informed, service providers must explain:
   a. All available options.
   b. That information (as agreed with the survivor) will be exchanged with others in order to access other services.

(40) Ibid

c. Precisely explain the results of accepting other services.
d. The benefits and risks of the service.
e. That survivors have a right to decline or refuse any part of the service.
f. The limits to confidentiality.
g. Information in 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 survivor, especially sexual violence cases, may require time to build trust with them, ensure that they fully understand all options and support them to take informed decisions. During case management, informed consent is an ongoing process which involves discussing with the survivor different options over time.

Mandatory Reporting

Confidentiality and informed consent should always be given priority when responding to all forms of GBV, FV and CP cases. Nevertheless, under Jordanian law, service providers receiving information about certain types of violence are compelled to report this information to the legally competent authorities. Failure to do so could subject the service-provider to penalties including a prison term of not more than a week or a fine of not more than 50 JOD or both. It is important that survivors and others receiving services are made aware of these mandatory reporting rules, the type of information which may trigger them, and the possible consequences of reporting before beginning any interview. In this case, survivors and others may choose not to disclose vital information, which is within their rights under the law. If the survivors choose not to divulge certain information, services should still be provided according to the information that is shared and in accordance with the wishes of the survivors. Exchanging information without obtaining the consent of survivors will undermine trust and the integrity of the case management process. To avoid that, it is vital to advise the survivors with regard to the mandatory reporting before delivery of service[41].

(41) Adapted from: GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide), Guiding Principles for Standard Operating Procedures 2008, IASC Sub Working Group on Gender & Humanitarian Action.

Examples of mandatory reporting standards [42]

All individuals involved in case management and response to GBV, FV and CP should be aware of the requirements of mandatory reporting and the possible penalties for failure to do so. Below are the crimes that are subject to mandatory reporting by public or private sector employees who comes to a knowledge regarding these crimes. Failure to report such crimes could subject them to penalties. For example, mandatory reporting standards should be taken into account in the following family violence cases:

1. Any assault or act that is considered a misdemeanor when committed by a family member against an incapable or incompetent person. Incompetent persons include any child under the age of seven, and those who are senile or insane; incapable persons include children who are 7-18 years of age.
2. Any assault or act considered a felony when committed against a family member regardless of his/her competence or capability.

If public and private sector employees admit that they are aware of mandatory reporting and they fail to report such cases, they could be subjected to a prison term of not more than a week or a fine not more than 50 JOD or both.

Law enforcement employees and medical service-providers are subject to stricter requirements with relation to mandatory reporting. Therefore, they should be aware of the requirements of their respective professions. It is also important for service providers from all disciplines to be aware of the stricter responsibilities borne by law enforcement employees and medical service-providers as referral to these service-providers might obligate them to report any misdemeanor or felony at a later time.

Immediate Response Phase

1. Based on the results of the initial assessment and the evaluation of the urgent needs, the case coordinator coordinates an immediate response meeting with the service providers who are responsible for the provision of direct interventions including mental and psychosocial intervention, if appropriate.
2. The response meeting results in an immediate multi-sectoral, multi-disciplinary response plan based on the case priorities.
3. Survivors are referred to the appropriate services after obtaining their consent for follow-up (if required) to have the necessary services.
4. The case coordinator accompanies survivors to the social, medical and legal services and helps them attain these services (depending on the situation and the consent of the survivor).
5. Referrals should be made by either: by accompanying survivors; or by phone or email; and the process should be documented.
6. Case assessment and service provision might require home visits. Home visits should always be conducted very discretely taking into account the need to ensure confidentiality and privacy of the case and avoid putting the survivor to any further risk.
7. Every institution listed in the referral pathways of GBV and Family Violence should assign focal officers (focal officers should have received the proper training and should be fully

(42) Protection against Family Violence Law 2017

aware of how to receive cases and conduct referrals) to ensure smooth communication and follow-up.

8. The case coordinator follows up on the implementation of the plan internally, and with the other service providers, until realization of all goals.
9. The case coordinator evaluates the case for provision of comprehensive non-urgent services and follow-ups (in coordination with the concerned partners). If all risk factors have been successfully mitigated and additional services are not required, the case is closed.

Comprehensive Intervention Phase

The case coordinator undertakes the following:

1. Review the progress of the work plan and carries out monitoring and follow-up to ensure the efficiency and effectiveness of interventions.
2. Ensure that survivors have received appropriate assistance and services.
3. Identify any additional needs and areas of support and plan the implementation in consultation with the survivors. For child survivor cases, the consent of the child and/or his/her care-giver should be obtained.
4. After reviewing the intervention plan with survivors, makes a decision as to whether the plan should be implemented, adjusted or file closed. Procedures regarding informed consent/ reviewing views of child survivors should be followed and new referrals should be recommended if required.
5. Close the file after ensuring that risk factors are mitigated, urgent and comprehensive needs are met, and goals of the intervention plan are successfully realized.

Case Conference Mechanism

In cases of GBV and Family Violence, regular meetings should be convened for review of individual cases that require joint response among organizations (governmental, non-governmental and international). The meeting should focus on addressing immediate protection problems and the coordination of response procedures for each case separately:

1. Case conferences are in the form of closed small meetings which are held at the headquarters of the main concerned institution or another as agreed to discuss extremely sensitive information about certain cases. Only people who provide the direct services to survivors participate in the case conference. During the case conference, information should be shared on a need-to-know basis. Information irrelevant to the work of the service provider is not to be shared with him/her. For example, health service providers do not need to know details related to the perpetrator or how the case is being handled. When necessary, and to ensure respect to this principle, the concerned service providers can attend only a part of the case conference where relevant issues to their work will be discussed.
2. For adults, the informed consent of the survivor should be obtained to exchange informa-

tion with the participants in the case conference who do not provide direct services (such as the technical expert). If this consent is not given, the case should not be discussed.

3. In the case of children, the informed consent/assent by their guardian should be provided to share information with the participants in the case conference. In some cases, information can be shared on a need-to-know basis without the child or guardian's consent if it is in the best interest of the child.
4. In complex cases related to children, information is shared within the Best Interest Determination procedures to ensure the provision of necessary protection.
5. Persons are included in the case conference by invitation only. The conference should include participants with permission to receive/and exchange specific information regarding the survivor or the incident.
6. Only relevant information should be shared and must not include personal information or other details about the survivor or the incident.
7. All members of this meeting are responsible for ensuring that the dignity and confidentiality of survivors are respected and understand that the information discussed must be utilized to support management of the particular case and not for any other purposes.
8. Assigned case coordinators are responsible for ensuring information exchange after acquiring prior permission from the survivor. The case coordinators are to keep survivors informed with the decisions taken and the progress achieved.

Case Closure

Case closure is important to ensure that cases are not unnecessarily kept open for prolonged periods without follow-up, and dependency is not created. Case closure can take place when all the following conditions are met [43]:

1. **The goals of the immediate response plan are met; the risk factors are eliminated while ensuring non-recurrences.**
2. **The goals of the comprehensive intervention plan are met; the risk factors are eliminated while ensuring non-recurrences.**
3. **When the survivor moves out of the country for migration or residence,** while ensuring continuity and completion of the legal and administrative procedures in accordance to the laws, regulation and instructions relevant to the nature of the case.
4. **When the survivor dies,** while ensuring that the legal and administrative procedures in accordance to the legislation relevant to the nature of the case and the procedures of protecting the other family members are continued and completed.
5. **Refusal of the survivor to proceed with receiving multiple services,** while ensuring continuity and completion of the legal and administrative procedures in accordance to legislation relevant to the nature of the case.

A decision to close the case is taken based on the discussion and agreement during the case

(43) Detailed Procedures of the National Framework for Family Protection against Violence

conference on the reasons for closure with the entities responsible for the provision of service to the child and based on the majority of votes. The decision has to be documented.

Management of Child Protection Cases

For case management of children and CP issues, case coordinators should possess the knowledge and specialized skills required for working with children. They should adhere to the standard case management procedures used with adult survivors after adaptation to meet the needs of children.

Institutions (governmental, non-governmental and international) concerned with child protection issues must maintain confidentiality when handling cases through the following:

1. Ensuring that all case management workers are trained in confidentiality principles and procedures.
2. Keeping case files in locked cabinets and in secure location, and restricting access only to relevant and authorized case coordinators/supervisors.
3. Ensuring that staff authorized to access these files do not discuss children's details with non-authorized personnel.
4. All institutions handling child protection cases must have paper and/or electronic system to track and manage cases:
   a. The management of case files (hard copy and electronic) need to be governed by a data protection and information sharing protocol.
   b. Electronic case information management is recommended as they help prevent duplication of services and losing track of large numbers of child protection cases currently being supported.

When working with child survivors[44] , case coordinators should be able to:

1. Apply the appropriate child friendly skills during the process of case management.
2. Adapt the steps and procedures of case management of child survivors, and this includes:
   a. Being aware of the children's welfare and development.
   b. Taking into account the guiding principles for working with child survivors.
   c. Following procedures for informed consent/ assent (including in cases that require referral without the consent of the child or the caregiver whereby child and/or the caregiver should be informed with the interventions to be conducted on their behalf).
   d. Assessing the immediate needs regarding the child survivor's health and safety, in addition to the psychosocial and legal/judicial needs to ensure obtaining the early intervention services which guarantee the health and safety of the child.
   e. Conducting on-going assessment procedures for the safety of the child in the family and other social contexts after abuse disclosure.
   f. Taking decisive and appropriate procedures when the child is in need for protection.
   g. Involving any non-offending caretaker of the child throughout the case management process.

(44) Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.

h. Identifying the child-friendly service providers and conducting the appropriate referrals.
i. Interacting adequately with disabled children and their caretakers, including disabled caretakers, and providing information for them in a comprehensible manner.

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 who need case management services, including:

1. By child protection agencies during community-based child protection activities, such as Child Friendly Spaces (CFS), awareness raising activities or psychosocial services with children.
2. By other general service providers, such as educational staff, police, workers in the food and aid institutions and health workers etc.
3. Through local community individuals, including neighbors and employers, in addition to the CP community-based mechanisms such as CP committees, etc.
4. By self-referral: a child has the freedom and the right to inform anyone.
5. For children refugees, by UNHCR staff, especially registration and help desk staff or any of its partners.

General service providers (including service-providing CP staff) should:

1. Be aware of the kinds of violence, abuse, neglect and exploitation that children could be exposed to, and signs and symptoms that indicate they may have been exposed to them.
2. Be informed about CP case management services that are available in their geographical areas, when children or their caregivers disclose that a child has suffered violence, abuse, neglect or separation from their parents.
3. Provide basic emotional support to children and their families in line with principles and approaches of Psychological First Aid (PFA) [45].
4. Do 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.
5. Create a safe, supportive, confidential environment that allows children and/or their caregivers to disclose information on violence should they choose to do so.
6. Consult a CP case coordinator to determine how to proceed (without) disclosing the identity of the child), when suspecting that a child may have experienced violence, but the child or their caregiver has not disclosed this information.
7. Maintain confidentiality of the information provided by the child and/or others on the case.
8. Provide honest and complete information to child/caregiver about available services and options including general services and case management services.

(45) Psychological First Aid: guide for fieldworkers. WHO. 2011.

9. Encourage and support children to seek help. Use the CP Interagency Best Interest Determination (BIA) form to document information the child and/or caregiver chooses to share. Document their consent to share with other service providers in instances when leaving a copy of this referral form with the child or caregivers does not put the child at further risk. For child GBV 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.
10. Use the Inter-Agency Referral form to document the information the child and/or caregiver chooses to disclose to the service providers and agrees to share with other service providers.
11. Wherever possible and appropriate, accompany the child to the case coordinator, along with the child's caregiver.
12. Respect the child's wishes, if the child or caregiver does not wish to be referred to the case coordinator, except in circumstances where it is determined that it is in the child's best interest, or in cases that fall under mandatory reporting conditions. This includes instances where the child's safety is at imminent risk.
13. Consult the case coordinator (without disclosing the identity of the child), if not certain of the violence or abuse case and when it is in the best interest of the child.
14. If child's caregiver does not wish to receive 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). It is to be noted here that priority is always given to the child's best interests.

Initial Assessment by the Case Coordinator

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 coordinators in the concerned institutions.

The initial assessment of CP cases should be conducted as follows:

1. Child protection cases should be assessed by the institutions involved in handling CP case management (and in cases of child refugees, jointly with the UNHCR using the Best Interest Assessment (BIA).
2. The assessment should identify the needs, resources and strengths of the child.
3. The assessment should include basic demographic information; assessment of risks and protection requirements; current care arrangements; the child's social and family relations;

For children separated from their parents and unaccompanied children, the assessment should also determine whether family tracking and/or foster care services are required. (Refer Standard Operating procedures for Unaccompanied Asylum Seeking Children (UASC SOPs) and Best Interest Determination Standard Operating Procedures (BID SOPs) for more details.)

psychosocial wellbeing; access to education and/or vocational training; basic health services, nutritional status; access to water, sanitation …etc., and protection issues (see below).

4. 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 and/or her/his caregivers or others have taken to protect the child.
5. Identify the priority of the case. High priority cases requiring urgent action include: children in conflict with the law, children with immediate safety concerns (including self-harm/ suicide) and sexual violence that occurred in the last 72 hours.
6. Consent should be taken from the child and/or caregiver in order to initiate service provision and to exchange information with other institutions for referral purposes.
7. The assessment process and outcomes will differ according to the age and situation of each child and depending on the best interests of the child.
8. The case coordinator should prioritize based on the urgency of cases. Cases are classified into:
   a. High priority cases – direct danger to the survivor or someone else. The standards of mandatory reporting should be taken into account and accordingly take the required procedures.
   b. Low priority cases- in cases where services are needed but no imminent or immediate risks are present.

During assessment the case coordinators should do the following:

1. 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 with the presence of his/her guardian or the behavior observer.
2. Wherever possible, ask to talk to the child separately from the caregivers or peers. If this is possible/or appropriate, taking into account the age and maturity of the child and if not possible in the first interview, arrange another appointment.
3. Avoid methods that could further stigmatize the child.
4. Ensure the child's privacy and psychosocial needs during interviews.

Acquiring Informed Consent/ Assent from Children and Care-Givers [46]

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

- Obtain the consent of the parents, the custodian or the legal representative, whenever possible, for the child to receive appropriate services, and if it is in the best interest of the child [47].
- Ensure necessary consent is obtained to proceed with providing case management services and other services.
- Decisions related to the determination of the best interests of the child should be taken by the BID Panel. (Refer to the Best Interest Determination Standard Operating Procedures -UNHCR and FPD)

(46) Caring for Child Survivors of Sexual Abuse. IRC/UNICEF. 2012.
(47) According to Law of Criminal Procedure no. 9 for the year 1961 and its amendments, Article 3/2, if the victim in 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.

- Children and their caregivers should be informed with the requirements of the relevant mandatory reporting procedures.

The section below describes the guidelines on how to obtain the informed consent/assent. The ages listed below are only indicative, and therefore, the child's individual level of development and ability to understand options and take decisions should be taken into account.

1. **Infants and Toddlers (ages 0–6):** Informed consent for children in this age range should be sought from the child's caregiver, 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 consent will not be sought. The service provider should still seek to explain the situation and the procedures to the child in a simple and easy to understand manner.
2. **Younger Children (ages 7–11):** Generally, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent to receive services. However, they are able to express views or their "willingness" to participate. The views of children in this age group should be taken into consideration before proceeding with services and procedures which affect them directly. Children can provide a verbal assent which needs to be documented as such on the informed consent form. For children in this age range, written guardian/caregiver informed consent is required, along with the child's assent.
3. **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 to proceed with services. The case coordinator should seek the child's views about participating in services, as well as the guardian/caregiver's written informed consent.

In cases that entail the case coordinator or service provider to take decisions without seeking the child's assent or obtaining the informed consent of the parent/caregiver, it is important that the reasons to do so are explained to the right persons. This includes cases that requires the case coordinator to report to the Family Protection Department or take any other procedures to ensure the safety of the child.

Immediate Response

If the initial assessment shows that that a child requires assistance, a case file should be opened and all services accessed should be documented, recorded and monitored. The case coordinator should provide the child and his/her guardian (and where appropriate, the caregiver) with information about available options for support, so that they can make an informed decision about those services. An individual plan of action should be developed that takes the following into consideration:

1. Describe the procedures that will be undertaken taken to address the primary issues facing the child.

2. Focus on the identified needs and strengths/resources of the child and his/her caregivers and his/her support networks.
3. Include a risk assessment and, if required, establish a safety plan.
4. Focus on the best interest of the child, taking into account the wishes of the child (and the caregiver's wishes, when in the best interest of the child) in addition to the age and level of maturity of the child.
5. Include goals, timeframes for implementation, and follow-up mechanisms.
6. Delineate responsibilities including referrals to service providers (see below).
7. Set out procedures for monitoring and reviewing the case so that an appropriate assessment can be done at the right time to ascertain whether the child's needs have been met or not.

Comprehensive Intervention

Child protection cases often need referral to services not provided directly by the case coordinator, 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 financial and in-kind support. Case coordinators should facilitate the referral of the child and/or their caregiver to other services as follows:

1. Case coordinators should be familiar with the services offered in their geographical areas as outlined in the child protection referral pathways and should update their information regularly.
2. 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).
3. Take the consent of the child/caregiver to refer the child to specific services and obtain their consent to exchange information using the consent form. In case the child/caregiver does not give consent to the referral to service provider, the case coordinator shall provide information on the relevant alternative services that are available.
4. In urgent cases, the referral could be done through phone, however, should be followed by relevant documentation (with the relevant consent). In such cases, the case coordinator may accompany the child/caregiver to the service provider.
5. The child's access to the service should be ensured as a part of the case follow-up (see below).

Follow-up is one of the most important activities in CP work and relates to the duty of care that institutions have assumed when receiving the case. Follow-up comprises the following elements [48]:

1. It should be timely and as regular as possible, according to the needs of the child taking into consideration the priority of the case and its gravity.
2. Monitoring the general welfare of children and ensuring progress is being made or services have been delivered as planned.

(48) Save the Children Case Management Manual

3. Ensuring that children and adults are kept regularly informed on the progress made, the care received is in place and the social integration of the child is monitored.
4. Identifying changes to the child's circumstances, which will then require further assessment.
5. Allowing further assessment if interventions are found to be unsuccessful.
6. Helping to determine the number and frequency of visits based on the specific needs of each child on a case-by-case basis. Continuing with this manner until protection concerns have sufficiently improved.

Case Closure Procedures

Case closure can take place after the completion of all actions listed in the intervention plan, follow-up, elimination of risk factors and non-requirement of other services. If the legal representative refuses to proceed with the case management procedures, the best interest of the survivor should be taken into account while ensuring the completion and continuity of the legal and administrative procedures according to the legislation relevant to the nature of the case and the procedures pertaining to the protection of the other family members.
Based on the case conference, discussions on the justifications of closure with the parties concerned with providing services to the child, and the consent of the majority, a decision to close the case is made. The decision should be documented.

Best Interest Determination (BID) Procedures [49]

All procedures pertinent to children should be guided by the principle of best interest of the child. Every day, CP workers encounter situations which entail taking decisions regarding children where the need for guidance by the BID principle is needed. These decisions may include alternative care arrangements or assessing the protection needs for a child at risk or determination of a permanent solution for a child separated from his/her parents. There is no doubt that these decisions have long term implications on the individual child. Therefore, they cannot be taken lightly; rather some regulations and procedures need to be abided by in order to ensure the implementation of the BID principle in a manner suitable with the child's particular situation. Ensuring the child's capability to express her/his views in this process is one of the key regulations which should be taken into account in all the procedures regarding children:

1. The children's best interest should be the base for all proposed interventions and the best interest principle must be implemented on all children without discrimination.
2. The best interest principle cannot be effective unless the children are viewed as right holders and their right to participate is respected.
3. Determining the best interest is a key instrument for the protection of children which ensures that procedural safeguards and additional protection measures for children at risk are in place.

(49) Field Handbook for the Implementation of UNHCR Best Interest Determination Guidelines, 2010.

4. BID facilitates case management, monitoring and follow-up on children at risk.
5. BID is a key element of the CP system and it is essential to integrate it into the comprehensive protection strategy.

Key steps to determination of best interests are as follows:

1. Assigning a supervisor responsible for determining the best interests.
2. Forming a (BID) panel and assign members from the institution handling the case.
3. Setting SOPs for the determination of best interests developed in collaboration with partners.
4. Provide adequate training on CP and BID process for members of the BID panel and other employees.

The BID Panel formation depends on the context in which the BID process is conducted:

1. The panel should comprise 3-5 persons who are highly qualified in the domain of CP and social or psychosocial work.
2. Panel members should be fully aware of the child and youth development and the psychological and physical welfare of children including the pedagogical and protection aspects.
3. Panel members should be aware of the legal, cultural, religious, political, social and financial environment of the children in question.
4. Panel members should be capable of evaluating the safety requirements of the decisions special to BID of individual children.
5. Workers who possess basic knowledge on research topics related to family members, permanent solutions, education, mental health, psychological and social work, sexual and physical violence and social welfare can contribute efficiently in the BID Panel which allows for a higher response when following up on BID decisions.
6. It should be emphasized that the relevant panel should determine the best interest by involving the committees that work directly with/or provide services to the concerned communities and children.
7. The BID Panel should be multi-disciplinary and should take gender-balance into consideration.

Chapter Four: Family and Gender-Based Violence Prevention and Response Programmes [50]

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

Prevention of Family and Gender-Based Violence

The National Framework for Family Protection against Violence has set three levels of protection against violence. These levels aim at promoting healthy behavior within the family and society, eliminating risk factors, detecting family violence cases early on, and addressing them by taking necessary procedures.

These levels are:

1. First protection level (awareness programmes): includes raising the awareness of the public on the aspects of family violence and its risks on individuals and families.
2. Second protection level (prevention programmes via intervention programmes): is concerned with the provision of integrated and holistic services to the survivor.
3. Third protection level (prevention programmes during after-care): focus on the re-integration of the survivor with their families and society, in addition to rehabilitation of families and perpetrators.

Accordingly, actors involved in the prevention and protection against GBV and Family Violence should implement all measures to coordinate and make collaborative efforts to implement programmes and procedures for prevention of violence, such as:

1. Provide or participate in training on FV and GBV issues and their management mechanisms; the National Framework for Family Protection against Family Violence; National Operating Procedures for Prevention of and Response to GBV and Family Violence and CP; and other relevant documents and national and international resources.
2. Adopt codes of conduct for all workers that focus on preventing sexual exploitation and abuse. Related procedures include: providing training workers; signing the code of conduct by all workers; establishing safe and confidential reporting mechanisms; and following-up on reports.
3. Actively seek equal participation of women, girls, boys and men (especially groups that are more vulnerable to violence) in the design and delivery of services during the preparation, planning and implementation phases.
4. Ensure services are inclusive and accessible for persons with disabilities.
5. Coordinate to develop and implement FV and GBV awareness-raising activities within the community and mobilize support from other humanitarian actors and local government authorities.
6. Organize economic empowerment activities to reduce vulnerabilities.
7. Promote a protective environment by assessing security and safety and addressing protection issues. When designing projects, and implementing interventions, intended and unintended consequences of activities should be considered, and strategies should be reviewed to ensure protection of the survivor in accordance to their best interest.
8. Promote local community mobilization and awareness campaigns to prevent further inci-

dences of violence and stigmatization of the survivor by:

a. Maintaining awareness of GBV risks and issues among community members and exchange information and lessons learned.
b. Taking part in problem-solving discussions to continuously strengthen prevention strategies.
c. Actively promoting respect for human rights and women's rights, and supporting the role of women and youth as equal decision makers.
d. Promoting male role models and positive masculine norms and behaviors that are non-violent.

9. Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described, which include:
   1. **Health:** Ensure health services are accessible to women and children; integrate GBV and Family Violence awareness-raising and behavior change activities into community-based health activities.
   2. **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 counseling; and promote community acceptance and social reintegration of survivors from GBV.
   3. **Security:** Maintain awareness of protection and security issues related to GBV and FV; develop and strengthen specific prevention strategies to address evolving security issues in addition to mechanisms to deal with violence cases and their procedures.
   4. **Legal justice:** Raise awareness in the community on national laws and available legal aid services; promote respect for survivors and their families by the Criminal Justice System to encourage them to come forward to report violence [51] , apply relevant laws and policies, and adjudicate GBV and FV cases affectively.

All actors involved in prevention should collaborate and coordinate with each other and plan activities. Public information messages, awareness-raising campaigns and behavior change strategies should be coherent, consistent, and directly connected to service provision to avoid confusion in the community.

(51) The National Framework for Family Protection from Violence, NCFA, 2006.

GBV and FV Multi-Sectoral Response Programmes

Medical Response

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

Medical services providers are required to practice the following procedures:

1. Ensure confidentiality and privacy, show compassion and facilitate access to medical services.
2. Provide survivors with information about medical procedures, and obtain their informed consent.
3. Provide appropriate medical care to GBV survivors.
4. Ensure medical services are accessible for survivors with disabilities and take into account their specific needs.
5. Ensure referral to and follow-up with other service providers, as guided by the wishes of the survivor and as required by law.
6. Ensure the safety of the survivor at all times.
7. Provide emotional support to the survivor.
8. Ensure documentation and follow-up.
9. Coordinate with the concerned parties to ensure that the survivor is exempted from any fees or medical expenses that the case might entail.

For sexual violence cases, the minimum healthcare standards include [52]:

1. Medical examinations conducted in rooms where privacy, dignity and comfort are ensured for the survivor.
2. History taken and comprehensive examination completed promptly by a healthcare provider (of the same sex or as preferred by the survivor) having adequate knowledge and experience on clinical therapeutic measures for sexual assault, including pelvic/ genital examination, if the survivor consents.
3. Within the set timeframe, treatment of injuries, prevention of diseases, including preventive treatment of post-exposure to (HIV) within 72 hours, STIs, hepatitis and tetanus.
4. Prevention of unwanted pregnancy within 120 hours of the incident.
5. Information documented thoroughly, while maintaining confidentiality and stored securely.
6. Follow-up on care/secondary referral for each case.
7. Doctors and nurses shall provide emotional support tailored to the gender, age and circumstances of the survivor. Training should be provided to all relevant medical providers.

(52) For more information, please refer to the National Guidelines of the Health Sector for Management of Sexual Violence

8. Medical facilities should include a safe space for children and have trained personnel available, who are able to adapt the medical exam and treatment for child survivors.
9. When reporting to FPD or the concerned legal entities, the forensic doctor, when required, examines the survivor with his/her consent then collects forensic evidence to be sent to the laboratory. The forensic doctor provides the preliminary medico-legal report.
10. In children cases, the informed consent of the guardian or caregiver, in addition to the informed assent of the child should be obtained for forensic medical examination procedures.
11. In FPD, the evidence of the forensic medical examination is collected in the forensic clinic in the FPD. However, if the survivor was in hospital, the evidence is collected by the forensic doctor in the hospital.

Medical service providers responding to FV and/or GBV child survivors must have the knowledge, skills, attitudes and tools to provide specialized medical care, and that includes [53]:

1. Understanding child development and child sexual abuse concepts.
2. Communicating effectively with child survivors.
3. Understanding and being able to apply clinical therapeutic care for child survivors.
4. Adapting the medical examination and treatment to meet the needs of child survivors.
5. Ensuring safe and appropriate referrals and follow-up systems are in place.
6. Monitoring activities using established tools.

Psychosocial Response

All actors conducting interview or in direct contact with survivors should adhere to the guiding principles. They should also be aware of their responsibility to listen carefully and give information and provide community-based psychosocial and Community-based support, which includes:

1. Listening to survivors and asking non-intrusive and non-judgmental questions for clarification only. Avoiding pressing survivors with additional questions if they are unwilling to share more information
2. If survivors express self-blame, care providers need to gently reassure them that sexual violence is always the fault of the perpetrator and never the fault of the survivor.
3. Giving honest and complete information about services and facilities available.
4. Prioritizing safety at all times.
5. Avoid telling survivors what to do, or what choices to make. Rather, empower them by helping them to make informed decisions.

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

1. Psychosocial support to assist with recovery and healing, including psychological first aid, individual and group counseling.

(53) Caring for Child Survivor Survivors of Sexual Abuse. IRC/UNICEF. 2012.

2. Support social re-integration, including vocational training and women's empowerment, literacy training, school reintegration and child friendly spaces.
3. Mental health services: survivors who require/request specialized mental health support should be referred to mental health programmes including:
   a. Individuals who might require specialized support include those who are unable to manage their daily tasks, cannot maintain good relationships with others, or are unable take care of their physical health. Individuals with pre-existing mental health problems might also need specialized support.
   b. Acting parties in the protection domain should provide counseling on the available mental health services to survivors who are suspected of requiring such services, and upon their consent, refer them to a specialized service provider.

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

Security/Safety Response

The safety of survivors should always be prioritized. Case coordinators should undertake the following actions (Safety and security plan):

1. Find strategies that enable survivors to stay with their families, and always prioritize safety when required.
2. Explore and address any concerns about social stigma for survivors that may prevent them from agreeing to certain procedures to secure their own safety.
3. Provide safe communication mechanisms so that survivors can contact the case coordinator and vice versa in a risk-free way.
4. Provide survivors with a hotline number call during emergencies.
5. Provide an alternative temporary accommodation while waiting for conclusion of long-term solutions and provide financial support and transfer to the safe location. However, security risks related to this option should always be assessed in addition to ensuring the ongoing monitoring of protection risks.
6. Refer survivors of FV and GBV from urban communities and camps to safe houses (shelters) if in imminent danger. The informed consent of survivors should be obtained (for a child survivor, seek the child's assent and/ or obtain informed consent of the caregiver wherever it is in child's best interest) prior to making any such referrals. Referral to a safe shelter should be the last resort and such a decision should be made through 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 survivors.

Remember, when the survivor is in imminent danger, shelters can be accessed through coordination with FPD, Ministry of Social Development (MOSD) and the concerned Governor to provides shelter in any of the centers affiliated with the MOSD or the Jordanian Women Union (JWU). In the case of refugees and asylum seekers, it is coordinated with the UNHCR:

1. Referrals to shelters require a clear strategy and a case management plan leading towards a solution.
2. When necessary, the referral agency will ensure case follow-up.
3. When necessary, the referral agency will follow-up on necessary measures and procedures including social welfare, medical, and psychosocial services in coordination with the FPD, the MOSD and the shelter home.
4. All actors involved in this process will ensure the safety and security of survivors.
5. All actors will ensure that survivors are treated with dignity and compassion.
    a. Dar Al-Wifak (shelter home) accepts women survivors of violence and their children (boys up to 5 years old, and girls of all ages). The shelter home provides diagnostic and counseling services to women or girls works to resolve the problems and obstacles encountered
    b. Dar El Fatayat Care Home for Girls –a MOSD shelter home- accommodates girl survivors of violence between the ages 12-18 years. Empowering, rehabilitation and community re-integration services are provided at the home.
    c. There are no specialized shelter homes for boy survivors of violence above age 12. However, MOSD shelter homes accepts boy above 12 year sold as an alternative procedure involving FV and GBV cases.
    d. The Jordanian Women's Union shelter provides comprehensive medical care, psychosocial support and legal support to women over 18 and their children directly (girls of all ages, and boys up to 13 years). Girls below the age of 18 can access the shelter in coordination with the FPD. are provided to survivors of GBV at the center.

Legal Response

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

1. Information about existing measures that can prevent further harm by the alleged perpetrator.
2. Information on court procedures, and any issues pertaining to national justice mechanisms, including foreseen timelines.
3. Information on available support in the event that legal proceedings are initiated.
4. Information on the pros and cons of all existing legal options.
5. Legal representation before the court if the survivors wish to litigate.
6. Wherever possible, legal actors and others should provide financial support with regards to

court-related fees and transportation to and from the courthouse by legal actors or others. The survivor to be informed of any other potential costs from the beginning.

7. Child survivors and their caregivers/custodians 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 him/herself and to take part in the decision-making process [54].
8. The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing, and is provided with legal representation before the court.

Police Procedures

GBV cases, specifically cases of sexual violence and other cases of family violence are reported to the legally competent authority after obtaining the survivor's consent and according to the survivor's best interest, or following the mandatory reporting procedures.

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

- Priority is given to emergency medical treatment when deemed necessary prior to any interview with the survivor.
- Interviews with the survivor are conducted in private settings with an officer of the same sex or as preferred by the survivor.
- Cases are handled with extreme confidentiality and FPD uses a coding system for such purposes.
- Informed consent of the survivor is obtained to proceed with the procedures.
- In case of children, guardians/caregivers are informed of the case and their consent for relevant procedures are obtained for implementation of relevant procedures.
- Spatial and qualitative specialty of the department office where the case is reported is indicated.
- Complaints are documented in the registry.
- The forensic doctor is consulted with at all times.
- The forensic doctor issues a medical report, collects and seals forensic evidence samples. The department is responsible for sending them to the laboratory.
- The situation may require the forensic doctor to examine other family members who may have been exposed to or at risk of abuse.
- The scene where the abuse took place is visited if/when necessary, and evidence is gathered to be sent to the laboratory.
- A casefile is opened and procedures are taken to obtain all relevant documents to be sent to the judiciary if/when necessary (see below for details).

1. The results of the investigation are followed-up on at the Judicial Department.
2. Temporary protection is provided to the survivor and/or other family members during the

(54) Caring for Child Survivor Survivors of Sexual Abuse. IRC/UNICEF. 2012

period of investigation if/when necessary.

3. A follow-up on the welfare and safety of survivors is maintained and their access to social, medical, psychological and forensic services is ensured.
4. The perpetrator is held in demand for the legal period if/when necessary.
5. Safe passage of survivors to and from safe houses is ensured.
6. The FPD may refer some violence cases, which involve wider security concerns –such as disputes between tribes or families, or honor crime threats, to the administrative governor.

The procedures taken by the FPD may vary according to the type of violence and whether the survivor is an adult or child as described below. In all cases, the following basic initial steps are conducted [55]:

1. A receptionist takes basic information about the case; including demographic information and information related to FV or GBV.
2. The case is internally referred to the supervisor of case coordinators to classify it according to intervention priority and assign it to a suitable case coordinator.
3. The case coordinator initiates the case management procedures in coordination with the concerned service providers.

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

1. FPD refers the case to the public prosecutor who will decide whether or not to refer the case for court proceedings. In this case, their statement can be used by the public prosecutor and they might be called to testify.
2. FPD refers all cases of sexual assault against adults (men and women) and children to the public prosecutor.

Physical violence against adults perpetrated by a family member (misdemeanors):

In cases of misdemeanors, case proceedings against perpetrators are conditional to a complaint made by the survivor if s/he is an adult. Case management procedures are commenced with the survivor by the case management team to asses risk factors and determine the survivor's needs in accordance with the survivor's best interest and the legislation in force in a way that guarantees the survivor's safety, and insuring his/her participation in the decision-making process (as much as possible).

Physical violence against children perpetrated by a family member (misdemeanor):

In cases of misdemeanors in which case proceedings against the perpetrator are conditional to a complaint from the survivor, the caregiver takes the responsibility of filing a complaint to the public prosecutor, and the survivor -above 15 years- can also file a complaint. Case management procedures are commenced with the survivor by the case management team to asses risk factors and determine the child's needs in accordance with the child's best interest and the legislation in force in a way that guarantees the child's safety, and insuring his/her participation in the decision-making process (as much as possible). Take into account the following:

(55) For details on the case management process methodology in Family Protection Department, refer to the National Procedures Framework for Family Protection against Violence.

1. In cases of physical violence against children perpetrated by a family member, the child is referred to the forensic doctor for examination.
2. The case is referred to the public prosecutor if the medical report indicates a disablement ratio above ten days, and if the general condition of the case is poor or medium or needed admission to hospital.
3. If the forensic report indicates the absence of any bruises or injuries, case management procedures are continued. The child's informed assent is taken into account in all the respective decisions on his/her case. Furthermore, the informed consent is obtained from the custodian/caregiver, and if the custodian/caregiver is not present, the behavior observer working in the MOSD is authorized to give the informed consent on behalf of the child.

Procedures of Governors

Governors deal with the FV and GBV according to the legislation in force. Survivors either file a complaint to the governor or the case is referred to him/her by the FPD. The governor decides whether to consider the complaint on a case-by-case basis, refer it to the FPD based on the nature of the case, or (if it is regarded as high security risk case) refer the survivor to shelter homes pursuant to the provisions of the Women at Risk Shelters By-law for the year (2016), under which women at risk are admitted in shelter homes in accordance with the principles and conditions stipulated in this by-law.

Due to the privacy of family violence cases, a Family Protection Unit has been established in the Human Rights Directorate, in addition to a Family Protection Division in the governorates' centers which fall under the Office of the Governor to maintain privacy and confidentiality of the cases. Security protection is provided while giving testimonies and a written statement is taken from the perpetrator to ensure the safety of the survivor and to take the required administrative procedures.

Judicial Procedures

Civil Court 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 legislation in force. It is noteworthy that there is no special family court to deal with such cases. Survivors can file a regular lawsuit in the Civil Court (Court of First Instance or Court of Magistrate) and/or a civil status lawsuit in the Sharia Court (or Religious Community Council Courts for non-Muslim Communities).

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

Given the sensitivity of cases of sexual violence, judicial procedures are different from those

for physical violence- 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:

1. According to the new Juvenile Law 2014, interviews with children can be videotaped at the public prosecutor's office and used as evidence in court.
2. Hearings for children take place in private chambers, and privacy is ensured at all times.
3. The child will be consulted on the choice for legal justice and made aware of the available services and limitations.
4. 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 him/herself and to take part in the decision-making process.

Sharia Courts Procedures

Sharia Courts deal with Family Violence cases, in particular throughout the stages of case management. Violence cases, many times, can be identified while handling family-related cases. Accordingly, and upon the judge's discretion, the case is followed up directly or through the Sharia prosecution or is referred to FPD for evaluation and follow-up.

The case coordinator should, according to case assessment and needs, and in coordination with the Sharia prosecution, provides all relevant special information and risk factors for review and referral to the Sharia Court.

to make the necessary ruling (money arrest, travel ban on the perpetrator, transfer the child custody or join it to another person or party, etc.), and take the required procedures on all matters related to personal status as divorce lawsuits, alimony and custody.

Family Reconciliation Offices also follows up on cases and provide sharia and legal counseling.

Basic Support Services

In a variety of cases, survivors may need basic assistance in order to ensure their immediate welfare, safety and security. Material assistance, such as emergency food, food vouchers and non-food items (NFI), 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 where the services are provided.

Procedures Specific to Certain Cases of Gender-Based Violence

Sexual Exploitation and Abuse (SEA) by the UN and the Humanitarian Relief Employees [56]

Reporting on exploitation and abuse by humanitarian relief employees is mandatory and the survivors should be informed accordingly, and that all information disclosed is going to be exchanged through appropriate mechanisms.

Protection against Sexual Exploitation and Abuse (PSEA) [57] standards include the following:

1. 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.
2. Sexual exploitation and sexual abuse constitute acts of serious misconduct and are grounds for disciplinary measures, including summary dismissal.
3. Sexual activity with children is prohibited. Mistaken belief in the age of a child is not deemed a defense.
4. Exchange of money, employment, goods or services for sex, including sexual favors or other forms of humiliating, degrading or exploitative behavior is prohibited. This includes any exchange of assistance that is due to beneficiaries.

PSEA mechanisms are currently being established in Jordan. Currently, all incidents of sexual exploitation involving humanitarian workers or refugee workers must be reported to UNHCR. These mechanisms include detailed description of prevention and accountability procedures.

Child Marriage

In Jordan, the legal age of marriage is set at 18 years. Sharia judges may authorize marriage for those who are 15 to 17 years, if the spouses-to-be have completed 15 years and there is a benefit that is determined by standards issued by the Chief of Justice for this purpose.
The Chief Justice in Jordan has issued a special instruction [58] that regulates granting marriage permits by Sharia courts for those who have completed 15 calendar years but have not completed 18 years which are:

1. Determination of the upper limit for age difference between spouses whereby the age of the would-be husband should not exceed 35 years, which is near the average age of marriage for males in Jordan.
2. Requiring the would-be husband to demonstrate through legally accepted proof that he

(56) Reporting mechanisms and procedures are guided by Secretary-General's Bulletin on sexual exploitation and abuse and are applied according to national laws.
(57) Prevention of Sexual Exploitation and Abuse
(58) Under the authorities granted to the Chief Justice pursuant to Paragraph b. Article (10) of the Personal Status Law no. (36) for the year 2010, new instructions will commence on 1/8/2017.

has financial ability to provide for the wife, pay dowry, and furnish a suitable house to ensure the availability of an adequate physical environment for the bride-to-be after marriage.

3. The approval of the matrimonial guardian of the bride-to-be should be ensured before obtaining a marriage permit, in addition to his/her approval to the marriage contract. The disapproval of the guardian is deemed as a bar to granting permission.
4. The marriage permit argument should state the amount of dowry that will be included in the contract, provided that it is not less than the dower of the like to ensure non-violation of her right.
5. The court should ensure the understanding of the bride-to-be of her right to place conditions that will be to her benefit in accordance with the provisions of the law, provided that any such conditions should be listed in the marriage permit argument upon its issuance to be taken into account when writing the contract.
6. The prospective bride and bridegroom are compelled by law to pass a course for spouses-to-be organized by the Chief Justice Department through the Sharia Judiciary Institute, the Family Reconciliation Department or any other body authorized by the Chief Justice for this purpose with a view to raise awareness on key issues pertaining to the continuation of married life such as marital rights and duties, communication skills between spouses, family economics, relevant medical issues and other issues which will be incorporated into these courses.
7. Marriage requests are referred to the Family Reconciliation and Mediation office established under the jurisdiction of the court. The office examines the referred case and advises the court on it.
8. For documentation and accuracy purposes, the Instructions provide that the court should establish a file for each case containing any corroborating evidence on which its decision was based and should maintain official reports of its investigations.

According to Jordanian law, marriage for those below 15 years is not allowed; therefore, Sharia Prosecution offices and FPD offices (who will coordinate with Sharia Prosecution offices) should be notified to examine the case and undertake the necessary actions to stop the marriage.

However, upon receiving existing cases of child marriage, the following services should be provided:

1. Provision of legal aid and representation in obtaining birth registration and marriage certification and when needed, provision of aid on issues specific to the Personal Status Law.
2. Provision of reproductive health counseling and services, including family planning.
3. Access to educational and vocational training.
4. Advice and information regarding available psychosocial services including women's allocated spaces, counseling and couple counseling and referral.

In cases where violence or other protection concerns are disclosed, follow the same procedures carried out in any other GBV case.

Chapter Five: Prevention and Response Programmes for Child Protection Cases

In order to stress the importance of the best interest principle to be applied in all decision affecting children and the state's obligation to implement measures to have the child's best interest appropriately integrated in administrative, judicial and social work proceedings,

Child's best interest is aimed at ensuring both the full and effective enjoyment of all rights recognized in the Convention and the holistic development of the child. Holistic development is interpreted as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development [59] .'

Child's best interest is complex and its content must be determined on case-by-case basis. 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 interest must be assessed and determined in light of the specific circumstances of the child [60] .'

Assessing the child's best interest is a unique activity that should be undertaken in each individual case, in light of the specific circumstances of each child or group of children. These individual circumstances relate to the individual characteristics of the child or children concerns, such as, inter alia, age, sex, level of maturity, experience, belonging to a minority group, having a physical, sensory or intellectual disability, as well as the social and cultural context in which the child or children find themselves, such as the presence or absence of parents, whether the child lives with them, quality of the relationships between the child and his or her family or caregivers, the environment in relation to safety, the existence of quality alternative means available to the family, extended family or caregivers, etc [61] .

of Violence, Exploitation, Neglect and Abuse against Children

All service-providing parties are responsible for child protection (preventing violence, neglect, abuse and exploitation of children) and this is not limited to only institutions concerned with CP.

All parties involved in the CP domain are recommended to take the following actions:

1. Provide or participate in training on child protection, the National Framework for Family Protection against Violence, the National Operating Procedures for the Prevention of and Response to GBV, FV and CP, and other documents and relevant national and international resources in order to adapt them to the sector of intervention.
2. Adopt codes of conduct for all staff on prevention of sexual exploitation and abuse. Related actions include: training all staff; requiring all staff to sign the code of conduct; establishing safe and confidential reporting mechanisms and following-up on reports.
3. Actively seek equal participation of girls and boys in the design and delivery of interventions – for feedback on accessibility to assistance, safety, and security related to services and facilities so as to strengthen the protective environment for children, by assessing and addressing protection issues.

(59) Convention on the Right of Children/C/GC/14
(60) Convention on the Right of Children/C/GC/14
(61) Convention on the Right of Children/C/GC/14

4. Ensure services are inclusive and accessible for all people with disabilities including children and caregivers.
5. Develop and implement CP awareness-raising activities within the community and mobilize support among other humanitarian actors and local government authorities.
6. Institutions should work with different formal and informal parties in local communities (e.g. CP committees) in order to:
   a. Maintain awareness of the risks and issues of CP, exchange of information and lessons learned on the implemented programmes.
   b. Take part in problem solving discussions to continuously strengthen the prevention strategies.
   c. Actively promote respect for human rights and children's rights, and support the role of children and youth as equal decision makers.
7. Reinforce and activate the role of schools in the implementation of extra-curricular activities.
8. Reinforce the role of parents/caregivers councils in schools.
9. Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described in these SOPs.

Child Protection Services and Procedures

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

Community-based Child Protection, Psychosocial Support and Mental Health Services

Community-based child protection and psychosocial services aim to mobilize and support community members to better protect and support children affected by violence.

These types of services should be available to all children. However, children who are direct survivors of violence, abuse, exploitation or separation from their parents particularly benefit from these activities. They should be integrated into activities with other children to avoid stigmatization and promote social integration. These activities should be implemented in a coordinated manner by CP institutions to ensure coverage and equitable access to these services for all children, avoid duplication of services and ensure a harmonized approach among different institutions that meets international standards and is culturally/contextually appropriate.

Community-based Child Protection Mechanisms (CBCPM)

Community-based child protection mechanisms - often termed 'child protection committees' - are "networks or groups of individuals at the local community level which work in a coordinated manner towards achieving child protection goals which include local and traditional structures or informal procedures for promoting or supporting the welfare of children". [62] These committees are responsible for:

1. Working on prevention of abuse, violence and exploitation of children.
2. Raising awareness and acceptance of existing child protection and other services for children in communities.
3. Identifying key child protection issues, mobilizing communities and advocating with relevant actors to address these issues.
4. Identifying child protection cases, mobilizing community resources and referral to formal service providers including child protection case coordinators or other relevant service providers. Child protection committees should be trained on how to identify and refer cases as per the CP referral pathways.

Child Friendly Spaces (CFSs)

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 a sense of normalcy for children who have experienced violence and displacement." CFSs should be established and operated in line with the following guidelines [63]:

1. All children in the community including children who have directly experienced violence should have access to CFSs.
2. Provide age and gender appropriate activities for younger children (6-12 years) and adolescents (13-18 years).
3. Ensure active participation of children and community members, including engaging family members in supporting their children.
4. Provide a range of services including psychosocial services, non-formal education, recreational activities and life skills training for children; in addition to awareness and discussion sessions with parents/caregivers and family members on how to support and care for their children in difficult situations.
5. Provide safe, supportive and stimulating environments for children.
6. Child friendly spaces should be inclusive for all children, including children with disabilities, and ensure integrated activities.
7. Include older persons and persons with disabilities as volunteers in CFS activities.

(62) Minimum Standards for Child Protection in Humanitarian Action.CPWG.2012, p.143.
(63) Guidelines for Child Friendly Spaces in Emergencies 61 and Standard 17: Child Friendly Spaces from the (CPiE) Minimum Standards

8. Identify and, where appropriate, refer children who need protection.

Other Types of Community-based Psychosocial Activities

All child protection actors should ensure the provision of timely and appropriate psychosocial support to children, including children with disabilities and the integration of this process into their child protection response. The key step are as follows:

1. Coordinate mental health and psychosocial support services according to the IASC intervention pyramid, from interventions that benefit all community members to more specialized mental health services along with other sectors such as education and health care [64].
2. Train CP staff on the effects of violence and related issues on children's and adults' psychosocial welfare.
3. Provide child protection services in a way that promotes self-healing.
4. Provide basic emotional support to children and families through approaches such as psychological first aid (PFA) [65].
5. Respect the basic 'Do no harm' principle. Avoid pressing children and caregivers to share their personal experiences beyond what they would naturally disclose, and do not use clinical terminology to describe children's normal reactions (for instance, 'trauma', etc.).
6. Involve the affected community in the planning and implementing of child protection and psychosocial activities.[66]
7. Identify and refer children and families experiencing severe mental illness to appropriate mental health services.
8. In addition, CP and psychosocial actors should work together in ensuring that children affected by violence and other related issues have access to structured psychosocial services within and managed by the community, to support children's psychosocial welfare [67] The services include:

- Structured training sessions on resilience building and life skills, to help strengthen children's coping skills.
- Awareness sessions for caregivers enabling them to better support and care for their children within the community.
- Implementing "peer support and education" activities and youth mentorship programmes.
- Supporting children's engagement in recreational, sports, cultural and civic activities [68].
- Implementing community-based social support activities for caregivers (for instance, women's groups, reestablishment of religious activities) that has a direct positive impact on children's protection and welfare.

(64) Guidelines for Child Friendly Spaces in Emergencies 62 and Standard 17: Child Friendly Spaces from the (CPiE) Minimum Standards
(65) IASC Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Coordinators Know? IASC. 2010
(66) IASC Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Coordinators Know? IASC. 2010
(67) See pyramid 'Level 2 Community and Family Supports' in IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, IASC, 2007.
(68) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007.

- Integrating these activities into CP programmes and activities rather than creating stand-alone psychosocial services.[69]

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, behavioral or social problems that require professional services such as counseling or case management. CP services should either include these types of services in their programme or establish referral pathways to them. These services include:

1. Case management services (see Chapter 3).
2. Individual counseling, couple and family counseling.
3. Group counseling.
4. Support groups.

These services should be provided in a way that maintains confidentiality and enables children and their caregivers to exercise control and choice in shaping the support they wish to receive. They should be integrated into wider systems to reach more people, increase sustainability and reduce stigma [70] Services should be provided to all children in need, including those who are direct victims of violence, abuse and exploitation.

Mental Health Services

Children experiencing a mental disorder or levels of distress that lead to impaired functioning should be referred to mental health services. Any general CP service provider who is uncertain if a child requires mental health services can refer him/her first to CP case coordinators and/or counseling services, who on their part will conduct an assessment and determine the type of psychosocial/mental health service required.

Security and Protection Services 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 each child at risk of experiencing further violence is provided with services to ensure his/her safety. The key parties involved in providing protection and security services include the Public Security Department (PSD), border police, Family Protection Department and governors.

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

1. Ensure police patrols in areas where children are particularly at risk, and maintain adequate security presence in camps and community areas with high concentrations of refugees.

(69) Mental Health and Psychosocial Support in Humanitarian Emergencies: What should Protection Programme Coordinators Know? IASC, 2010.
(70) IASC Guidelines on Mental Health and Psychosocial Support.

2. Ensure that security staff-including border patrols and security officers in refugee camps-are adequately trained on issues related to violence, exploitation and abuse of children.
3. Organize awareness sessions for police and/or FPD (and UNHCR in cases of refugee children) on reporting mechanisms related to violence against children.
4. Involve FPD and other actors in monitoring incidences of violence, abuse and exploitation against children, and collaborate with security actors in developing and implementing standard response to common forms of violence.
5. Establish links, at local level, between community-based CP 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.
6. Ensure that personnel working in shelter homes have adequate information and training on CP issues, including unaccompanied and separated children, sexual exploitation and abuse, and exploitative child labor, and ensure that they have signed the code of conduct and received the required relevant training [71].

Procedures relevant to child survivors and/or children at risk of violence include:

1. General service providers who identify child violence cases or children at risk of violence should provide information about the children and their caregivers to child protection case coordinators and the FPD.
2. Child protection case coordinators dealing with cases of violence against children makes 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 him/her and, where appropriate, their caregivers.
3. A safety plan could include: actions that can be taken by the child and/or his/her caregiver; working with other persons known to the family/child to ensure her/his safety; involving child protection committees/ networks; reporting to FPD (see details on FPD procedures below); reporting to the Public Security (in case of physical assault of a child by a non-family member); based on the court's decision, it is possible to place the child in a superseded alternative care arrangement within the community, or – as a last resort, within in a child care center/ shelter provided that this decision is made according to the comprehensive risk factor assessment for the child and his/her family, taking into consideration the child's best interest and in accordance with legislation in force.

Removal of children from their families for neglect and/or security reasons can only be done by FPD via a judicial decision from the relevant court. When children are removed from their family for their safety, they should be placed with another member of the extended family, if safe, supportive care can be provided. FPD is authorized to remove children and place them with another family member or in a shelter, on the basis of a court order of the relevant court. The children's informed assent is taken into account in accordance with their age and developmental level with regard to decisions relating placement of the children with a family member. If a child needs to be removed from his/her current care arrangements and placed in a shel-

(71) Minimum Standards for Child Protection in Humanitarian Action, CPWG, 2012.

ter or an alternative family, this must be approved by the competent court. Caregivers who have the temporary custody of the child can provide safe accommodation for the duration of the judge verdict (which can be renewed and extended based on the assessment of MOSD and relevant CM actors involved) and with continuous training provided to the care givers [72].

Placing children in shelters should be a last resort and a temporary measure only. Community-based alternative care mechanisms are seen to be preferred over institutional care arrangements given the one-to-one care and family-like living environment. If seen to be the last resort and according to the child's best interests, the below programmes are currently available.

1. The MOSD manages several home shelters for children in need of protection according to the special admissions standards for each shelter. Referrals should take place through FPD following the approval of the Juvenile Judge and based on the report of the behavioral observer from MOSD.
2. Child care centers/ shelter homes provide integrated services for children including education, mental support and medical services, and facilitate the visits of family members when appropriate.
3. Governors have the main responsibility to ensure the safety and security within their respective geographical regions. Therefore, cases of violence against children related to broader security issues such as disputes between tribes and families may be referred to them. In addition, FPD may refer the case to the governor for further interventions. (see below).

Family Protection Department Services for Child Protection Cases

The Family Protection Department (FPD) has branch offices all over the Kingdom to manage cases of family violence, neglect and sexual abuse against children in Jordan. Family violence, neglect and sexual abuse can be referred to FPD by workers of governmental institutions and UN agencies, in addition to non-governmental national and international organizations. Additionally, any persons can also approach FPD to report abuse against her/himself. Cases of physical assault against children perpetrated by non-family members are addressed through the police stations and the Juvenile Police Department.

The FPD provides –through its partners- integrated medical, legal and psychosocial services to child survivors of violence and their families, following the below steps:

1. A receptionist takes basic information about the case including demographic information and information about the type of violence.
2. Children in need of immediate medical treatment are referred for medical care treatment prior to being interviewed.
3. FPD hears the testimonies related to the violence case, including interviews with the child, family members, other witnesses and the alleged perpetrator, when appropriate. Inter-

(72) For more details, refer to UASC SOPs.

views are conducted in a child-friendly manner, taking into consideration the age and maturity of the child. Interviews with child survivors of violence are videotaped as appropriate and according to legislations in force. Due consideration shall be given to privacy and confidentiality and children or survivors shall be interviewed separately where appropriate given the age of the child. Girls should be interviewed by female FPD staff systematically.

4. All cases are handled with confidentially and the informed consent of the child's caregiver is obtained in line with the best interests of the child.
5. The child survivor of violence, and where necessary, the alleged perpetrator, are referred to the forensic medicine unit for evidence collection.
6. FPD liaises with the relevant security departments in accordance with the case requirements.
7. FPD can refer the case to the judiciary when appropriate (See below for more information on how cases are referred to judiciary).
8. FPD will follow-up on the safety of the child, ensuring access to social care services, medical, forensic and psychological services.
9. Social workers can conduct family visits/case studies of the family, and provide psychological and social services and family mediation for the child and the family when appropriate.
10. FPD can refer the case to the competent governor to take the required administrative procedures, such as to have the alleged perpetrator sign a pledge to not harm the child again.
11. Where required, for the safety of the child, as described above, FPD can remove the child from the family and place him/her in alternative care arrangements. This should be done by court order which is based on the report and recommendations of the case management team and following the best interests of the child and legislation in force.

Physical or sexual assault against children (felonies):

The Family Protection Department refers the case to the public prosecutor who decides whether to refer the case to court or not, and case management procedures are continued. The videotaped deposition/interview can be used by the public prosecutor in the case.

Physical violence against children perpetrated by a family member (classified as a misdemeanor):

1. If the forensic report indicates that the child has experienced violence that resulted in bruises or injuries, the FPD refers the case to the public prosecutor, regardless of the wishes of the child/caregiver.
2. If the forensic report indicates the absence of any bruises or injuries, case management procedures are continued. The child's informed assent is taken into account in all the respective decisions on his/her case. Furthermore, the informed consent is obtained from the custodian/caregiver, and if the custodian/caregiver is not present, the behavior observer working in the MOSD is authorized to give the informed consent on behalf of the child.

Additional Administrative Procedures for Child Protection Cases

The required administrative procedures to prevent delinquency risks and youth deviance are taken to prevent juveniles from entering any tobacco shops, night-clubs, pubs and coffee shops, etc., and refer cases of abuse and neglect against children to the competent juvenile court by the governor to take the required procedures. Moreover, any person who exploits a juvenile for begging purposes is arrested, questioned and referred to the competent court to implement the penalties stated in the law.

Judicial Procedures for Child Protection Cases

Cases of violence against children are referred to the 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 alternative families).

Special child-friendly procedures include:

1. Interviews with children shall be videotaped at the FPD Office and used as evidence in court according to the legislation in force. Closed Circuit Television (CCTV) networks are also available in some courts in addition to the Grand Criminal Court which play an essential role.
2. Hearings for children take place in private chambers, and privacy is ensured at all times.
3. The child is consulted about the option for legal justice and made aware of the available services and limitations.
4. The child's rights, needs, views, and feelings are taken into consideration and every effort is made to enable the child to express him/herself and to take part in the decision-making process.

The Sharia court is concerned with all personal status laws related to CP cases. Sharia prosecution studies the case and its data, and coordinates with the Sharia Court to approve procedures and take the required decisions, including custody, guardianship and alternative care procedures, etc.

Legal Aid in Cases of Violence against Children

Special legal aid programmes are available in some of the civil society institutions for child protection cases whenever: 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 in the Sharia Court; or in case of alternative families or family members caring for separated children wishing to be granted legal custody of them [73].

(73) There are guidelines issued by the UN General Assembly on how to receive legal aid in the forensic justice systems no. 67, (1987) regarding the legal aid in Cases of Violence against children.

Legal aid should include the following:

1. Child survivors and, where appropriate, caregivers are provided with information and consulted on the legal and court proceedings and made aware of the available services and their benefits/limitations.
2. The child's needs, wishes and feelings are taken into consideration and every effort is made to enable the child to express him/herself and to take part the decision-making process.
3. The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing.
4. Legal representation is provided in court.
5. 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 costs implication from the beginning.

Procedures Specific to Juvenile Cases

Cases related to juveniles are dealt with in accordance with the Juvenile Law 2014, where they dealt with by Juvenile Courts. **Minimum age for criminal responsibility** in Jordan is twelve years [74].

Arrest and investigation:

The Juvenile Police Department deals with children in conflict with the law. During the interrogation of a child, a parent/ caregiver or a lawyer must be present. If none of them are available, a probation officer (behavior observer) must be in attendance [75].

The presence of a trusted person is important to safeguard the rights of the child during interrogations, especially the right not to be pressured into a confession [76].

Dispute resolution:

As part of the restorative justice pathways, the Juvenile Police Department is responsible for resolving conflicts in contraventions and misdemeanors for penalties under two years, based on the consent of the conflicting parties to the resolution of offenses which are conditional to the complaint of the aggrieved person.

The dispute resolution judge takes the responsibility of such settlements when the parties are not able to reach an agreement. The judge can also refer the dispute to parties or persons capable of reaching a settlement to avoid exposing the delinquent to the litigation system which may affect his/her behavior negatively, and drag him/her into crime. In addition, the judge may impose alternative measures and non-custodial penalties that enable rehabilitation and reintegration of the juvenile in society.

(74) Juvenile Law no. 32 (2014).
(75) Juvenile Law, Article 15
(76) Penal Code, Article 208

Police custody:

According to the Juvenile Law, only the Judiciary has the authority to detain children in juvenile detention centers which are operated by the MOSD and under the supervision of ministry personnel[77].

However, juveniles may remain in police custody for up to 24 hours in juvenile detention centers supervised by MOSD before being presented before the public prosecutor.

Children in conflict with the law are most vulnerable and in need of protection during the first 24 hours after they are arrested and questioned. Hence, children have to be held separated from adults throughout the interrogation stages, trial and execution of sentence [78].

They should not be handcuffed, subjected to any use of force, or isolated, except in cases where they show violence or disobedience, and only as appropriate [79] .

Legal representation:

Suspects, including children, have the right to representation by a lawyer throughout an investigation [80].

The investigation phase is initiated by the public prosecutor, but defense attorneys are permitted in the investigation and trial stages, but it is not mandatory. Free legal assistance is provided by several organizations, such as the Legal Aid Unit in the Human Rights Department in the Ministry of Justice established in 2015. Regulating Instructions for Ministry of Justice's Legal Aid no. 1 for the year 2016 were issued and published in the Official Gazette.

The presence of a lawyer with the juvenile in the offenses that constitute felonies is mandatory as per the Juvenile Law. According to the Code of Criminal Procedures, the court should provide a lawyer for the juvenile if she/he is unable to appoint one.

Bail out procedures:

Every child suspected of having committed a misdemeanor should be released from pre-trial detention if he/she provides a bail bond. [81]

In the case of an alleged felony (for instance, physical or sexual assault, etc.), this is only possible if special circumstances are found in the case. Usually, authorities demand that the caregiver 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 settlement methods that are applicable in customs and traditions. Often, short-term detentions could be avoided, if caregivers are willing and able to receive their child immediately from the police or the detention center. In some cases, children remain in detention because they have no other place to stay, or should not return to their caregivers for their own safety.

Pre-sentence detention:

1. If the juvenile is to be detained (pre trial) for a misdemeanor, s/he should be released for a bail bond or a personal pledge, or a cash guarantee that ensures his/her attendance in the

(77) Juvenile Law no. 32, Article 8, (2014)
(78) Article 5/a of the Juvenile Law no. 32, (2014)
(79) Article 4/d of the Juvenile Law no. 32, (2014)
(80) Article 9/a of the Juvenile Law no. 32, (2014).
(81) Article 16 of the Juvenile Law, 1968 and its Amendments.

interrogation stages or trial, unless the juvenile's interest requires otherwise.

2. The public prosecutor or court can release the juvenile detained (pre trial) for a crime if the case circumstances or the juvenile's state entails it, in return for cash or judicial bail bond which guarantees the juvenile's attendance to the interrogation or trial.
3. The juvenile detained on charges of felony or misdemeanor is detained in the Juvenile Education and Rehabilitation Facility for no more than ten days, while taking into account his/her best interests [82].
4. The public prosecutor can renew the detention of the juvenile once; accordingly, s/he should report this renewal decision to the Juvenile Education and Rehabilitation Facility in writing. Moreover, if the interrogation requires continued detention, the public prosecutor should request an extended detention, from the court, for no more than ten days.

Trial/sentencing:

Jordanian Law provides less severe penalties on children compared to adults. The maximum custodial sentence in juvenile rehabilitation homes inflicted on children aged 15 and older is 12 years. For those aged 12 to 14, the maximum custodial sentence is 10 years [83].

For cases of less risky misdemeanors and felonies, non-custodial measures such as reprimand from the judge, vocational training and public service and other measures (Instructions on Principles for Applying Custodial Penalties of 2015, Article 3) [84] are available. A child guilty of a felony under 12 years are in need of protection and care; a decision could be issued to place the child with a parent/custodian, or care institution, or appoint a probation officer (behavior observer) to supervise the child. [85]

The defense attorney [86] have the basic defense rights, such as the right to cross-examine witnesses, to call witnesses for the defense and to make copies of the case file [87].

Execution of custodial sentences:

Children deprived of their liberty can be visited by their caregivers and relatives on a regular basis. Children in detention enjoy basic rights, such as the right to education. Article 32 of the Juvenile Law provides for the possibility for an early release of children if one third of their sentence is served and other conditions are fulfilled.

Key responsibilities of police and prosecution are to:

1. Inform parents/caregivers of the child immediately after the arrest. In case of child refugees, inform UNHCR Child Protection or Detention Departments.
2. Handover the case to specialized police departments (JPD) whenever possible, and as early as possible.

(81) Juvenile Law, 2014
(82) Juvenile Law, Article 258, 26 and 124
(83) Ibid
(84) Juvenile Law, Article 33
(85) Code of Criminal Procedures, Article 221/1
(86) Code of Criminal Procedures, Article 175/2

3. Ensure that parents/caregivers, lawyers or probation officers are able to attend interrogations.

Key responsibilities of general humanitarian actors are to:

1. Seek the assistance of a lawyer or an organization specialized in juvenile justice before undertaking or suggesting any actions that might have legal implications.
2. Respect relevant laws; ensure the child's and caregivers' consent for any procedures, in addition to the best interest of the child.
3. Be especially aware of risks affecting the safety of the child due to acts of revenge or honor crimes.
4. Encourage persons trusted by the child, in particular caregivers, to attend interrogations, visit children in detention, and to support their reintegration after release.
5. Provide medical, psychosocial or other services needed by children in conflict with the law.
6. Report to the (JPD), where present, any arrested or detained refugee child. Report to the UNHCR also. Report child rights violations against refugees to the UNHCR focal point officers.

Key responsibilities of legal aid organizations are to:

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

Other Services

Child protection cases may need basic services, such as health, education and material assistance in order to ensure their immediate welfare, safety and security. This section will provide information on services provided by other sectors that are important when responding to CP cases. For example, in cases where a child is involved in child labor, supporting families through self-reliance opportunities is essential in helping a child return to school.

Health Services:

Primary, secondary and some tertiary health care services are available to all children under 6

years of age, either free of charge or under insurance coverage based on nationality and legal status in Jordan. To access health services, the patient should show the health registration card or the registration certificate issued by UNHCR to be able to receive services.

Vaccination services, antenatal care and postnatal care are provided free of charge at governmental health centers regardless of nationality and registration status.

Basic medical services for child protection cases include:

1. Access to primary health care services.
2. Treatment of severe injuries.
3. Access to MHPSS (Mental Health and Psychosocial Support Services).
4. Referrals to other relevant and specialized services.
5. Life-saving interventions for injured/wounded children and surgeries.
6. Vaccination and treatment of infectious diseases.
7. Medical documentation.
8. Follow-up care.

Educational services:

Educational services are considered one of the most important services provided in child protection programs and access to these services must be ensured to all children without discrimination based on race, color, race, nationality or disability.

And all measures for dealing with all children, including children with disabilities, must guarantee the fundamental right to education. And those services are provided as follows:

Formal education:

Approved and accredited educational programs offered by public and private schools (grades 1-12) and the target group includes students from the age of 6 to the age of 17 in accordance with the Education Act of 1994 and its amendments.

Non-formal education:

1. Adult Education and Literacy Program

This program aims at completing the education of those aged 15 years and more, who cannot read and write, through integrating them in the program and through providing them with the reading and writing skills and the various life skills. This is done through an integrated cycle of educational programs, starting from the first grade to the secondary school, which are provided by the ministry of Education such as Arabic language, Islamic education, mathematics, general culture, computer skills and English language.

2.Home studies:

This program aims to implement the concept of sustainable education and self-learning and

aims to allow those who left regular school to submit the exams in public schools with regular students at the end of each semester. And if one of them successfully passed the exam, he or she will be promoted to the next grade and all the principles of success, completion and repetition of that grade will be applied on him or her according to the formal education regulations. Through this program, the student can take the general secondary school certificate.

3.Evening studies:

This program aims to create suitable educational opportunities similar to the regular study environment for people who left regular school by joining these centers. They serve post-illiterate students from the seventh grade through the second grade. And those who are enrolled in these studies can apply for the General Secondary School Certificate.

4. Programs of academic studies (evening studies and literacy centers) in rehabilitation and rehabilitation centers:

This program provides educational services to the residents of the rehabilitation centers in order to contribute to their integration into the society by opening adult literacy centers in the rehabilitation centers, securing their books and stationery, paying teachers' salaries and providing the necessary facilities for those wishing to apply for the secondary school exam, And the Ministry of Education pays the general secondary examination fees for the residents of the center.

5. Program to improve the culture of the dropouts:

This program aims to provide drop out students with positive behavioral patterns of different habits, trends and values, provide them with better life opportunities and expand their options. The duration of this program is 24 months. The student will be enrolled in three learning cycles with duration of (8) months each and the learning
process is supervised by the Ministry of Education.

6 . Retract Education program:

It is an intensive educational program aimed at providing basic education for children who are out of school within the age group (١٢-٩) years. It is a compensatory opportunity given in three intensive levels of education for the first six basic grades (grades ٦-١) over three educational years, and it is implemented and supervised by the Ministry of Education. The program seeks to enable children who are not enrolled in formal education from the age of ١٢-٩ years to complete their education either by qualifying them for formal education or non-formal education programs, in additions, the program aims to reduce the school dropout rate of formal education in order to reduce illiteracy and child labor.

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 play a critical role in responding to various child protection cases, particularly child labor, child marriage, families caring for separated children, unaccompanied children or those who have dropped out of schools.

Cash assistance, small business enterprise opportunities, winterization support, education,

tuition fees, and other basic needs can be provided. This is based on a household assessment and can be extended if required on the basis of the child's best interests [88].

Cash for work and cash assistance programmes should be inclusive, making it accessible to persons with disabilities

Procedures Specific to Child Protection

Physical Violence

Physical violence takes a number of forms, and can occur 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 at schools, homes or in the community and can range in severity from mild to severe.

Physical violence in the family

1. Children who experience physical violence have the right to be provided with health, psychosocial, and educational services.
2. Children, aged 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, in addition to awareness raising sessions).
3. General service providers who identify children experiencing physical violence by a family member should refer them to a qualified CP case coordinator or to the FPD after obtaining the child/caregiver's consent. If the child/caregiver does not consent, the general service provider can refer to FPD, if they believe that the child's safety is at risk. If unsure, general service providers should consult with a child protection case coordinator without providing identifying details of the case.
4. CP committees and staff can help identify children at risk of or experiencing violence and help them access appropriate services.
5. Caregivers who use physical violence against their children should be supported with appropriate guidance, mentoring or counseling to prevent the violence including: positive parenting/caregiver skills including positive discipline; anger management; counseling to address causes of the violence; and/or family mediation.

Physical violence in the community (non-family related violence)

1. Children who are victims of physical assault, as defined under the Penal Code, perpetrated either by adult non-family members or other children, can report this to the police who will conduct an investigation. For children under 16, the complaint must be made by the

(88) UASC SOPs, UNICEF, 2013; Syria Regional Response Plan 2013, UNHCR, 2012

child's parents/caregiver, while children in the age of 16 and above can make the complaint themselves. Articles 333, 334 and 335 of the Penal Code define physical assault as follows: "hitting, cutting, or harming someone through any impactful act of violence or assault including what results in sickness inability to work."

2. Child survivors 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.
3. Caregivers of child survivors of violence should also be offered awareness-raising sessions on CP issues to help protect their children.
4. Child perpetrators of violence against other children should be offered information and services on their child rights and life skills (including managing emotions) as well as psychosocial support to deal with underlying causes of this violence, if required. Caregivers of these children should also be involved in any psychosocial services for these children.
5. Child perpetrators of physical assault (and other crimes) should be treated in accordance with the relevant Juvenile Justice Standards.

School Violence

The use of physical punishment by educational staff, including teachers and school management, is prohibited in the schools of the MOE under the Civil Service Regulations 2013, Article no.82 and its amendments. However, physical abuse is still being used as a punitive action and is registered within the host and refugee community.

To reduce the prevalence of violence in schools and based on the national study (2007) to identify violence levels children experience at schools in Jordan, the Ministry of Education in cooperation with UNICEF and other concerned parties developed a national campaign plan titled "Ma'An (Together) Towards a Safe School Environment". This plan aims to promote positive disciplinary methods among teachers instead of punishment to reduce violence in schools, especially violence of teachers against students with a view to create a behavioral change among teachers in MOE, UNRWA schools and Military Culture Schools. It promotes the use of educational methods to guide and adjust students' behavior at schools in line with the message of education in a manner that ensures a better future for generations and societies.

Violence among students is prohibited under the School Discipline Regulation no. 5 for the year 2017. Moreover, workers at the educational institutions are prohibited from using any form of physical punishment against students under the Civil Service Regulations 2013, Article no. 82 and its amendments.

The MOE Protection/Counseling Directorate represented by the Protection and Safe Environment, and Counseling units monitors and follows up on violence cases in schools through the hotline and the implementation of the monthly computer-based survey. Moreover, in coop-

eration with the partners, MOE conducts several training workshops to raise the professional skills of teachers and counselors to help them in dealing with students' problems to reduce school violence rates, in addition to implementing a group of programmes targeting students in order to develop and improve their self- enhancing skills, and endow them with skills to promote their positive behavior through the implementation of several activities and initiatives that reduce violence in schools.

MOE procedures related to the management of school violence cases:

1. Reports of violence and abuse of teachers against students are received through the MOE hotline by self-reporting or by the guardian or service providers according to the cooperation agreements in place.
2. The departments involved in the complaint to be contacted to form committees to verify/ investigate the complaint and take the required procedures in accordance with the Civil Service Regulations 2013, Article no.82 and its amendments.
3. Counselors should deal with violence cases among students inside schools according to the case management methodology by providing adequate counseling services such as (case study-group counseling- collective guidance classes…) and coordinating for the provision of other needed services.
4. Cases related to family violence should be referred to the concerned institutions (FPD) when detected at schools through formal procedures adopted by the MOE.
5. The case file is closed according to the case management methodology once the required procedures are taken by the Protection and Safe Environment and the Counseling Units (according to procedure).

Child Labor

Child labor is a pressing issue amongst children of Jordanian or other nationalities residing in Jordan which has a negative impact on the child's education and development as well as overall well-being. Jordan has ratified the International Labor Organization (ILO)'s Child Labor Conventions [89] 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 years, and education is compulsory up to the 10th grade. It is therefore illegal for children under the age of 16 to be employed. Child labor also includes labor carried out by children who have reached the minimum working age (16), but where the work done is harmful to their emotional, developmental and physical well-being.

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 Ministry of Labor (MOL) in June 2011 that includes: bodily hazards, psychological, moral and social 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.

(89) ILO Convention No.138 on Minimum Age of Employment (1973) and No.182 on the Worst Forms of Child Labor (1999).

Children aged 16-18 years shall have the following conditions on their employment:

1. They cannot work more than six hours per day and must be given a break of at least one hour after every four consecutive working hours.
2. They are not allowed to work between 8:00 pm and 6:00 am or on religious feasts, public holidays and weekends.
3. The employer must request the following from the child's caregiver: birth certificate; child's certificate of health for the required work issued by a doctor and approved by MOH and a written approval of the child's caregiver for the child to work in the establishment.
4. The employer must keep these documents in a special file for the child, with information on his/her place of residence, date of employment, the nature of work assigned to the child, wages and leave.

The National Framework to Combat Child Labor (NFCL):

In August 2011, the Jordanian government endorsed the National Framework to Combat Child Labor (NFCL) which serves as a National Reference Document that defines principles for addressing child labor issues and the roles and responsibilities of different bodies in order to provide services to working children and their families in an integrated holistic manner that can protect children from entering the labor force, and thus return to their natural place in school.

The third chapter of the Framework addresses the protection from child labor and its importance as an inseparable part from the integrated system of protection against child labor, and elaborates on suggested roles for the concerned parties. The community-based awareness programmes are emphasized due to their significance in promoting programmes that aim at combating child labor. The fourth chapter clarifies the response process to combat child labor through education with its four stages, from assessment and reporting to evaluation and intervention process. It also highlights the activities that require collaborative work, through case conference which is part of the intervention, reporting and closure stages, to achieve integration in the provision of services to the child and his/her family and ensure that the child has the opportunity to pursue his/her education. Moreover, the framework clarifies the roles of the concerned parties and sets the practical recommendations, in addition to the case assessment conference to ensure that the previous intervention process is successful for the ministries to proceed with implementing the framework.

The NFDL sets out mechanisms to respond to child labor through the following stages:

1. Detection and reporting
2. Initial assessment which includes assessment of the needs of the child and his/her family and formulation of appropriate recommendations and referral (to appropriate services).
3. Intervention stage.
4. Follow-up and evaluation.

The framework has been pilot-tested. A procedural manual has been developed for the implementation of the framework, outlining stages, information, data, implemented studies and the intervention follow-up and evaluation tools. Nevertheless, it is not yet fully operational due to shortage of staff working in the area of combating child labor and the lack of jurisdiction at that time. The framework is currently being updated to comply with the latest amendment introduced to the Juvenile Law, which grants the Ministry of Social Development (MOSD) the authority to work with child workers as children in need of protection and care, in addition to child beggars, dumpster divers and street venders. The framework defines explicit responsibilities of the three key ministries involved in the area of child labor which are: MOL, MOE, and MOSD. Furthermore, an electronic national monitoring system (framework stages) has been designed by ILO and MOL to form a new national database for child labor to assist in data collection, analysis and monitoring which is still not operational either.

The following support should be provided to the child involved in labor by qualified governmental and non-governmental child protection case management organizations:

1. Assess the situation of the child and family by qualified child protection case coordinators.
2. Assess the risk factors and report to concerned entity to handle the case.
3. Provide counseling to children and their families regarding the risks of child labor and what's contained in the Jordanian law in relation to child labor.
4. Provide information to child and families on education and vocational training options, and refer them to these services as appropriate.
5. Involve children and/or families in the psychosocial services and child-centered programmes.
6. Follow-up and monitor children and their families to ensure their access to services and reduce the risks of continuation or return of the child to work.
7. Assess the eligibility of the family for cash assistance through the National Aid Fund and other assistance. The refugee children assistance is provided through the UNHCR.
8. There should be concentration on GBV cases at the work place and coordination with various parties in order to protect children from any sort of physical or sexual assaults. In addition, legal procedures should be taken against any work place where such cases are proven to exist under the provisions of the Labor Law, which could lead to the closure of the work institution.

Procedures Specific to Response to Child Protection Cases in Crises

The below sets out particular procedures for refugee and asylum-seeker children. The overall protection of refugees is primarily the responsibility of the host government. Jordan is not a signatory to the 1951 Refugee Convention and its related Protocol but has offered generous support to the large number of refugees on Jordanian territory particular following the Syria Refugee crisis in 2011. Humanitarian agencies play an important role in supporting the Government of Jordan in extending protection and assistance to refugees. Child Protection is one

of their priorities given the considerable number of refugee children affected by the crisis and their heightened vulnerability.

Birth Registration

According to the Convention on the Rights of the Child (UNCRC), all children have the right to a registered name at birth, nationality and, to the extent possible, knowledge and care of their parents. As refugees and asylum-seekers might not always have the necessary documents on them to register births, the Jordanian Civil Status Department and the Chief Justice Department have adopted administrative procedures to facilitate birth registration including having a proof of marriage and affiliation of all children born on Jordanian land. Any family facing challenges in this regard, should be referred to appropriate legal service providers in accordance with the referral pathways. UNHCR has reached an agreement with the Civil Status Department regarding the minimum documentation requirements. The Department is working in Syrian refugee camps to collect birth certificate applications, review documents, instruct families on procedures and issue birth certificates and deliver them to families to avoid delays and incurred fines. Refugees living in host communities can contact any nearby branch of the Civil Status Department and obtain these services.

Unaccompanied and Separated Children [90]

As highlighted above, children have the right to be taken care of by their parents. Those unaccompanied or separated from their parents or relatives maintain the right to appropriate care under either community-based foster care arrangement, or – as a last resort – under MOSD run child care centers (see above under specific procedures on accessing alternative are and child care centers.

In 2015 it agreed to formalize alternative care arrangements for unaccompanied and separated refugee children within the Jordanian judicial system. This process includes legalizing care arrangements for this group through the Jordanian legislation in force based on the best interests of the child on a case-by-case basis.

Children Associated with Armed Forces and Armed Groups (CAAFAG)

Children are at high risk to be recruited or used by an armed force (government military or other security forces) or armed (opposition) groups in any capacity, including children being used in support activities or active fighting. Those children are exposed to physical developmental emotional mental harm. Protection and reintegration of CAAFAG should be sought at all times. All humanitarian actors should focus on prevention and identification of high-risk groups.

Key procedures to prevent and address children associated with armed forces or armed groups (CAAFAG) are:

1. If children are identified as having been recruited or used in the conflicts by government

(90) A definition of Unaccompanied and Separation is to be a found in the definition chapter relating to Child Protection.

forces or by armed groups, they should be referred to child protection case coordinators in the concerned institutions for further follow-up.

2. Provide sustainable solutions (including counseling, vocational training, ensuring formal and non-formal education) for boys and girls at risk of returning to their country for the purposes of participating in the conflict, or who may be at risk of recruitment by armed forces or armed groups.
3. Conduct awareness raising activities to youth, their caregivers and other community members on children's rights, including the potential risks and impacts on children involved with armed forces and armed groups.
4. Monitor and report on possible recruitment or use of girls and boys by armed forces or armed groups.

Child Trafficking

The Anti-Human Trafficking Law (2009) prohibits all forms of trafficking and stipulates penalties of six months to 10 years of imprisonment for forced prostitution, child trafficking, and trafficking of women and girls. In March 2010, the National Committee (consisting of the Ministries of Interior, Justice, Labor, and the police) launched a national strategy and an action plan to combat human trafficking for the period 2010-2012.

The Anti-Trafficking Law contains an article for the opening of shelters. Dar Al-Karama shelter has been opened under the MOSD to offer services for the victims of human trafficking. Protection of child trafficking victims requires determination of their identity at the right time; provision of a secure environment, social services, health care and psychosocial support; and their reintegration with family and community if proven that it is in their best interests.

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

1. Cases to be referred to child protection organizations for assessment and development of a case plan, including direct support and referral for services.
2. Reports/information of child trafficking victims should be reported immediately to the Anti-Trafficking Unit.
3. Missing children should be reported by their caregivers to the police.

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

Chapter Six: Prevention

Many elements of GBV and CP response are considered as preventive measures which entail 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).

When designing and implementing prevention strategies, it is important to focus not only on 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 Family violence and GBV, and CP related issues. The impact of family violence and GBV, and CP issues affects various systems, including physical and mental health, law enforcement, judicial and public social services and non-profit organizations, as they respond to violence and provide support to children and/or survivor. Without a strong prevention component, reactive service delivery alone will not change the attitudes and behaviors, and GBV and CP issues will continue to prevail in society.

Promotion of the Role of Society towards Prevention of Violence

Child protection and GBV and FV actors engages and partners communities towards prevention of violence through a range of activities, as follows:

1. Conduct trainings for community-based organizations.
2. Establish CFS and youth and women's centers that provide multi-sectoral services for women and children.
3. Establish protection committees, child protection committees and parent/caregiver and teachers' associations.
4. Conduct awareness sessions for children and parents/caregivers on CP issues.
5. Train children and youth on life skills
6. Conduct awareness session for women, men and children on GBV.
7. Motivate religious leaders to speak out on protection of women, men and children.
8. Motivate men and boys to prevent violence.
9. Use arts, social media and mass media to raise awareness and stimulate dialogue on prevention of violence.
10. Identify and encourage the participation of men, women, boys and girls with disabilities.

There are several considerations and key principles should be taken into account when disseminating information in society and among service providers, including:

1. Ensuring a coordinated approach and consistency of messages with other partners prior to conducting community-based awareness activities on protection.
2. Messages should be contextualized and adapted to the target audience, and tested prior to dissemination. Messages may require different methodologies to be used and will further vary according to the targeted group. This means that while the key elements of the infor-

mation shared will remain the same, the way in which that information will be relayed will vary according to age, gender, community, etc.

3. Special considerations should be given to illiterate (and less educated persons) or disabled audiences and appropriate messaging should be considered to ensure their equal access to information
   a. When disseminating messages on CP or family violence and GBV, benefit-based and dialogue approaches are preferred and have been consistently proven to contribute towards a longer-term prevention and behavior change outcomes. This implies highlighting the positive gains of procedures or services rather than focusing on the negative consequences (e.g. it is more acceptable and preferable to highlight the benefits for girls and their families when marriage is delayed as opposed to focusing only on the negative health and other consequences they risk in cases of child marriages)
4. Developing an action plan between governmental, non-governmental and UN agencies while setting priorities, timeline, scope and specific responsibilities.
5. Prioritizing informing communities on the existing services and their accessibility. The messages should focus, in particular, on safe and confidential access to assistance and on medical responses for emergency cases.
6. Sharing experience and lessons learned with other service providers to ensure regular information updates and revision of dissemination strategies to achieve maximum outreach to communities.

Information dissemination methods include but are not limited to:

1. Distribution of service identification cards with the relevant information on service locations, hours and focal point contacts. Cards can be disseminated at registration centers and community-based centers.
2. Installation of posters with slogans and images or information regarding access to services.
3. Radio / television information programmes facilitated by service providers on available services and their importance.
4. Commercial ads sites on radio/television which promote a bigger audience outreach.
5. Hotline; providing automated or over the phone information and support to callers on how to access services.
6. Community based information dissemination or awareness-raising activities which allow service providers to interact with groups or individuals at a given time and discuss services or protection concerns as it relates to them.
7. Use of social media platforms and local influencers for wider outreach and engagement.

Chapter Seven: Documentation and Data Management

Promotion of the Role of Service Providers towards Prevention of Violence

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

While many of the messages and tools used for the community can be used for service providers, messages to service providers must 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 are not limited to:

1. Presentation of the SOPs document on the handling of GBV, Family Violence and CP cases to the higher management of all acting institutions in the society, ensuring their ratification and signature on it.
2. Specific workshops, targeting workers in governmental, UN and NGO institutions, and workers in other sectors, to introduce or refresh knowledge on the SOPs and referral pathways for GBV, FV and CP cases and ensure the continuum of care and protection that links them.
3. Specific workshops to introduce or refresh knowledge of SOPs and referral pathways targeting non-protection related governmental, UN and NGO workers in other sectors.
4. Inter-sectoral coordination meetings.
5. Inter-agency training workshops on case management and other related capacity building initiatives.

Documentation and file management are essential in the case management process. GBV, FV and CP case files involve extremely classified and sensitive information which should be handled very carefully to ensure the protection and safety of the survivor and the achievement of the basic guidelines in dealing with these cases: confidentiality and privacy.

The "Accreditation and Quality Standards for Family Violence Services" document developed by NCFA in 2014 outlines the basic standards which should be adopted to achieve the minimum requirement of service provision for family violence cases, included under the "Data Management" standard that states the following: Family violence case files are preserved according to specific regulations to maintain their privacy.

Accordingly, all institutions acting in the protection domain should adhere to this standard while providing services (standard importance: critical).

To abide by this standard, there should be clear regulations on how to preserve and exchange information and case files among organizations and partners, and how to store and maintain

their confidentiality in line with the laws and legislations.

Three indicators were determined to measure the commitment of the institutions to the documentation mechanisms:
Indicator 1: Documentation of provided services in a special file called "Case file".
Indicator 2: The existence of a specific mechanism for documentation in the case file, which ensures documentation using standardized and certified forms with serial numbers to ease their follow-up and classification.
Indicator 3: Inclusion of the approval of the supervisor or the person in charge by signing the documents inside the file.

Electronic Information Management System

The following aspects should be taken into consideration to ensure a safe environment for case management on the information system:

1. Put passwords for all computers and documents which are used in the databases.
2. Take the required precautions, such as; anti-viruses and making extra copies for data.
3. Install a coding system for GBV cases to protect the privacy of the beneficiaries and their safety.
4. All information available online must protect the privacy of the beneficiaries by only listing the relevant data to the information copied on the e-mail, and avoid mentioning names as possible.
5. Code all files to be shared and/or protect with a password provided that the password is sent via a separate e-mail of the one with the attached file.
6. Provide mandatory training for the case management team in health institutions on how to use and apply the system.
7. Provide individual login accounts for the case management team to ensure the safety of the system.
8. Put restrictions on the access of the staff to the files, and grant full access only to the case coordinator.
9. The files cannot be accessed except through an electronic system for the case file that is protected safely by a password. In case printed copies of the file documents are used, they should be kept safely in cabinets inside lockable rooms.
10. SOPs should be developed to include information on the accessibility to those rooms, preserving their keys, in addition to the time allowed for keeping the files (File Storage Policy).

The National Family Violence Tracking System

NCFA has introduced an automated family violence response system to ensure the provision of a comprehensive system of response which is in the best interest of family violence cases. The electronic system, used by all institutions concerned with the provision of services in this

area, aims to follow-up on their procedures with regard to the services provided to the family in general and children in particular. It ensures prompt delivery of service in accordance with the response system outlined by the National Framework and the relevant institutions' procedures with a view to ensure the delivery of service in an integrated participatory manner that facilitates referrals and exchange of information. The system also requires periodic reporting on the response procedures identifying gaps and loopholes and recommending solutions to be presented to relevant entities to make proper decisions concerning them.

The project's objectives are:

- Harmonizing immediate response procedures for family violence cases and provision of required services via an electronic system.
- Linking all institutions concerned with the provision of services to family violence together and facilitating referral and follow-up of cases among them.
- Ensuring the response of all national institutions to cases of family violence through a participatory approach.
- Creating a national database to register, follow-up on and evaluate response to family violence cases.

Gender-Based Violence Information Management System (GBVIMS)

This system was first introduced in 2014. It enables parties providing services to survivors of GBV to collect, store and analyze data safely, and share information relevant to the reported GBV incidents.

GBVIMS is not a case management tool; it is a database that gives opportunity to organizations to jointly analyze special pathways of GBV incidents that are reported to case management organizations and pathways and refer them to services. Accordingly, organizations would be able to set priorities and strategies of response at an inter-agency level in Jordan.

Sharing and receiving non-identifiable GBV data will contribute towards improved inter-agency coordination, identification and targeting of gaps, prioritization of actions, and improved programming of prevention and response efforts. It may also result in improved advocacy efforts, increased leverage for fund raising and resource mobilization, and improved monitoring.

Organizations concerned with data collection developed, signed and endorsed an information sharing protocol (ISP) that sets the guiding principles for a safe and secure sharing of database information (anonymous aggregate data on reported cases of GBV) with UNHCR, which acts as consolidating agency in its capacity as SGBV Sub-Working Group co-chair for SGBV prevention and response work in Jordan in partnership with UNFPA. UNHCR and UNFPA also co-chair the GBV IMS task force, while UNICEF provides technical and capacity building support. All ISP signatories protect information to ensure that no harm comes to any survivor, service provider or the community as a result of information sharing efforts.

Child Protection Information Management System (CPIMS)

There are currently two child protection information management systems focusing on the Syria response operating in Jordan for non-government actors. The first system is the "CPIMS" which refers to the Child Protection Information Management System off line module that was established as a unit within the RAIS (Refugee Assistance Information System). This was established by UNHCR in 2015 and contains the CPIMS BIA Form and mirrors the data entered into stand-alone IA CPIMS format with agreed-upon fields that are shared between the case management agencies. CPIMS+/PRIMERO is an online case management tool, that was rolled out in 2017 and adopted for use by UNICEF's and some of UNHCR'S partners. It is hosted on UNICEF cloud. "CPIMS+/Primero" refers to an open source web application created by UNICEF to facilitate case management, incident monitoring, and family tracing and reunification, known as Primero™ ("Primero"). Primero is designed to be configurable, secure and easy to use and includes a range of enhanced interagency child protection information management systems, including the Child Protection Information Management System Plus ("CPIMS+"). This system is currently used by case management agencies.

Chapter Eight:

Coordination, Supervision, Follow-up and Assessment

Effective prevention and response to CP and GBV require a minimum level of multi-sectoral coordinated procedures in the health, legal and social services area, human rights area, security sectors and the local community.

Non-protection organizations with a strong field presence also play a key role in reporting cases that come to their attention while undertaking non-protection specific activities.

Internal Supervision, Follow-up and Assessment of Institutions Concerned with Implementing the National Standard Procedures [91]

The implementation of national standard procedures in institutions are administered internally by establishing or identifying a department solely responsible for that. This department should adopt the following indicators and missions to supervise and follow-up on their implementation procedures internally:

1. Ensuring the Commitment of the institution to GBV, FV and CP issues considering them as a priority in the strategies, executive schemes and their regular assessment.
2. Developing its systems and internal procedures regarding service provision and assessment to avoid an unorganized and repeated response.
3. Updating its service delivery procedures manuals in conformity with the updated version of the framework and procedures, rolling out and following-up on the implementation of these manuals.
4. Setting the groundwork for coordination for all activities related to family protection to ensure service integration, comprehensiveness and avoidance of gaps.
5. Following-up on the staff performance, ensuring their commitment to the protection policies, confidentiality and the quality of the provided services.
6. On-going capacity-building of the staff and service providers, based on a needs assessment, on the procedures of service delivery in accordance with quality control standards
7. Adopting specialized indicators related to the type of service, the commitment of the institution to the application of the Accreditation and Quality Standards for Family Violence Services adopted by the Prime Ministry in 2014, and building up on it to improve response to family violence cases.
8. Using the "automated" procedures system when dealing with family violence cases to manage, follow up on and refer cases.
9. Regular assessment and customer service satisfaction assessment to develop and enhance the quality of the provided services.

(91) Adapted from: The National Framework for Family Protection against Violence 2016.

Supervision, Follow-up and Assessment of the Commitment of Institutions Concerned with Implementing the SOPs at National level

It is of utmost importance to select one entity that is responsible for supervision, technical support, follow-up and comprehensive assessment of national institutions' commitment to the implementation of the National Framework for Family Protection document and procedures and to delivery of service. This entity will represent the governmental and non-governmental institutions involved in GBV, family Violence and CP in the Hashemite Kingdom of Jordan.

Based on Article 4 of the National Team for Family Protection against Violence Bylaw no. (33) for the year 2016, the National Team undertakes the responsibility of monitoring and supervising the implementation of national policies and guidelines in the area of family protection. It also monitors and supervises the commitment of national institutions to these policies and guidelines as reference documents that inform their institutional plans of action in the area of family protection.
To fully implement its mandate, the team undertakes the following:

1. Follow-up on the commitment of institutions concerned with family protection in implementing and enforcing decisions taken by the team on relevant policies, strategies and legislation.
2. Study, identify and follow up on the implementation of the national priorities in the area of family protection.
3. Supervise the implementation of the National Framework for Family Protection against Violence, adopted by the Cabinet, and follow-up on the implementation of procedures emanating from it.

The National Team for Family Protection against Violence will develop the following mechanisms:

1. A mechanism for supervising the response of partner institutions to family protection and implementing the National Framework for Family Protection against Violence.
2. A mechanism for determining the institutions concerned with providing services to family violence cases and providing protection services in accordance to the Accreditation and Quality Standards for Family Violence Services.
3. A mechanism for evaluating the application of the framework procedures and the partners' performance periodically (every two years), and issuance of periodic reports.
4. A mechanism for designing and following up on national indicators on family violence in coordination with partners.
5. Continued follow up and assessment of national framework implementation, and identification of the bottlenecks and ways to confront them.

Coordination Mechanism in Crisis

Effective prevention and response to GBV, FV and CP require minimum multi-sectoral coordinated procedures among actors in the health, social and legal services, human rights, and security sectors and the local community.

In Jordan, sub-working groups of CP and GBV work as coordinating bodies which aim at promoting prevention and responding to issues of CP and GBV in emergency cases, with the emphasis on refugees in camps and host communities, including residents of the host country as well as other populations affected by crisis. Sub-working groups on CP and GBV ensure harmonization and coordination of the national sector on issues related to CP and GBV.

The sub-working group (SWG) of CP is chaired by the UNICEF and UNHCR, while the (SWG) of GBV is chaired by the UNFPA. Both groups are SWGs for the Community-based Protection Group which is chaired by the UNHCR. Members of the SWGs consist of UN agencies, national and international non-governmental organizations and acting institutions in the aforementioned sectors.

The national SWGs meet every two weeks. Extraordinary meetings and ad-hoc task forces are created by the chairs and at the request of members of the SWGs, when this is considered necessary to address an issue of urgent matter. There are also SWGs for CP and GBV on the level of refugee camps and governorates, with responsibilities specific to each and cleared in the booklet of Terms of Reference (TOR). Meetings are held weekly at camp level.

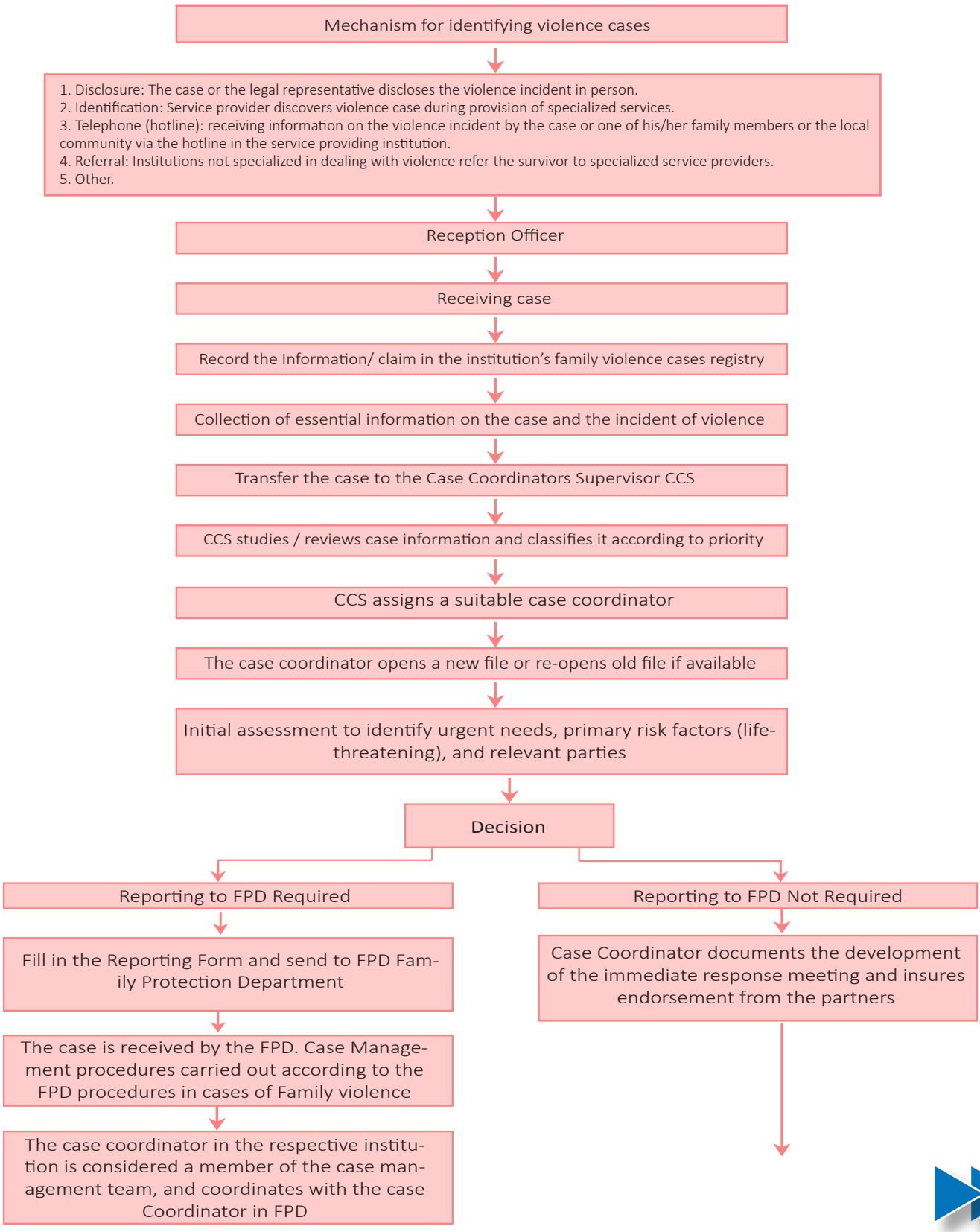
Information is exchanged -at least- monthly among SWGs through dissemination of meeting minutes. Meeting minutes define the issues and problems which need procedures implemented by other working groups. The appropriate working group takes the procedures and presents the required information on follow-up. The SWGs of CP and GBV submit regular reports to the Community-based Protection Working Group on the national and field level.

All other sectors (such as; health, education and protection, etc.) should determine the responsibilities of each regarding prevention and response to CP and GBV, and the form of coordination with SWGs for CP and GBV, in addition to the coordination agencies each in their respective positions.

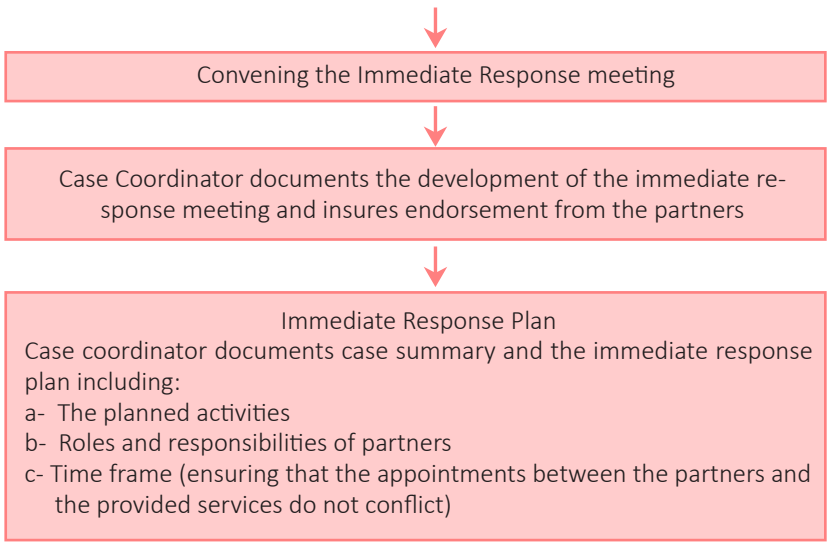
Case Management Approach within Service Provider Institutions

a. Detailed Working Procedure Workflow

Identification and Reporting Phase in Service Provider Institutions

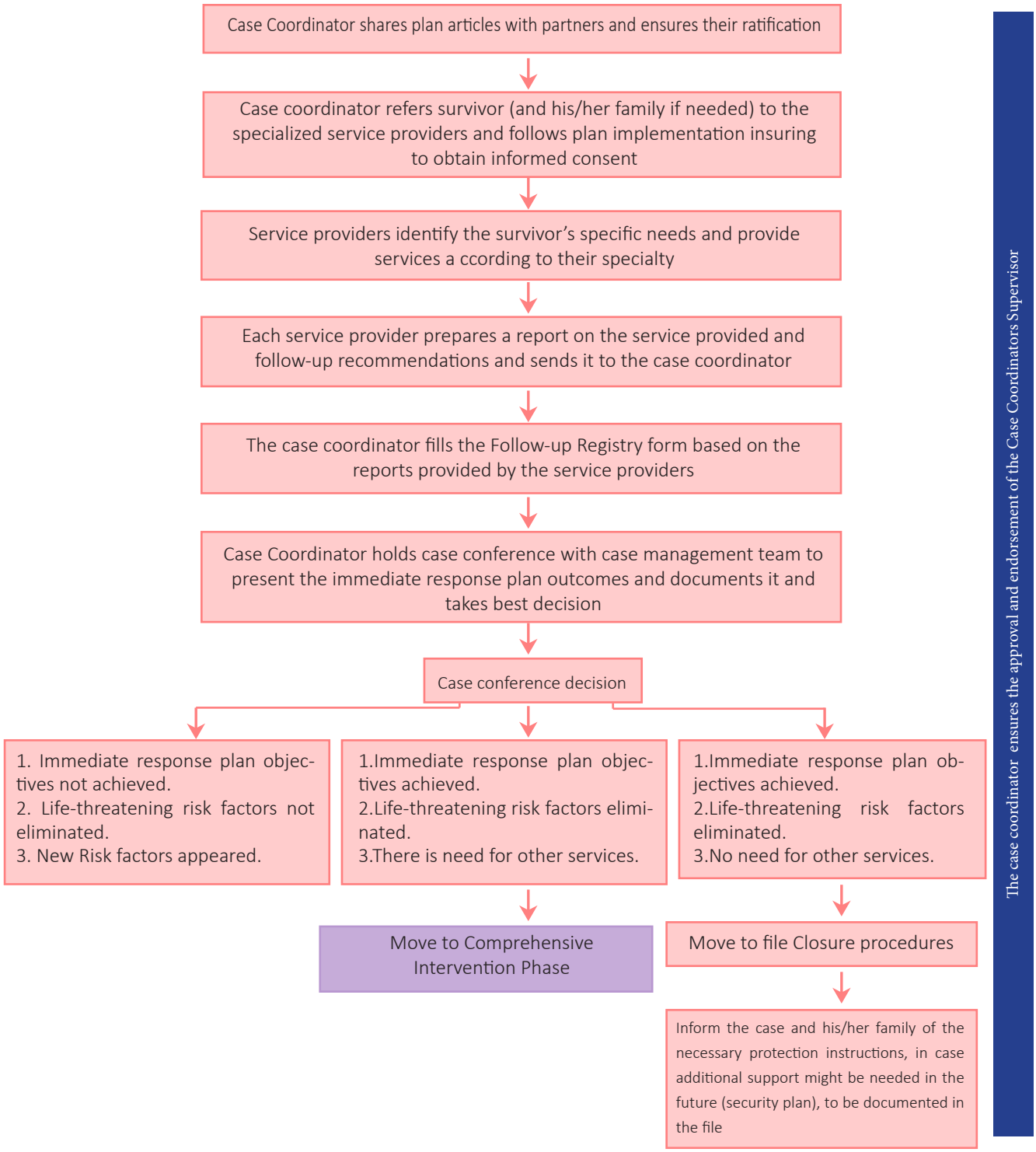


Immediate Response Phase



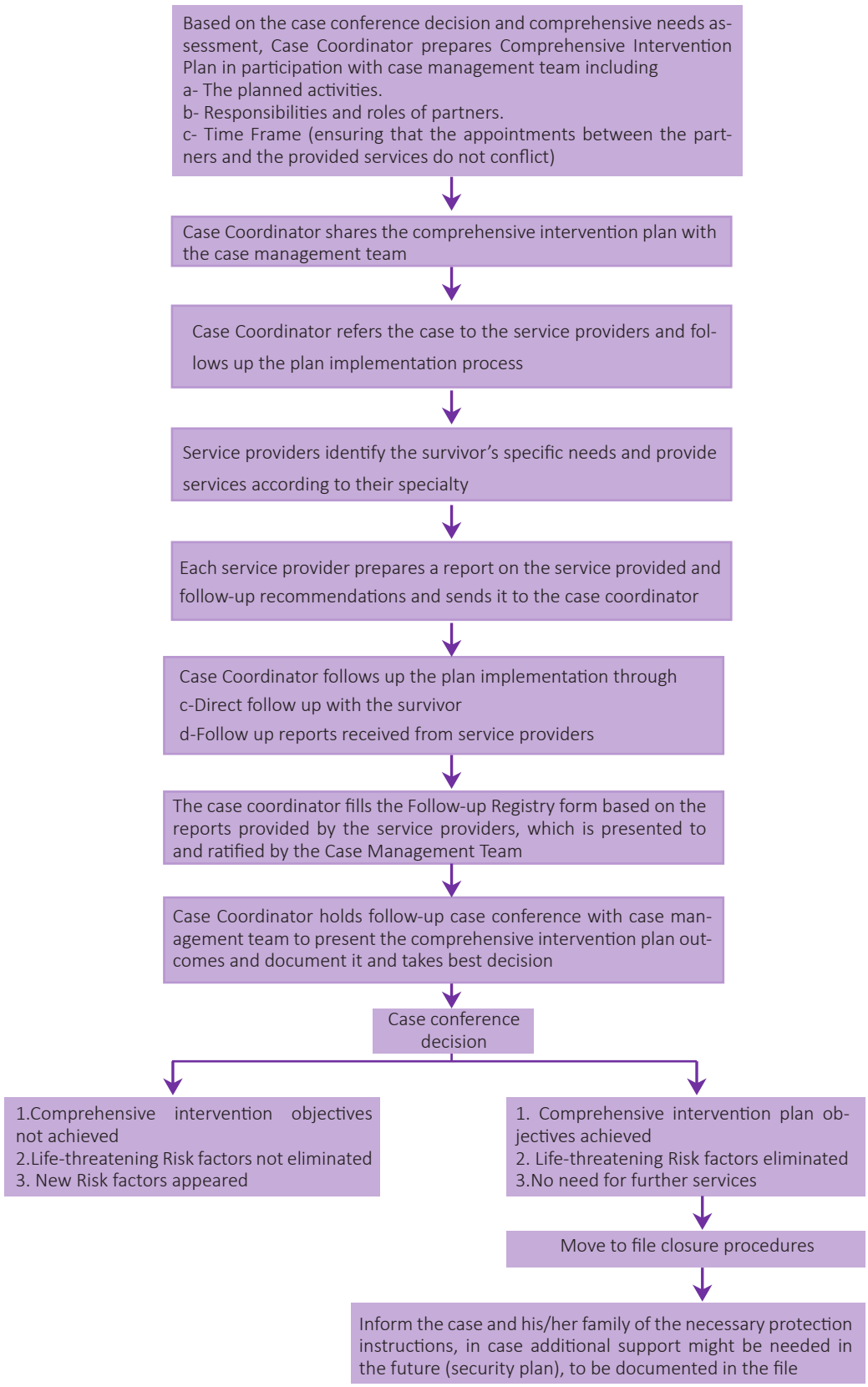
The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

Example on Immediate Response Plan in Service Providing Institutions					
Medical Services		**Psychosocial Services**	**Legal Services**	**Pedagogical/Educational Services**	**Other Services**
Health Services	**Psychiatric Clinic**				
The case coordinator, coordinates with the Medical regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately	The case coordinator, coordinates with the Psychiatric regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately.	The case coordinator, in case of need transfers the case to the Social Service Office	The case coordinator, coordinates with Legal Services	Case Coordinator, coordinates with pedagogical/educational services	The case coordinator, coordinates with any institution needed for the case providing all information
Medical cadre carry necessary medical checks and deliver the needed treatment services	Psychiatric interviews the case and carry Psychiatric check (including family members and perpetrator if needed)	The Psycho/social specialist carries necessary needed actions	Legal Services Provides necessary legal services	Pedagogical/educational service provider carries all agreed actions	Service provider interviews the case and deliver the required services
Medical cadre Prepare medical reports and recommendations, send to Case Coordinator	The Psychiatric prepares the report on the case with the recommendations	The Psycho/social Specialist, prepares Case report and send to Case Manager	Legal Services prepares case report and sends it to case coordinator	Pedagogical/educational service provider prepares Case report and send to Case Coordinator	Service Provider prepares report on provided services including recommendations
Case Coordinator attach the repot to case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file
Case Coordinator follows the implementation of the recommendation	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations
Official implementation body MoH or any other health service provider	**Official implementation body** Psychiatry clinic at MoH or any other psychiatric service provider	**Official implementation body** Any social service provider	**Official implementation body** Any legal service provider	**Official implementation body** MoE, Education guidance division	**Official implementation body** Any institution providing services to the survivors and their families based on the needs assessment


Case Coordinator shares plan articles with partners and ensures their ratification
Case coordinator refers survivor (and his/her family if needed) to the specialized service providers and follows plan implementation insuring to obtain informed consent
Service providers identify the survivor's specific needs and provide services a ccording to their specialty
Each service provider prepares a report on the service provided and follow-up recommendations and sends it to the case coordinator
The case coordinator fills the Follow-up Registry form based on the reports provided by the service providers
Case Coordinator holds case conference with case management team to present the immediate response plan outcomes and documents it and takes best decision
Case conference decision
1. Immediate response plan objectives not achieved.
2. Life-threatening risk factors not eliminated.
3. New Risk factors appeared.
1.Immediate response plan objectives achieved.
2.Life-threatening risk factors eliminated.
3.There is need for other services.
1.Immediate response plan objectives achieved.
2.Life-threatening risk factors eliminated.
3.No need for other services.
Move to Comprehensive Intervention Phase
Move to file Closure procedures
Inform the case and his/her family of the necessary protection instructions, in case additional support might be needed in the future (security plan), to be documented in the file
The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

Comprehensive Intervention Phase



Example on Comprehensive Intervention Plan in Service Providing Institutes					
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Health Services	Psychiatric Clinic				
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Case Coordinator attach the repot to case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file
Case Coordinator follows the implementation of the recommendation	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations
Official implementation body The case coordinator ensures continuous follow-up based on the reports and procedures, and responds immediately.					

Case File Closure Procedures

- Case Coordinator closes the file according to follow-up case conference results based on:
- Immediate response plan achieved, and risk factors eliminated
- Comprehensive intervention plan achieved, and risk factors eliminated

File Closure Justification:

a. Realizing the goals of the immediate response plan, eliminating the risk factors and ensuring they don't recur.
b. Realizing the comprehensive intervention plan, eliminating the risk factors and ensuring they don't recur.
c. Moving abroad for residency or immigration.
d. The death of the survivor; and the procedures regarding the protection of the other family members.
e. The refusal of the case to receive the multiple services.

If the case was incompetent or a child, and if the legal representative refuses to pursue the procedures of the case management, the best interests should be taken into account while ensuring the completion and the continuity of the legal and administrative procedures according to the regulations, instructions, and laws regarding the nature of the case and the procedures related to the protection of the other family members.

File Closure Regulations:

1. The attendance of service providing representatives who deal with the case.
2. The documentation of justifications and closure standards.
3. The written documentation of any reservation if present.
4. Based on the majority decision, the case management team takes a closure decision.
5. The signature and endorsement of the case management team members on the proceedings of the case conference which resulted in the file closure decision.
6. The case and his/her family are notified with the required instructions for future follow up, in addition to the safety plan to prevent the recurrence of violence.

The case coordinator ensures that the decision of file closure conference is documented, endorsed and signed by all the partners.

The case coordinator closes the file and saves it according to filing policy in the institution

Inform the case and his/her family of the necessary protection instructions if additional support needed in the future (security plan) and document it in the file

The file is re-opened if any new future complaints are received

Thanks List

List of	Nmae
Ministry of Social Development	Mr. Jalal Ghreeb
	Mr. Mo'wiah Masadeh
	Ms. Ibtessam Alzghool
	Ms. Samar Sabha
	Mr. Abd Alsalam Alrawahnah
	Mr. Maher Kloub
	Ms. Hailanah Hammad
	Mr. Ahmad Shhadat
	Ms. Suhad Mobaydeen
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	Dr. Malak Al Awari
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	Dr. Eman Shhadeh
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	Ms. Rudaynah Halasa
	Ms. Asma Tabasha
	Dr. Tagreed Al Baddawi
Ministry of Interior	Mr. Hussam Al Gaber
Ministry of Justice	Ms. Alfat Khanfar
Department of the Chief Justice	Dr. Ashraf Al Omari
Judicial Council	Judge Ali Al Masimi
Family Protection Department	Lt. Col. Eyas Daoudieh
	Lt. Col. Sadiq Al Omari
	Captain Ayman Al Rifai
	Captain Mohammed Al hzaima
	Captain Sultan Al Abdullat
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	Ms. Iman Al Akrabawi
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	Ms. Esraa Shakbouha
	Ms. Haneen Al Zoubi
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Justice center for legal aid	Ms. Suhad Al Sukari
	Mr. Mutaz Al Douhni
	Ms. Samia Haboub

Union of Jordanian Women	Ms. Najeyah Al Zoubi
United Nations Children's Emergency Fund	Ms. Maha Homsi
	Ms. Suzan Kashet
	Ms. Maryam Al Qasem
United Nations High Commissioner for Refugees	Ms. Zaina Jad'an
United Nations Population Fund	Ms. Yara Al Dair
	Ms. Layali Abo Sair
Arab Renaissance for Democracy and Development	Ms. Suzan Mohareb
Intersos Jordan	Ms. Majedah Mahasneh
Save The Children Jordanian Association	Ms. Sana Al hyari
	Ms. Rawan Iydah
International Medical Corps	Ms. Lama Al As'ad
	Ms. Ibtisam Al Khasawneh
International Rescue Committee	Ms. Samah Al Dmour
National Council for Family Affairs	Mr. Hakam Al Matalkah
	Mr. Faris Al Bashiti
	Mr. Nasser Al Dmour
	Ms. Hadeel Al Hawari
	Ms. Majed Sweiss
Advisory Group	Eng. Jamal Al Salah
	Ms. Troub Malhas
	Dr. Manal Tahtamouni

المجلس الوطني لشؤون الأسرة
NATIONAL COUNCIL FOR FAMILY AFFAIRS

In partnership with





Procedural Manual for Management of Family Violence Cases

2018

the Standard Operating Procedures (SOPs) for Prevention of and Response to Violence in Jordan

(Gender-Based Violence , Family Violence and Child Protection)

Table of contents

[Introduction]

The procedures for dealing with cases of domestic violence were developed by the National Council for Family Affairs in 2018 in partnership with the United Nations organizations (United Nations Children's fund/ UNICEF, the United Nations High Commissioner for refugees/UNHCR, the United Nations Population Fund/UNFPA), National institutions, governmental and non-governmental organizations, international organizations and sub-working groups (GBV, child protection) and all under the supervision of the national team for family protection , to ensure service delivery to all cases of domestic violence with high quality and efficiency.

The manual focuses on the translation of frameworks, policies, guidelines and operating procedures with the cases of violence described in the policy document and guidelines for the prevention and response to violence in Jordan within a participatory, institutional and executive implementation procedures using detailed sequential procedures reflecting the methodology for working with cases of domestic violence based on the rights, wishes and needs of the survivor .

The manual also defines the roles and responsibilities of all the concerned institutions in dealing with cases of domestic violence in different sectors in order to strengthen the framework of cooperation, coordination and consistent monitoring of the operating procedures cases workflow for all service providers from the moment they receive the case and until the file is closed, the manual also defines the time frames for different stages of intervention, and the information and data that should be documented in a way that promotes comprehensive integrated response to the needs of the survivor , to strengthen the principle of responsibility and accountability within the framework of supervision, follow-up and monitoring by all service providers for cases of domestic violence, also the procedural manual will be reviewed periodically to ensure updating of information and to reflect national and international best practices in this field.

Objectives of the Manual

- Set a framework for policies and programs pertaining to protection from, and prevention of GBV, FV and violence against children.
- Consolidate inter-agency procedures in a manner that guarantees their sequencing including by: accurately defining roles and responsibilities of all relevant entities; setting regulatory timeframes; and specifying data and information which should be filled in each procedure's specific form.
- Create a common language and understanding among specialists and workers in the area of GBV, FV and Child Protection by introducing unified definitions, terms and guiding principles to be used in the management of cases.
- Provide a detailed articulation of violence case procedures for each phase (detection and reporting, immediate response, comprehensive intervention and case closure) though a modular structure that illustrates each procedure and step.

Target Group

This manual targets all sectors, governmental and non-governmental institutions, both national and international, in addition to staff and workers who are directly involved in providing specialized or non-specialized services to family violence survivors within the borders of the Hashemite Kingdom of Jordan.

I- Sectors:

a. **Psychological and social services:** Manages psychological and social case assessments of the case for delivery of appropriate services to the survivors of violence and their families.
b. **Educational sector:** Provides guidance and psychological support and awareness within the educational institutions' sector.
c. **Health services:** Provides medical testing services, emergency and non-emergency medical service including forensic and psychiatric services.
d. **Police and security:** Undertake investigation of family violence cases and referral of cases to judicial authorities
e. **Judicial services:** Responsible for judiciary processes related to investigation of family violence; and decisions on alternative measures, care, protection and rehabilitation and referral of the case / offenders to the subsequent services' sector. This sector includes the Sharia Judiciary / Court dealing with implementation of the Personal Status Law and related measures in cases of divorce, alimony, custody, guardianship and other measures, in addition to intervention, such as counseling and family reform programs.
f. **Legal services:** Provision of appropriate legal advisory and representation for the case and the alleged offenders where needed.
g. **Administrative procedures (Governors):** taking administrative measures and decisions in cases of family violence, and taking the necessary measures against the perpetrators in accordance with the legislation in force and referring them to appropriate services.

II- **Institutions:** based on this manual, institutions affiliated to the above-mentioned sectors who provide various services are required to prepare **internal operating procedures manuals** based on the best interests of the survivor, and the training of relevant professional and administrative staff with direct and indirect relation in dealing with cases of family violence. The responsibilities of the cadres will be determined according to the internal working procedures manual of the relevant institution. All institutions must be committed to provide services in a participatory and complementary approach with other institutions in order to ensure the best interests of the survivor.

III- **Individuals working in Institutions:** Service providers in related institutions are required to adhere to the procedures in this manual and the internal procedures of their institutions.

Preparing the Manual

Preparing this manual started with review of the second edition of the "National Framework for Family Protection against Family Violence" (2016). A form was prepared to collect information from relevant institutions and was submitted to the technical committee for the preparation of this procedures' manual at a meeting held at the National Council for Family Affairs. The form was sent to all members of the technical committee to ensure that their opinions and feedback were taken into account. The work team organized field visits wherein in-depth interviews were conducted with individuals working in institutions providing services, in addition to meetings with representatives of interested and relevant United Nations organizations. After analysis of the information gathered, the team established a panel for row cases procedures and actions in close coordination with the National Council for Family Affairs and members of the technical Committee. The analysis was presented at several meeting and adjustments were made under the guidance of the Technical Committee and the members of the National Council for Family Affairs.

A national workshop was held with members of the technical committee and representatives of the service provider institutions and others. The contents of the manual were presented and discussed, and observations were collected during the workshop sessions. Some institutions sent their comments after the workshop. All received comments were considered and incorporated in this version.

Definitions and Terminology

The definitions below are nationally adopted, and are procedural definitions related to the provision of services to cases of family violence and may differ from the adopted legal definitions.

First: Family Violence Definitions and Terminology

- Family violence: any act or omission by a family member against any other individual within the same family resulting in physical or emotional harm. It includes several forms of violence
- Physical Violence: the use of physical force or threat of force, which may result in bodily injury or bodily harm, such as beatings, wounding, punching, biting, burning by throwing incendiary materials or caustic or distorting. It also includes any other actions that may cause physical harm.

- Sexual Violence: violence due to sexual activity or behavior, including harassment and sexual comments, sexual seduction and coercion. It includes also luring him/her to participate in sexual activities, regardless of whether the ch ild is aware of them or not, or encourage him/her to watch pornographic materials or to participate in their production, marketing or dissemination or to encourage him/her to behave in an inappropriate sexual way.
- Psychological Violence: is the violence which results in disturbance in mental behavior or causes psychological or emotional pain, such as: insults; verbal abuse; demeaning; isolation from friends and family; making fun of him/her; intimidation; prohibitive demands or arbitrary deprivation of rights and freedoms.

* Neglect: is the refusal or failure to fulfill the obligations of a person or his or her duties towards any person in the family while being capable; it includes failure to provide health and medical care, failure to provide basic needs such as food; dress; shelter; health and education.

Second: Definitions Related to Case Management

- Survivor: A person who was subjected to any form of violence.
- Perpetrator: Any person who has committed an act of any form of violence against another person.
- Case Management: A working methodology that aims at addressing the individual needs of a person. based on the wishes of the survivor, it includes planning for the case intervention; evaluation; coordination; directing; monitoring; follow-up and the provision of the necessary services, in coordination with the relevant partners by using sequential procedures defining the responsibilities and the roles since receiving the case till its closure.
- Case Coordinator: Is the specialized employee who has the necessary skills, experience and qualifications to deal with the case at the concerned institution, and assumes case management duties from its identification to conduct risk assessment sources until case closure through supervision and communication with the existing case management team to follow up on the survivor. This is done within the concerned institution or with partner institutions, in addition to meetings related to the survivor.
- Case Coordinators Supervisor: a dedicated employee who has the skills of supervision and holds a supervisory position within the institution. He is responsible for the distribution of cases on the case coordinators of the institution. He ensures follow up on cases and provides technical and administrative support (logistical) to the case coordinators and makes sure to provide quality services, according to the action plan to the case and his/ her family.
- Service Provider: is an employee at the institution who deals directly with the survivor and his/her family through the provision of specialized service to him/her. He is specialized in the following areas: social work; psychology; counseling; sociology; child-rearing; medicine; nursing; law; or any other areas related to humanities disciplines.

Basic Guidelines of the National Framework for Family Protection

1-**Respect the survivor's rights and desires:** The survivor's desires, rights and dignity should be respected at all times. The procedures should be directed towards the best interests of the survivor. He/she should participate in all the actions impacting his/her life while taking into account the family and its needs and the surrounding environment where not in contrast to the best interests of the survivor. All necessary procedures should be carried out with professionalism by all concerned institutions.

2-**Informed Consent:** The voluntary consent of a person, who is eligible to give consent to receive services or share information, based on an informed decision-making process. To provide consent, the individual should have the ability and maturity to know and understand the services that are available to them. Usually the parents/guardian responsible for taking care of the child are responsible for giving approval on his/her behalf until the child reaches the age of eighteen, taking into account the applicable laws and the national legislation. Informed consent should be taken to provide services to the survivor according to the legislations, the laws and the national implemented regulations. To ensure the informed consent, the service providers should explain the following:

- All options and their implications are available for the survivor.
- That certain information pertaining to the case will be shared with others only for the purposes of accessing other services.
- Accurate explanation of the benefits and risks of consent to obtain other services.
- Provide necessary information, using various communication alternatives (sign language; images; oral and written information; etc.), where necessary, to enable persons with disabilities to understand the procedures and their consequences.

3-**Confidentiality and privacy**: Confidentiality and the privacy of the case should be maintained at all times. Information can be shared and exchanged only with institutions that will be involved to provide necessary support and interventions. Discussion of any matter with the survivor should take place only at allocated places, and any person not involved in the case should not be present at such meetings. The strict confidentiality is essential and must be always maintained, except in case of a risk to the safety and security of the survivor. All information pertaining to the case should be documented in written forms and filed in a safe place accessible only to service providers managing the case.

4-**Best Interests of the Child**: to ensure the full and effective enjoyment of all the recognized rights under the CRC, and the inadmissibility of dropping the duty to respect all the rights under the pretext of an adult estimation for the best interests of the child; in addition to the lack of hierarchy of rights, and that all rights are to serve the child's best interests and it cannot prejudice to any negative interpretation of the right to the best interests of the child. It requires the full application of the concept of the child's best interest, the development of a rights-based approach and the involvement of all stakeholders to ensure the comprehen-

sive and physical, psychological and moral child health, whether he was a boy or a girl and to enhance his/her human dignity.

5- **Protection:** Ensure that the safety and security of the survivor and his/her family is maintained to their best interest, at all phases and times, taking into consideration the psychological and health situation of the survivor, and to investigate the current and future risk factors. And avoid exposure of the survivor to any physical, health or psychological risks, and follow procedures that ensure his/her safety and support him/her with professionalism in order to maintain his/her safety and the safety of the person/s assisting him / her (eg: family, their members and service providers).

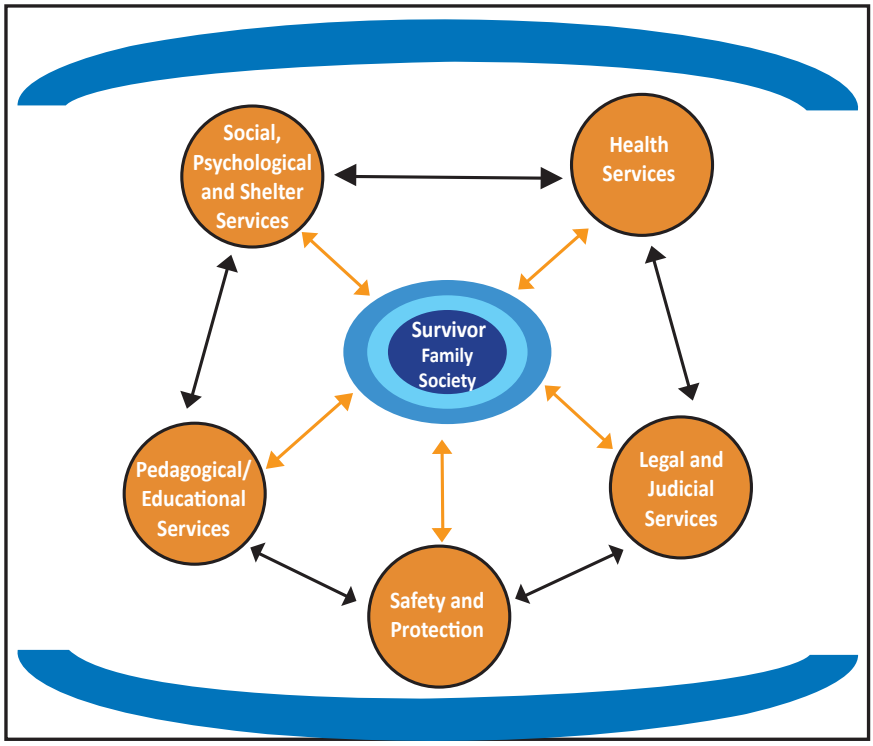
6- **Non-discrimination:** No discrimination should be made while providing the appropriate services to survivors. The services must be of high quality and meet all the needs of the individual (and their families), regardless of social status; economic; family background; cultural background; nationality; religion; gender; age; or disability.

7- **Survivor-Centered Multi-Agency Approach:** The National Framework is based on a cooperative and coordinated approach among agencies working in the field of family protection, and clearly identifies and describes common roles and responsibilities. It also emphasizes on a high degree of mutual understanding and respect for different professional perspectives; exchange of information and experiences; and provision of comprehensive multi-sectoral services that are of high quality within the agreed standards.

Case Management

The National Framework for Family Protection against Family Violence Operating Procedures manual focuses on a survivor-centered multi-agency case management approach based on the survivor and his/her family's needs, aimed at achieving the best interests of the survivor and his/her family on a wider scale in some cases.

It is a process by which the needs of survivors and their families are assessed and identified, to determine the services required for the survivor and his/her family, if needed. These services are coordinated and managed in a systematic manner and they are followed-up in coordination with the stakeholders using sequential procedures since receiving the survivor until closing the file while taking into account the best interest of the survivor. Violence cases There are complex cases of violence, and therefore require support, intervention and services by several institutions. It should be noted here that the term "case" in the Framework refers to the survivor, and service provision and support for him/her, in addition to assessing studying and supporting the needs of his/her family.



Graph 1: Survivor-Centered Approach according to the Jordanian Framework for Family Protection

First: Case Management Approach:

The main objective of the application of the case management approach for family violence cases is to enable the survivor and his/her family to understand the options and services available, and to support them in taking an informed decision. Through the case management process, a wide range of relevant services are provided in a participatory manner to meet the needs of the individual case, such as health care, psychological and social services, security and protection and legal services. Essential services are provided to the survivor to recover from the harmful effects of violence and protect them from being exposed to any further violence, while guaranteeing their confidentiality and privacy.

When registering or referring a case of family violence to a specialized institution, a case coordinator is assigned to follow-up the case through the application of case management methodology while taking into account the regulations and instructions concerning the specificity of the cases and mechanisms to deal with them within the concerned sector.

Second: Case Management Tools and Mechanisms:

The case management process is based on consistent and flexible steps, which allow the transition to and from any phase within the case management cycle based on assessment of the progress and consultation with the survivor and his/her family.

The case coordinator is responsible for following up the case management process and is sup-

ported by a multidisciplinary case management team, which is considered an integral part of each and all case management phases and procedures and will be presented in detail later on. They are:

1- **Case assessment:** is a dynamic and continuous process of collecting and analyzing relevant information about the survivor or his/her family, to determine the appropriate support services. The evaluation process starts by collecting and analyzing information. This stage includes the following:
   - Collect relevant data of the case and his/her family, ensure accuracy of the information to assist in the understanding of the case and the surrounding circumstances.
   - Exchange information and share them with relevant information on additional services available where needed, for the protection and safety of the case and his/her family, maintaining the confidentiality of this information and privacy in addition to the best interests.
   - Identify and assess risk factors, and analyzing the strengths and weaknesses of the case and his/her family.
   - Identify the required services and procedures for the case and his/her family and for the service providers in addition to defining the best methods to provide services.

Graph 2: Case Management Tools

2. Case planning and preparing the intervention plan: Planning is an essential element in the case management process that determines the actions to be taken by the case coordinator, the case and his/her family and sets out the overall outputs. This interactive process

is carried out by the case coordinator with participation of all institutions involved in the provision of services to the case under the supervision of the case coordinator.

The planning stage is a subsequent process of the evaluation/reviewing phase. Based on the evaluation results, the appropriate steps and actions are planned in order to provide protection, health; education; social; psychological; and legal needs for the case and his/her family. The intervention plan / care plan should be discussed, as much as possible, with the individual and his/her family (where appropriate). The plan should be inclusive of all aspects and based on the correct, professional and relevant information about the case and his/her family. The intervention plan should be documented, including:

- goals and the strategies to achieve them,
- time frames to carry out services,
- roles and the responsibilities of all the institutions involved in the provision of services,
- assessing the role of the family while taking into account any immediate action that must be carried out,
- planning short and long-term actions while focusing on the importance of coordination with the case and his/her family concerning all the plan procedures.

3. Plan implementation: The implementation might include the provision of direct services or referral to services of other institutions. According to the intervention plan, all institutions involved in the provision of services shall have a clear understanding of their role, and the role of the other institutions at this stage. Proper implementation of the intervention plan is depending on the following:

- Continuous monitoring of the occurrence of any changes in the individuals/ family conditions that may increase the likelihood of risk on the individual and his/her family.
- Understanding, mutual respect and professionalism among service providers from partner institutions, taking into account the views on the case and his/her family and any issues related to providing the service.
- Holding regular meetings, as per the nature of the case and the risk factors, with the institutions involved in the provision of services in accordance with the intervention plan.
- Emphasizing that the successful implementation of the plan is linked to coordination and cooperation between the institutions, and the mutual understanding that while some differences in views can occur, these must be solved immediately, so as not to affect the process of providing services for the case and his/her family.
- Documentation of all procedures and information, and maintaining files and confidentiality.

4. **Follow-up / monitoring of the case**: A continuous follow up process which is required to ensure that interventions are progressing as planned and the case and his/her family remain protected and safe. The follow-up process also helps in identifying challenges that may impede or change the course of the intervention plan. This review process assists in identifying necessary adjustment measures or alternatives to overcome those obstacles in a timely, efficient and effective manner.

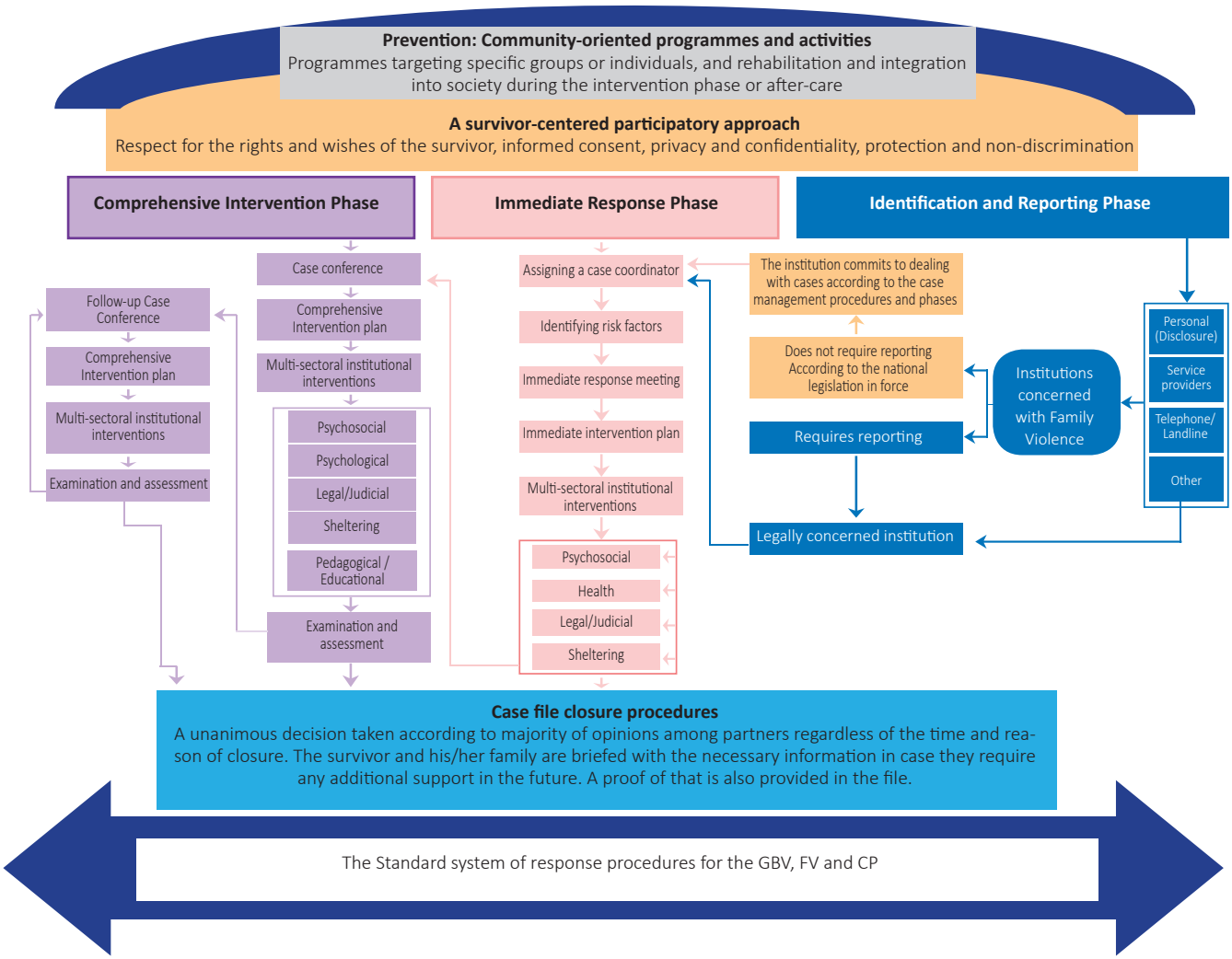
It is important to ensure the commitment of the case coordinator or his/her replacement in following up the services provided by the relevant service providers to the case and his/her family.

It is also important to obtain regular feedback from service providers and the individual receiving services in order to:

- ensure that the implementation of the plan as planned and that the services provided achieve the objectives of the plan.
- monitor any change in needs;
- easy and quick detection of any challenges occurring during the implementation process.
- Ensuring the regular participation of the survivor and his/her family.

Roles and Responsibilities

Reception Officer	Case Coordinator Supervisor	Case Coordinator	Specialized Service Provider Staff
– Reception of cases. – Filling out preliminary data of the case and the incident of violence, which include a description of the reality of the situation. – Recording the case (or report) in the reception register. – Record all information received and personal notes on case and family status. – Report to Case Coordinators Supervisor on received cases.	– Receive cases transferred from reception officer or from other service provider, institutions. – Ensure qualitative specialization where relevant and needed (Family Protection Department) – In the case of difference in mandate (including geographical) the case is referred to obtain services from another service provider. – Review the initial data of the case and classify urgency according to priority. – Check whether the case is new or has an old file. – Appointment of case coordinators (according to criteria for selection of case coordinators). – Check and endorse results of the initial assessment, immediate response plans, intervention and closure procedures. – Oversee and supervise the implementation of work plans and provide technical and administrative support to case coordinators. – Reporting to the Family Protection Department in cases which require mandatory reporting.	– Start a new file or request previous one. – Fill in details the information of violence case. – Evaluate the general conditions; – Assess the general state of the survivor and his/her family including their safety, psychological, health and social needs, as well as determine the relevant stakeholders/service providers relevant to those needs based on the consent of the individual; – Contribute to the development and implementation of immediate response plans and intervention plans with all relevant partner, and promoting the participation of service providers during the case management process and providing them with the necessary information. – Provide support and follow-up to service providers to meet the objectives of response and intervention plans, and plan interventions to meet the needs of the case and her/his family. – Organize coordination meetings (immediate response meeting, case conference, and follow-up case conference) as required; – Obtain informed consent from the survivor, or his/her family, in accordance with legislation in force, including providing choices rather than making decisions on behalf of the case or advising him / her. In case of children, it should be appropriate to the child's age and stage of development and to the child's best interests. – Documentation of work procedures with the survivor and his/her family and ensuring endorsement stakeholders. – Periodic assessment of the case including risk factors (such as unmet needs, change of circumstances, etc.…) – Follow-up case file closure according to case closure justifications, insure the endorsement all stakeholder, provide the survivor with an appropriate safety plan. – Contribute to the assessment of the initial needs and the specialized evaluation according to its specialization – Direct coordination with the Case Coordinators Supervisor regarding the case and interventions and ensure the approval of the Case Coordinators Supervisor on the case periodic reports (follow-up report of the immediate response phase, follow-up report of the intervention phase).	– Contribute to the assessment of the initial needs and the specialized evaluation according to specialization – Contribute in setting the immediate response and intervention plans and the implementation to meet the plans objectives. – Provide specialized services, by each accordance to specialization; prepare periodic follow-up reports and send them to the case coordinator. – Participate in case consultative meetings and provide services (immediate response and case conferences) to follow up the case as required. – Document all work procedures with the case and his/her family. – Ensure services are provided within immediate response and intervention plans.


Prevention: Community-oriented programmes and activities
Programmes targeting specific groups or individuals, and rehabilitation and integration into society during the intervention phase or after-care
A survivor-centered participatory approach
Respect for the rights and wishes of the survivor, informed consent, privacy and confidentiality, protection and non-discrimination
Comprehensive Intervention Phase
Immediate Response Phase
Identification and Reporting Phase
Case conference
Comprehensive Intervention plan
Multi-sectoral institutional interventions
Psychosocial
Psychological
Legal/Judicial
Sheltering
Pedagogical / Educational
Examination and assessment
Follow-up Case Conference
Comprehensive Intervention plan
Multi-sectoral institutional interventions
Examination and assessment
Assigning a case coordinator
Identifying risk factors
Immediate response meeting
Immediate intervention plan
Multi-sectoral institutional interventions
Psychosocial
Health
Legal/Judicial
Sheltering
The institution commits to dealing with cases according to the case management procedures and phases
Does not require reporting According to the national legislation in force
Requires reporting
Institutions concerned with Family Violence
Legally concerned institution
Personal (Disclosure)
Service providers
Telephone/ Landline
Other
Case file closure procedures
A unanimous decision taken according to majority of opinions among partners regardless of the time and reason of closure. The survivor and his/her family are briefed with the necessary information in case they require any additional support in the future. A proof of that is also provided in the file.
The Standard system of response procedures for the GBV, FV and CP

Working Procedures for cases of family violence according to the case management approach

The National Framework for Family Protection (NFFP) against Family Violence has adopted two pathways for Case Management among institutions dealing with family violence cases, which are based on the mandatory reporting requirements as per national legal framework, regulations and special instructions that regulate the roles and procedures of institutions dealing with all types of family violence. The two pathways include case management services provided to cases falling under mandatory reporting requirements and non-mandatory reporting requirements.

NFFP stresses the importance of the commitment to an institutionalized case management approach to ensure comprehensive and participatory response to family violence cases by all concerned institutions, and the importance of the commitment of institutions to establish partnerships and memorandum of understanding with all service provider institutions (Medical, psychological, social, legal, pedagogical/educational, etc.) that ensures effective coordination to provide comprehensive services.

A detailed explanation of case management procedures at the two levels, as well as the forms and required tools to implement them are presented below.

First: Cases requiring mandatory reporting to the Family Protection Department

- Reporting of cases to the relevant legal party (Family Protection Department- FPD) is mandatory if the act is a felony or a misdemeanor according to national legislation, laws and regulations in force. All institutions are obligated to notify the FPD on cases of family violence through established referral channels, coordination and communication mechanisms adopted for these purposes, ensuring the participation of the reporting entity in the case management team.

  The FPD is responsible to follow up and organizing all case management procedures, case conferences/ coordination meetings related to the case and his/her family, as well as the follow-up on decisions emanating from these meetings. FPD also conducts an assessment of the social status, needs, desires of the survivor and his/her family.

Case Management Approach for the Family Protection Department:

a. Detailed procedures workflow
b. Explanation of the detailed procedures workflow
c. Case management forms

Case Management Approach within the Family Protection Department

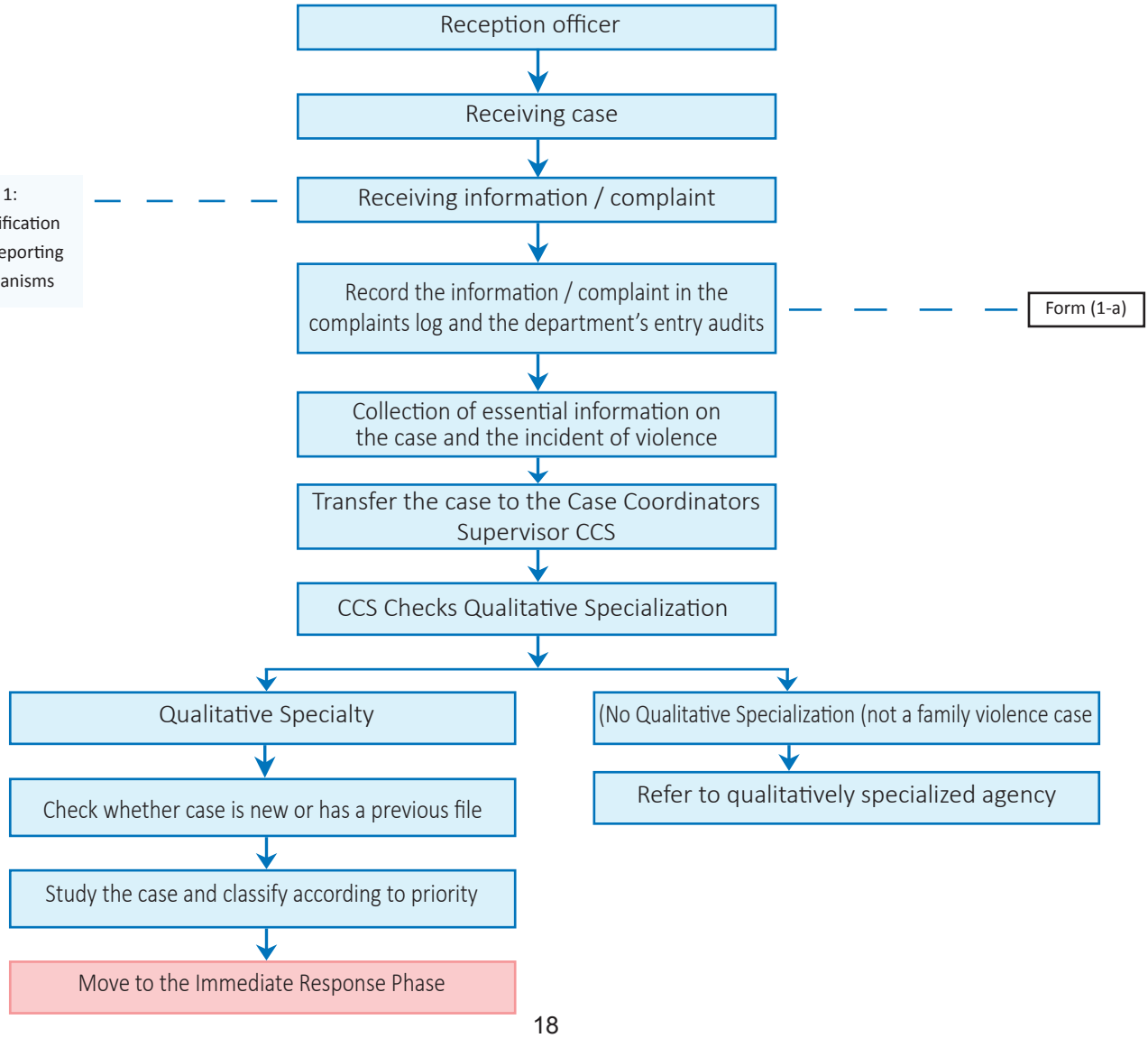
A. Detailed Procedures Workflow

Identification and Reporting Phase in Family Protection Department

Mechanism for identifying violence cases

1. Personal report / complaint (self-referral): The case or the legal representative files a complaint to the FPD in person.
2. Telephone: receiving information through the case or one of his/her family members or the local community via:
   a. The main department phone numbers or its offices.
   b. The national emergency line (911).
3. Reporting: Receiving the approved reporting form from a service provider
4. Police station: transfer from a police station that received a complaint or a personal reporting, or from the incident representative of the police station inside hospitals.
5. FPD Email / website.
6. Other.

Table 1: Identification and reporting mechanisms



The case coordinator ensures the approval and endorsement of the case coordinators supervisor and carries regular assessment of risk factors

Immediate Response Phase

Table # 6: Criteria for case coordinator selection

CCS assigns suitable Case Coordinator

Case Coordinator moves to the and is responsible for all documentation and follow-up with all partners

Case Coordinator opens a new case file, or re-opens old file if available

Case Coordinator receives the case and family (depending on case's best interest)

Initial assessment to identify urgent needs, primary risk factors (life-threatening), and relevant parties — Form (2-a)

Table # 7: Mechanisms of holding immediate response meeting

Convening the Immediate Response Meeting

Immediate Response Plan
Case cordinator includes the case and his/her family in the immediate response plan, produces, available option and the consequence of each, in accardance with the best interests, legislation, laws and national regulations in force.

Case Coordinator documents the developments of the immediate response meeting and the agreed procedures; ensuring its endorsement from the partners

Immediate Response Plan
Case coordinator documents case summary and the immediate response plan including:
a- The planned activities
b- Roles and responsibilities of partners
c- Time frame (ensuring that the appointments between the partners and the provided services do not conflict)

Form (4-a)

Example on Immediate Response Plan in FPD (Where the case may require all or some of these services, and determine the services according to the nature of the case and its needs)								
Family Protection Department	**Judiciary/ Public Prosecutor**	**Sharia Court**						**Other Institutions**
Judicial Division			**Protection against Family violence Division**	**Forensic Clinic**	**Hospitals and Health Centers**	**Psychiatric Clinic**	**Social Service Office and Shelters**	
The case coordinator coordinates with the Judicial Division, providing all information related to the case and the primary risk factors	The case coordinator, coordinates with the magistrate or the prosecutor regarding the case and provides all information and risk factors.	The case coordinator follow-up with the Sharia Court and the family reform office, and follow-up necessary measures according to case assessment and needs	The case coordinator shall coordinate with Protection against Family violence Division branch Section, providing all information related to the case and the primary risk factors	The case coordinator, coordinates with the Forensic Physician regarding the case and provides all information and risk factors.	The case coordinator, in case of need transfers the case to Medical Treatment immediately	The case coordinator, coordinates with the Psychiatric regarding the case and provides all information and risk factors.	The case coordinator, coordinates with the Social Service Office regarding the case and provides all information and primary risk factors.	The case coordinator, coordinates with the any institution needed for the case providing all information
Judicial Division takes all necessary police procedures/ actions	Magistrate or the prosecutor studies the case and takes the appropriate decision	The Sharia Judiciary studies the case and refer to the Sharia Court to decide	Protection against Family violence division follows with the administrative Governor for taking necessary decisions	Forensic Physician carry necessary Checks for the case and the perpetrator, and any other parties required	Medical cadre delivers the needed treatment services	Psychiatric interviews the case and carry Psychiatric check (including family members and perpetrator if needed)	Office manager appoint Social specialist to follow the case socially and to carry necessary actions (Study (the Case	Service provider interviews the case and deliver the required services
Judicial Division prepares a report of procedures carried with recommendations	Case coordinator documents the decision of the magistrate or the prosecutor in the file and obtains the decision document	Case coordinator obtains sharia court decision document and attach it in the case file	Case coordinator obtains the decision of the governor	Forensic Physician Prepare forensic reports including recommendations	Medical cadre Prepare medical reports and recommendations	The Psychiatric prepares the report on the case with the recommendations	Social Specialist, prepares Case Study report and obtains the endorsement of the office Manager	Service Provider prepares report on provided services including recommendations
Case Coordinator includes the report of Judiciary Division in the case file	The case coordinator follows the implementation of the Judicial decision	The case Coordinator follows the implementation of the Sharia court decision	Case coordinator attaches the decision of the governor in the case file	Case Coordinator attach the repot to case file	Case Coordinator attach the repot to case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file
The case Coordinator follows the implementation of police procedures			The case Coordinator follows the recommendations and decisions with the Protection against Family violence div.	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of the recommendation	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations

Table 9: Mechanisms of holding a case conference

Case coordinator refers survivor (and his/her family if needed) to the specialized service providers and follows plan implementation insuring to obtain informed consent — Form (7-a)

↓

Service providers identify the survivor's specific needs and provide services according to their specialty

↓

Each service provider prepares a report on the service provided and follow-up recommendations and sends it to the case coordinator — Form (8-a)

↓

The case coordinator fills the Follow-up Registry form based on the reports provided by the service providers — Form (9-a)

↓

Case Coordinator holds follow-up case conference with case management team to present the comprehensive intervention plan outcomes and document it and takes best decision — Form (6-a)

↓

Case conference decision

1. Immediate response plan objectives not achieved. 2. Life-threatening risk factors not eliminated. 3. New Risk factors appeared.	1. Immediate response plan objectives achieved. 2. Life-threatening risk factors eliminated. 3. There is need for other services.	1. Immediate response plan objectives achieved. 2. Life-threatening risk factors eliminated. 3. No need for other services.
	↓	↓
	Move to Comprehensive Intervention Phase	Move to file closure procedures
		↓
		Inform the case and his/her family of the necessary protection instructions, in case additional support might be needed in the future (security plan), to be documented in the file

The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

Comprehensive Intervention Phase

Case Coordinator includes the case and his/her family in the immediate response plan, procedures, available options, and the consequences of each, in accordance with the best interests, legislation, laws and national regulations in force.

Based on the case conference decision and comprehensive needs assessment, Case Coordinator prepares Comprehensive Intervention Plan in participation with case management team including
a- The planned activities.
b- Responsibilities and roles of partners.
c- Time Frame (ensuring that the appointments between the partners and the provided services do not conflict)

Form (6-a)

↓

Case Coordinator shares the comprehensive intervention plan with the case management team

↓

Case Coordinator refers the case to the service providers and follows up the plan implementation process

Form (7-a)

↓

Service providers identify the survivor's specific needs and provide services according to their specialty

↓

The risk assessment should be performed and responded to periodically as needed. In the event of new or renewed risk factors, the Case Coordinator re-assess the initial emergency needs; risk criteria, and accordingly:
1. Make necessary adjustments to the intervention plan
2. Coordinate with relevant partners.

Each service provider prepares a report on the service provided and follow-up recommendations and sends it to the case coordinator

Form (8-a)

↓

Case Coordinator follows up the plan implementation through
a- Direct follow up with the survivor
b- Follow-up reports received from service providers

↓

The case coordinator fills the Follow-up Registry form based on the reports provided by the service providers, which is presented to and ratified by the Case Management Team

Form (9-a)

↓

Table # 9: Mechanisms of holding a case conference

Case Coordinator holds case conference with case management team to present the immediate response plan outcomes and documents it and takes best decision

Form (6-a)

Case conference decision

1- Comprehensive intervention objectives not achieved
2- Life-threatening Risk factors not eliminated
3- New Risk factors appeared

↓

Comprehensive needs assessment and fill Form (5-a)

Form (5-a)

1- Comprehensive intervention plan objectives achieved
2- Life-threatening Risk factors eliminated
3- No need for further services

↓

Move to file closure procedures

↓

Inform the case and his/her family of the necessary protection instructions, in case additional support might be needed in the future (security plan), to be documented in the file

The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

Comprehensive intervention plan in the case management within the participatory approach in the Family Protection Department									
Family Protection Department	**Judiciary**	**Sharia Court**	**Ministry of Interior**	**MoH**	**MoH**	**MoH**	**Ministry of Social Development**	**Ministry of Education**	**Services by other institutions**
Judiciary Division	**Public Prosecutor**	**Ministry of Interior**	**«Protection against Family Violence Division**	**Forensic Medicine**	**Hospitals and Centers**	**Psychiatry Clinic**	**Social Development office and Shelters**	**Guidance department**	
The case coordinator coordinates with the Judicial Division, to implement actions in intervention plan	The case coordinator, coordinates with the magistrate or the prosecutor for the implementation of actions agreed in the intervention plan	The case coordinator follows-up with the Sharia Court for the implementation of actions agreed in the intervention plan	The case coordinator follows-up with the «Protection against Family Violence Division» for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with the forensic physician for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with the Medical care for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with the psychiatric physician for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with Social Development office for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with Guidance Department for the implementation of actions agreed in the intervention plan	Case Coordinator. Coordinates with respective institution, providing related case information
Judicial Division takes all necessary police procedures/ actions		Family reform office, follow-up on the case, provide Legal, Sharia and judiciary advice	Protection» against Family Violence Division» coordinates with the local Governor for the implementation of actions agreed in the intervention plan	Forensic physician carries necessary checkup for the case and perpetrator and any other party involved	Medical care carries clinical check and provision of needed treatment services	Psychiatric physician carries necessary checkup for the case and perpetrator and any other party involved	Social Specialist / worker carries the necessary actions	Guidance department implements the actions as agreed	Service provider in the institution interviews the case and provide required services
Judicial Division Prepare a report on procedures carried with recommendations				Forensic physician Prepare forensic, periodic and final reports including recommendations	Medical care Prepare reports and recommendations	Medical care Prepare reports and recommendations	Social Specialist / worker Prepare reports	Guidance department prepare the report including recommendations	Service provider prepare report on services provided including recommendations
Case Coordinator includes the report of judicial Division in the case file				Coordinator includes the report in the case file	Coordinator includes the report in the case file	Coordinator includes the report in the case file	Coordinator includes the report in the case file	Coordinator includes the report in the case file	Coordinator includes the report in the case file
The case Coordinator follows the implementation of police procedures	. The case Coordinator follows the implementation of the Judicial decision	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations	The case Coordinator follows the implementation recommendations
Official implementation body **FPD Judiciary Division**	**Official implementation body** FPD case coordinator	**Official implementation body** Sharia Court and family reform offices	**Official implementation body** "Protection against Family violence Division"	**Official implementation body** Forensic Medicine clinic	**Official implementation body** Hospitals and health centers of MoH	**Official implementation body** Psychiatry clinic, other provider	**Official implementation body** Social Development Office and any other social service provider	**Official implementation body** Guidance department in MoE	**Official implementation body** MoE, Education guidance division

Case File Closure Procedures

Table # 10: Regulations and Justifications of the case file closure

Case Coordinator closes the file according to follow-up case conference results based on:
- Immediate response plan achieved, and risk factors eliminated
- Comprehensive intervention plan achieved, and risk factors eliminated

Form (10-a)

File Closure Justification:

a- Realizing the goals of the immediate response plan, eliminating the risk factors and ensuring they don't recur.

b- Realizing the comprehensive intervention plan, eliminating the risk factors and ensuring they don't recur.

c- Moving abroad for residency or immigration.

d- The death of the survivor; and the procedures regarding the protection of the other family members.

e- The refusal of the case to receive the multiple services.

f- If the case was incompetent or a child, and if the legal representative refuses to pursue the procedures of the case management, the best interests should be taken into account while ensuring the completion and the continuity of the legal and administrative procedures according to the regulations, instructions, and laws regarding the nature of the case and the procedures related to the protection of the other family members.

File Closure Regulations:

1- The attendance of service providing representatives who deal with the case.

2- The documentation of justifications and closure standards.

3- The written documentation of any reservation if present.

4- Based on the majority decision, the case management team takes a closure decision.

5- The signature and endorsement of the case management team members on the proceedings of the case conference which resulted in the file closure decision.

6- The case and his/her family are notified with the required instructions for future follow up, in addition to the safety plan to prevent the recurrence of violence.

The case coordinator ensures that the decision of file closure conference is documented, endorsed and signed by all the partners.

The case coordinator closes the file and saves it according to filing policy in the Family Protection Department

Inform the case and his/her family of the necessary protection instructions if additional support needed in the future (security plan) and document it in the file

The file is re-opened if any new future complaints are received

The case coordinator notifies the case and his/her family with the results of the file closure conference and provides him/her with the necessary instructions to prevent the recurrence of violence, in addition to follow up guidelines in case of the need for any additional support in the future (safety plan) and documents that in the file.

The case coordinator ensures the approval and endorsement of the Case Coordinators Supervisor

Application of Case Management

b. Explanation of detailed procedures for the application of the case management approach in the Family Protection Department.

Identification and Reporting Phase

Identification and reporting phasel
General criteria for all the workers on the case management
1)The absolute belief in the importance of dealing with Family violence cases and providing protection for them.
2)Ensuring confidentiality in dealing with the data of the case and his/her family and the information of the informant.
3) Respect to the wishes of the survivor and respectful treatment of all individuals following a non-discriminatory approach.
4)Professionalism and neutrality in dealing with violence cases.
5) Adherence to the code of conduct and the moral principles and values.

Mechanism of identification and reporting of violence cases:

1) **Personal report/complaint (self-referral):** the case or the legal representative files a complaint to the Family Protection Department in person.
2) **Telephone:** receiving information through the case or one of his/her family members or the local community via:
   a. The main department phone numbers or its offices.
   b. The national emergency line (911).
3) **Reporting:** receiving the approved reporting form from a service provider.
4) **Police station:** the transfer from a police station that received a complaint or a personal reporting, or from the incident representative of the police station inside hospitals.
5) **FPD Email / website.**
6) **Others.**

Procedures of dealing with the family violence cases inside the Family Protection Department:

a. The reception officer of the department receives the information/complaint from various sources, and deals with it based on the following:

Table (1): Mechanisms of identification and reporting of family violence and procedures to deal with them in the Family Protection Department	
Mechanism of identifying a violence case	**Procedures of dealing with the cases inside the Family Protection Department**
Personal reporting/complaint	The procedures of receiving the case are immediately initiated.
Telephone	a. If the information is received from the case or his/her family or his/her legal representative, he/she is asked to attend personally to the department to file a complaint, then immediately start the reception procedures. In case the survivor or his/her legal representative fails to attend due to convincing justifications, the reception employee collects all the possible information of the violence incidence and transfers the case to the case coordinators supervisor to take the case management procedures and assign a case coordinator to start the immediate response procedures which focuses on the verification of the Family violence case. In case of suspecting a case with a priority where the case and his/her family are prone to danger, the case coordinator takes the emergency immediate procedures necessary to ensure the safety of the case and his/her family. And the necessary procedures are taken according to the results of the verification results. b. In case the information is received via Phone from another party (not the case nor his/her legal representative), such as: family members, local community, or a service providing institution or a service provider; the reception employee collects the possible information on the violence incident and the concerned parties, then informs the case coordinators supervisor, who in his turn, initiates the case management procedures through assigning a case coordinator to start the immediate response procedures which focus on the verification of the reporting. The necessary procedures are then taken accordingly.
Reporting	In case of receiving the approved reporting form, the reporting is dealt with as a «complaint», and the case coordinators supervisor immediately initiates the case management procedures.
Police station	These cases are received under official correspondence, and are dealt with as «complaints», and the case management procedures are immediately initiated.
Others	Such as communication by email.

b. The reception officer records the information/complaint in the complaints log and the department's entry audits.

c. The reception officer fills in the available data concerning the case and his family in the special form "Reception Form" (Form 1-a).

Table 2: Special criteria for the reception officer
1. To have sufficient knowledge and experience when receiving the Family violence cases and the mechanisms to deal with them. 2. To have high communication skills and the ability to provide the necessary support to the case and his/her family. 3. To have the ability to identify priority cases that require immediate intervention and the appropriate mechanisms to deal with them.

d. The reception officer transfers the case to the case coordinators supervisor to start the procedures of the case management.

Table 3: Special criteria for the case coordinators supervisor
4. To have sufficient knowledge and experience in classifying the cases and the mechanisms of dealing with them. 5. To be familiar with the expertise of the case coordinators and have the ability to allocate the cases accordingly. 6. To have managerial and administrative skills to assign the cases to the case coordinators fairly. 7. To have high communication skill and the ability to provide the necessary technical and administrative support to the case coordinators. 8. To have the ability to identify priority cases that requires an immediate intervention and the mechanisms to deal with them.

a- The case coordinators supervisor receives the transferred case from the reception or the reporting form from the institutions.

b- Ensuring the qualitative specialization of the department: the case coordinators supervisor ensures the qualitative specialization of the administration of the Family Protection Department and its case receiving offices:

- In case of qualitative specialization, the supervisor checks for previous files for the case.
- The supervisor studies the case and classifies it into high or low priority cases, (Table (4)), and selects the suitable case coordinator for it based on the case coordinator selection criteria (Table (6)) who continues with the case management procedures.
- In case of incompatibility of the qualitative specialization (not a family violence case), the supervisor refers the case to a relevant qualitatively specialized agency.

Table 4: High priority cases
A case coordinator is assigned within a maximum period of one hour from receiving the case and the case management procedures are initiated within 3 hours. Services are provided according to the initial assessment of the case.
• The presence of serious physical injuries that require immediate medical care. • The use of weapons or sharp tools in the assault. • Sexual assaults within the past 72 hours for administration of preventive treatment after being subjected to the sexual violence (emergency contraceptives, preventing the transmission of sexually transmitted diseases, and preventing the transmission of HIV). • Threat to life of the survivor from the perpetrator or one of the family members (fear of honor crimes). • In case the survivor suffers from one of the following symptoms; severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety. • Suicide attempts or planning for or threatening to hurt others by the Case.

c- The case coordinators supervisor completes the reception form/ field of case coordinator selection (including the name of the coordinator and the alternative coordinator).

For high priority cases: a case coordinator is assigned within a maximum period of one hour after the case is received.

Table (5): Criteria for case coordinators
1. To have sufficient knowledge and experience in classifying the cases and the mechanisms of dealing with them. 2. To have high communication skills. 3. To have the ability to identify risk factors that require immediate intervention and the mechanisms to deal with them. 4. To have coordination, follow up, assessment and documentation skills. 5. To have practical experience and specialized training in the area of case management.

Table (6): Criteria for case coordinator selection
1. Taking into account the gender of the case when assigning the cases to the case coordinators. 2. Categorizing the severity of the case and the experience of the case coordinators when assigning cases. 3. Considering the jurisdiction of the case coordinators when assigning the cases. 4. Providing clear grounds in identifying cases where there is a conflict of interest among the case coordinator, the case and the service provider. 5. Ensuring that the number of cases for each case coordinator does not exceed 50 cases at a time.

In the event that the Family Protection Department receives information of a violence incident but the survivor or his/her legal representative is not present to complete the procedures of the case management, the case coordinators supervisor assigns a case coordinator to arrange the verification process with the coordination of the concerned staff from FPD (the judicial division) and the social workers (the social service office) to verify the information as one of the immediate response procedures.

d- The supervisor of the case coordinator provides technical support to the case coordinators and follows up on the procedures, endorses and checks all the procedures and the intervention plans.

The Immediate Response Phase

a- The case coordinator transitions to **the Immediate Response Phase** according to the information received from the supervisor and the reception form.

b- The case coordinator is responsible for all documentation procedures and for the follow up with all the partners up to **the procedures of file closure.**

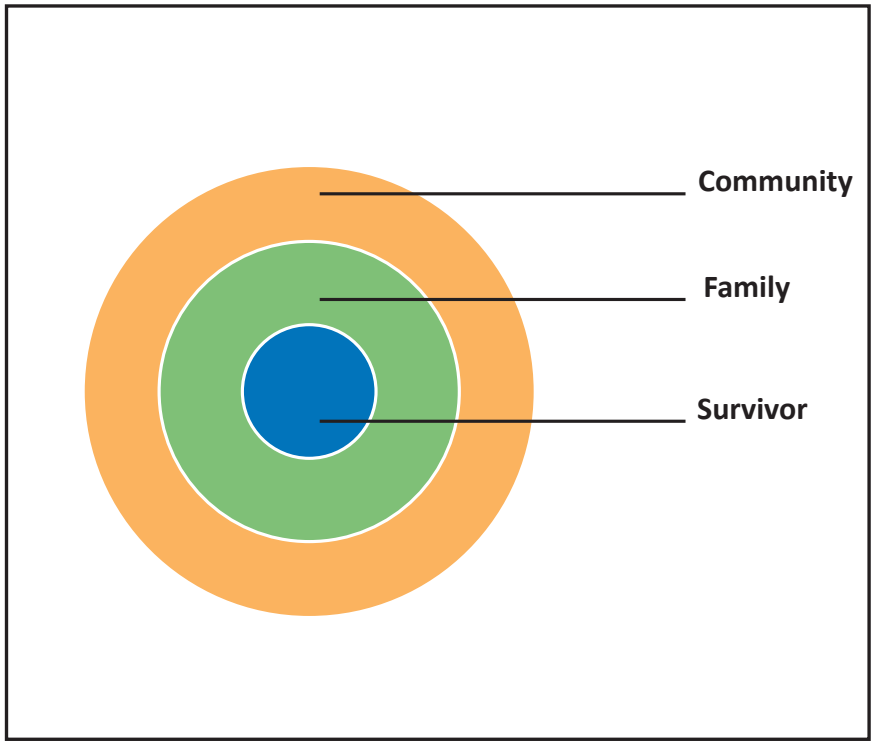
c- The case coordinator opens a new case file or re opens the old file (if applicable).

d- The case coordinator receives the case (with or without his/her family depending on the case and the best interest) and controls all the documents and reports he/she holds if available.

e- The case coordinator conducts a preliminary evaluation of the case to identify the urgent needs (physical, psychological/social, safety and protection) and the preliminary risk factors according to an "Initial Assessment Form" (Form 2-a) to specify the concerned partners with

the case. The preliminary evaluation is shared with the concerned service providers.

Life-threatening risk factors are assessed based on three levels: individual (the survivor, family, community)



Life-Threatening Risk Factors

Definition	Is a set of indicators and characteristics of the survivor, or the perpetrator, or the family or the community, which lead, individually and / or combined, to a direct threat to the life of the sruvivor and / or his/her family.
Classification	• These indicators may be: 1. Imminent danger and life threat to the case or his/her family, which requires provision of a safe place for the case until it is eliminated. 2. Frequent threat of family violence towards the case or any of her/is family members. • These indicators can be permanent or temporary, therefore a case periodic review is necessary. • Assessment of these indicators (dangers and threats) requires a specialized study by the case coordinator and service providers to identify and deal with. • Can be classified according to: 1. Level of influence on case, perpetrator or the family) as shown in the model below (risk assessment: probability of occurrence / impact), accordingly, intervention priorities can be identified. 2. Type of indicators: physical, psycho / social, economic, legal and other
Response	**Response to risk factors Requires** 1. Categorize factors into a permanent or temporary to develop appropriate response plan 2. Linking the risk factors to the multiple needs of the case and / or the family, and services required for the intervention.

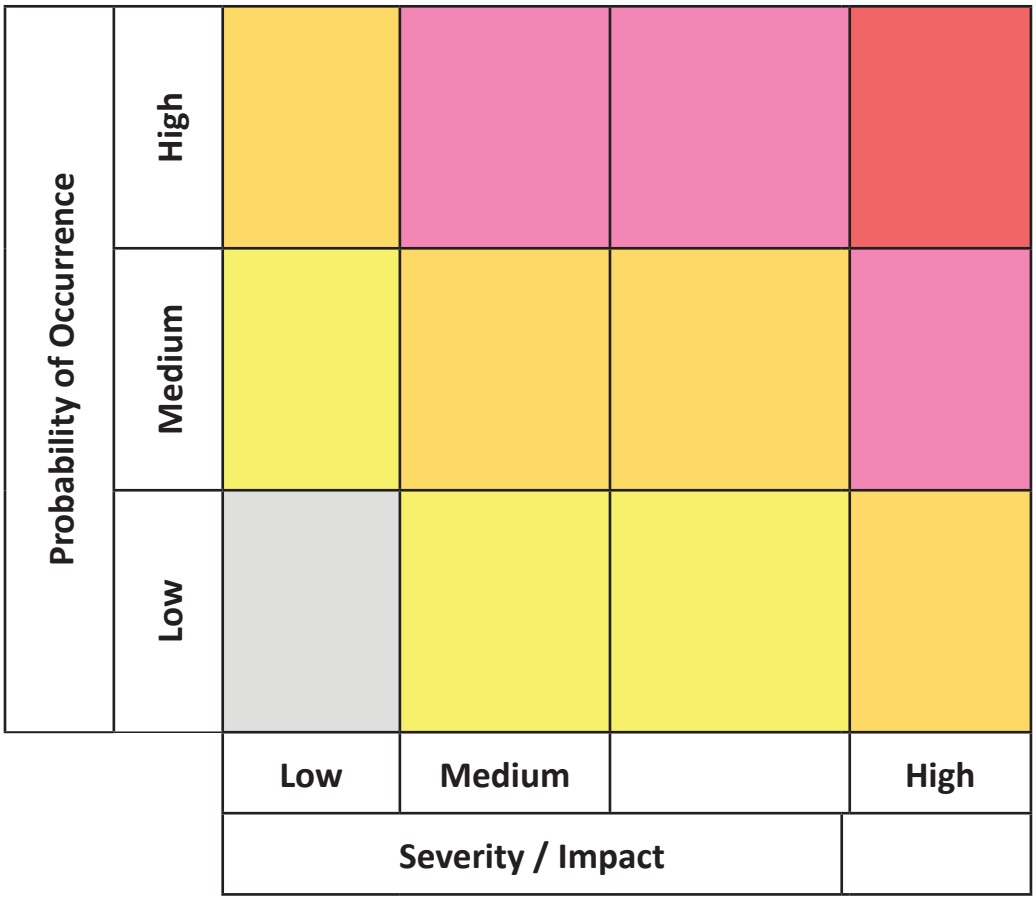
Examples of factors that pose a risk to the life of the survivor or any of the family members		
Survivor	**Family**	**Community**
– A severe psychological state and a low self-esteem by the case that may increase the probability of suicide – A previous suicide attempt – Sexual violence on the case, whether from inside or outside the family – The recurrence of any form of violence in a manner that may affect the life and physical integrity of the individual	– The survivor lacks a social support network of parents and relatives- – The culture of the family may not tolerate reporting any case of violence by any of its memb ers, therefore there is possibility of serious action against the case or family members. – A direct threat from the perpetrator in the event that the offender and the case remain together within the family – Previous security records for any family member may pose risk to the lives of individuals – Use of weapons by family members.	– The surrounding social environment accepts violence and can't tolerate the request by the case for assistance, and considers the survivor / the case as a stigma, that must get rid of by killing

Risk Assessment:

Probability and impact Severity

Based on the available information, the case management team investigates the circumstances and conditions of the case to identify and assess the potential risks as per the attached matrix. Based on the comprehensive assessment of the overall risk factors and needs of the case, the environmental conditions of the case, the service provision reports of the survivor, his/her family and the perpetrator.

Usually the orange squares are taken into serious consideration, pink squares are considered risky, while the red squares are considered high risk. The risk level is assessed by the case management team.



f- The case coordinator arranges to hold "the immediate response meeting" with the institutions and the partner bodies to draft "the immediate response plan" according to "Immediate Response Plan Form for the Family Protection Department" (Form 4-a).

Based on the risk factors and needs assessment, the case coordinator starts the procedures of case management within one hour of receiving the case for high priority cases and within three hours for other cases.

Table 7: Mechanisms of holding immediate response meeting	
What?	It is a consultative meeting held by the case coordinator jointly with the concerned institutions to draft the immediate response plan, to deal with the case and his/her family according to the priorities, needs, risk factors and the family of the survivor.
Who?	The **case coordinator** calls the concerned partners. - The health sector including forensic medicine and psychiatry when needed. - The police sector. - The judicial sector. - The administrative sector. - The social sector, that is concerned with the study of the initial social case of the case and his/her family. - Others: according to the evaluation and assessment of the case needs.
When?	The time frame is defined based on the classification of the cases and their priorities. According to risk standards, coordination is made with the concerned partners within a maximum period of 3 hours.
How?	Through direct phone call with the concerned bodies or via holding a conference with the presence of the concerned bodies if possible. The case coordinator presents and discusses the initial information of the case and the necessary information to take the response procedures according to the appropriate sector.
Why?	To have an **immediate response plan in place**, in cooperation with the case management team, while defining the following: a. The planned activities. b. The responsibilities and roles of the executive partners. c. The time frame: while ensuring that appointments are not conflicting, and according to the procedures' priorities needed by the case. Accordingly, each partner starts providing services and sends a service provision report to the case coordinator clarifying the procedures undertaken in accordance with the immediate response plan.
Documentation, endorsement and follow up	a. Documentation of all the immediate response meeting proceedings by the case coordinator and endorsing it by all the concerned partners. b. Ensuring that the partners abide by the articles of the immediate response plan. c. Ensuring the thorough follow up by the case coordinators to implement the articles of the immediate response plan within the agreed time frame. d. Ensuring the endorsement of the case coordinators supervisor.

g- The case coordinator documents the developments of the immediate response meeting and the agreed procedures; in addition, he/she ensures its endorsement from the partners.

H- The case coordinator includes the case and his/her family in the immediate response plan in addition to the available options, including the consequences of each according to the best interest and the laws and legislations and the national regulations in force.

h- The case coordinator documents the work plan and all its details (including the activities of the immediate response plan, responsibilities and roles of the service providing partners, and the time frame) "Immediate Response Plan Form for the Family Protection Department" (Form 4-a).

The time frame for activities of the immediate response plan should be documented, and the priorities of the procedures should be taken into consideration according to the needs of the case while ensuring that the appointments between the partners and the provided service do not conflict.

Institution	Some examples on the immediate response plan procedures
The Family Protection Department- The judicial division	**1. Police procedures:** The case coordinator, in coordination with the judicial division, agrees on the appointment of police procedures, such as: • Bringing identification documents. • Taking statements: from the survivor/ witnesses/ parents. • Bringing involved parties. • Subpoenaing the perpetrator. • Seizing samples and sending them to the forensic evidence and the laboratory department. • Recording the interviews with the case children using video recording as mentioned in the instructions for such cases. • Verifying records and preparing a precedents report if available. • Referring the case to the judicial authority. • Initiating the verification procedures (meeting the survivor). • Transferring the case immediately to an emergency center for treatment. • Notify the coroner immediately with the presence of a case in the emergency room. • Transfer to the governor to take the necessary administrative procedures. • The security procedures. • Taking any procedures agreed upon with the case coordinator. • Prepare a report with the procedures and recommendations and send them to the case coordinator. **2. Procedures related to the judiciary authority and the Prosecutor General:** a. Case coordinator coordinates with the Prosecutor General on the case, providing him/her with all the information and the risk factors. b. The case coordinator acquires the ruling of the magistrate/ the Prosecutor General. c. Case coordinator documents the ruling in the case file and follows up with its enforcement. d. Follow up on the judicial proceedings. **3. Procedures Sharia Court/ public prosecution:** a. The case coordinator coordinates with the Sharia Court regarding the case and provides it with all information and risk factors. b. The prosecution studies the case and transfers it to the forensic court to adjudicate (such as; obtaining a provisional order for the attachment of the assets of the perpetrator, transfer the child custody or give it to another party, etc.…) c. The case coordinator documents the Sharia Court report in the case file. d. Follows up on the Sharia Court procedures.

Ministry of health	**Forensic clinics**	**1.** Conducting the examinations and the procedures according to the immediate response plan of the perpetrator and the case and any other parties, such as: a. Conducting the forensic examination for the case or the perpetrator. b. Making a preliminary forensic medical report. c. Collecting samples and criminal evidence. d. Provide clinical management of sexual violence. **2.** Prepare the preliminary reports including the recommendations and send them the case coordinator. **3.** The case coordinator follows up with the implementation of the recommendations.
	Psychiatry clinic	**1.** The case and/or caregiver are interviewed and a preliminary psychiatric assessment is conducted. **2.** Prepare a psychiatric medical report and its recommendations which might include a submission to the national psychiatric center and sending it to the case coordinator. **3.** The case coordinator follows up on the implementation of the recommendations.
The Social Service Office		**1.** The head of the office receives the transfer form from the case coordinator. **2.** The head of the office assigns a social expert to follow up with the case. **3.** The social expert conducts the required procedure/s, such as: – Preliminary home visit If appropriate. – Conducting a social study, and interviews with the case and his/her family in addition to the perpetrator. – Shelter-care, temporary protection. – Emergency financial aid. **4.** The social expert prepares a social study and sends it to the head of the office. **5.** The head of the office endorses the social study and sends it to the case coordinator. **6.** The case coordinator follows up on the implementation of the recommendations.

i- The case coordinator shares the articles of the plan with the partners and follows up on its implementation with them. Each service provider is considered a member of the case management team.

j- The case coordinator refers the case (and his/her family if the case needed) to the specialized service providers according to the immediate response plan, "Referral Form" (From 7-a) making sure to acquire informed consent.

After completing the needs assessment, the case coordinator begins referring the survivor, within a maximum of one hour, to the service providers based on the coordination with the partners and the sequence of needs.

Table (8): Criteria for the case management team member

1. To have sufficient knowledge and experience in assessing the cases and the mechanisms of dealing with them.
2. To have high communication skills and the ability to provide the necessary technical support to the cases through the Service Provision Form and the recommendations mentioned in it.
3. To be directly concerned in dealing with the cases within his/her institution and possesses the full authority to be familiarized with the work procedures with them.
4. Ensuring the commitment to attend all the meetings and the conferences related to the case.

k- The service providing partners identify the case's special needs, each according to their specialty, and commences service provision. The Service Provision Form is completed (Form 8-a) listing the undertaken services and follow up recommendations according to the regulations and internal instructions for each partner institution. In addition to sharing the report with the case coordinator via the agreed follow up mechanism.

The risk assessment procedures should be conducted periodically according to the needs of the case and the response should be implemented accordingly.

In case of the emergence of new and evolving risk factors, the case coordinator re-conducts the preliminary assessment to define the urgent needs and the risk standards, and accordingly:

1- Makes the required amendments on the intervention plan.

2- Coordinates with the concerned partners.

l- The case coordinator fills the Follow-up Registry Form (Form 9-a) based on the service provision reports submitted by the partners and shares it with the partners ensuring the endorsement of the case coordinators supervisor.

m- Based on the follow up registry report of the implementation of the immediate response plan, and the notes and recommendations of the concerned partners, the case coordinator briefs the supervisor on the course of the case and the implementation of the immediate response plan, in addition to having the latter's endorsement on the procedures.

The case coordinator prepares the Follow-up Registry Form for the implementation of the immediate response plan within one hour of receiving the service provision report and takes appropriate measures based on the recommendations of the service provider.

n- The case coordinator coordinates to hold a case conference to present the outcomes of the immediate response plan and taking the best decision (Form 6-a)

Within a maximum period of 24 hours following the receipt of the final service provision report, the case coordinator completes the Follow-up Registry Form for the implementation of the immediate response plan and the comprehensive risk factors assessment, shares it with the service providers, and sets an appointment for the case conference within a maximum period of two weeks based on the case priority and nature.

Table (9): Mechanisms of holding a case conference	
What?	This is a meeting that the case coordinator calls for with the participation of all the representatives of the concerned institutions to deal with the case and his/her family, in order to study all of its aspects (health, mental/social, legal, judicial, administrative, pedagogical, and any other services he/she might need). In addition to developing an intervention plan that identifies the required procedures to support and help the case and his/her family, and the perpetrator if needed. The case conference reflects the efficiency of the multi-sectoral collaborative approach in responding to the Family violence cases, and in providing the appropriate comprehensive services to the case and his/her family.
Who?	The **case coordinator** calls the concerned partners: - The health sector including the psychiatric and forensic when needed. - Social service: enabling and rehabilitation/shelter-care. - Legal service. - Judicial service. - Administrative service. - Pedagogical service: administrative procedures might be required or providing technical service from the Ministry of Education. - Economical enabling service. The concerned partners who provide service are called the **"Case management team members".**
When?	After implementing the immediate response plan or the comprehensive intervention plan, and that is based on the work priorities with the survivor, his/her family and the perpetrator.
How?	A representative of each of the partners is called (provided that the service is directly provided to the survivor, his/her family or the perpetrator).
Why?	To develop the comprehensive plan, and to identify the following: a. The plan's activities. b. The responsibilities and the roles of the executive partners. c. The time frame of the implementation. d. The follow up mechanism.
Regulations	a. Taking into account the selection of the representative partnering institutions who is directly concerned, or the selection of the direct service provider to the survivor. b. Ensuring the commitment of the partnering institutions representative as a communication officer between his/her institution and the case coordinator. c. Ensuring the continuity of the representation by the same person (as long as possible).
Documentation, endorsement and follow up	a. Documenting and endorsing of all case conference proceedings. b. Ensuring that the case management team abides by the articles of the comprehensive intervention plan. c. Ensuring close follow up of the implementation of the comprehensive intervention plan.

Within three hours following the case conference, the case coordinator prepares the comprehensive intervention plan and allocates tasks for service providers, or schedules a new time and date for the follow-up case conference including reasons for not convening the conference. And in the event the case conference results in file closure, the case coordinator finishes the case file closure procedures within 24 hours.

During the case conference and based on the discussion of the case management team, decisions are made to undertake one of the following procedures:

- Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team participating in the conference, evaluates that the goals of the immediate response plan have been realized, the activities have been implemented, the life-threatening risk factors have been eliminated, and in case of the absence of the need to provide any other service, moreover, if the team decides to close the case file, the case coordinator resorts to the **file closure procedures**. The case coordinator notifies the case and his/her family about the required instructions to protect him/her in case he/she needed any additional support in the future in order to prevent the recurrence of violence, and documents that in the case file.
- Based on the multi-sectoral and multidisciplinary assessment, and if the case management team participating in the conference, found that the goals of the immediate response plan of the case have been realized (the case and his/her family), all of the activities have been implemented, the Life Threatening risk factors have been eliminated, and the case management team found the need of the case for other services (the case and his/her family), the case coordinator coordinates with all partners to move to the **comprehensive intervention phase**.
- Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team participating in the conference evaluates that the goals of the immediate response plan of the case have not been realized, and the Life-Threatening risk factors still exists (the case and his/her family), the case coordinator re-conducts the preliminary assessment and the preliminary needs in coordination with the case management team. In addition to the amendment of the immediate response plan accordingly, and the commencement of taking the required procedures to provide the immediate services for the case in coordination with the concerned partners.

The case coordinators supervisor provides technical and administrative support to the case coordinators, follows up the course of the case, endorses and controls all procedures and intervention plans.

The case coordinators supervisor inspects the progress of the cases and endorses the procedures that the case coordinator will undertake within a maximum period of 24 hours.

Special case

In case of sexual abuse, the case coordinator should take into consideration the time between the occurrence of the incident and attending to receive services.

Within the first seventy-two hours of sexual abuse, there must be a direct coordination of the examination by the forensic doctor to seize the criminal evidence. In addition, the case must be transferred to the health service provider for urgent therapeutic services for any physical injuries, which should be documented. Moreover, ensure provision of preventive medical services such as emergency contraceptives and anti-transmission drugs of sexual transmitted diseases and HIV.

Comprehensive Intervention Phase

The case coordinator moves to this phase based on the decision of the case conference taken by the case management team to continue with the intervention procedures, and based on realizing the immediate response plan goals, implementing all its activities, elimination of any life-threatening risk factors, and based on the survivor's need for other services.

1. After deciding to move to the Comprehensive Intervention Phase, and during the case conference, the case coordinator coordinates to conduct a comprehensive assessment of the overall risk factors and needs of the case, taking into consideration the multiple needs of the survivor; health, physical, social, economic, etc.…) and fills out the "Comprehensive Needs Assessment Form" (Form 5-a) in cooperation with the members of the case management team all within their respective competencies.

Comprehensive Risk Factors	
Definition	Is a set of indicators and characteristics of the case, or the perpetrator, or the family or the community, which lead, individually and / or in combination, to Increase exposure to family violence or increase in incidence frequency, and these include the comprehensive risk factor ((life-threatening factors and risk factors associated with comprehensive needs assessment (social, psychological, pedagogical/educational, health, legal, economic, etc.) for the survivor and his/her family)).
Classification	• These indicators may or may not indicate Imminent danger and life threat to the case or his/her family. • These indicators can be permanent or temporary, therefore a case periodic review is necessary. • Assessment of these indicators requires a specialized study by the case coordinator and service providers to identify and deal with. • Can be classified according to: 1. Level of influence on case, perpetrator or the family) as shown in the model below (risk assessment: probability of occurrence / impact), accordingly, intervention priorities can be identified. 2. Type of indicators: physical, psycho / social, economic, legal and other.
Response	Response to risk factors Requires 1. A specialized comprehensive assessment and study on the life aspects of the case and perpetrator to determine the extent to which the risk indicators affect the case life or his/her family members or increase the intensity of the practiced violence. 2. Categorize factors into a permanent or temporary to develop appropriate response plan. 3. Linking the risk factors to the multiple needs of the case and / or the family, and services required for the intervention.

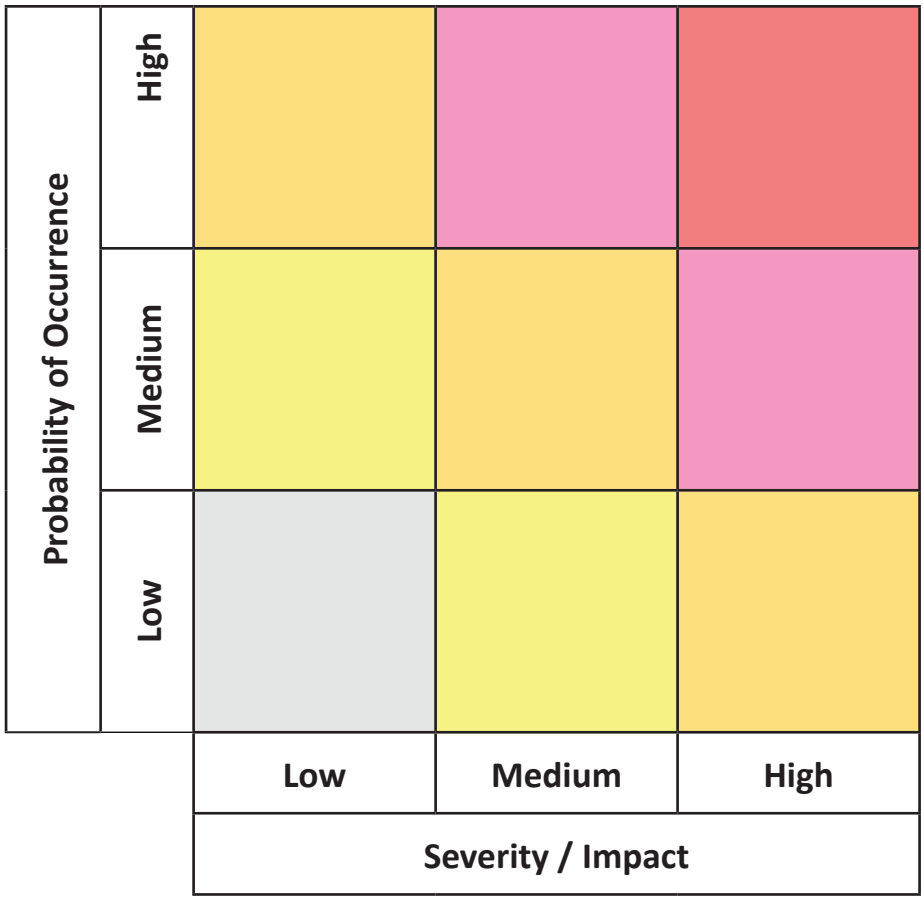
Risk factors are connected to the determination of the comprehensive needs of the survivor or any of his/her family members, but pose a threat of recurring violence and requires interventions from all relevant partners, each according to their specialization.		
Survivor	**Family**	**Community**
– A severe psychological state and a low self-esteem by the case that may increase the probability of suicide – A previous suicide attempt – Sexual violence on the case, whether from inside or outside the family – The recurrence of any form of violence in a manner that may affect the life and physical integrity of the individual	– The survivor lacks a social support network of parents and relatives- – The culture of the family may not tolerate reporting any case of violence by any of its members, therefore there is possibility of serious action against the case or family members. – A direct threat from the perpetrator in the event that the offender and the case remain together within the family – Previous security records for any family member may pose risk to the lives of individuals – Use of weapons by family members.	– The surrounding social environment accepts violence and can't tolerate the request by the case for assistance, and considers the survivor / the case as a stigma, that must get rid of by killing
– Exposure to frequent physical violence that did not result in acute injuries that requires urgent health care, with the possibility of recurrence – Addiction to sedatives, or alcohol. – The inability to protect oneself from violence due to disability or chronic illness – Current or previous psychiatric disorders	– Family Disintegration. – Tension among family members. – The family needs urgent / ongoing financial assistance to meet their living obligations – Presence of family members who may repeat the violence. – Having more than one individual exposed to violence – perpetrator Addicted to drug or alcohol. – Possibility of the offender reaching the case within the family space. – Absence of a reliable person to care and or protect the case within the family.	– The Community culture renounces violence in general but considers it normal if it occurs within the family and can be dealt with within the family and does not require the intervention of parties outside the family.

Risk Assessment:

Probability and impact Severity

Based on the available information, the case management team investigates the circumstances and conditions of the case to identify and assess the potential risks as per the attached matrix. Based on the comprehensive assessment of the overall risk factors and needs of the case, the environmental conditions of the case, the service provision reports of the survivor, his/her family and the perpetrator.

1. Usually the orange squares are taken into serious consideration, pink squares are considered risky, while the red squares are considered high risk. This categorization is based on the case management team's assessment.



A risk assessment should be conducted periodically and the response adjusted accordingly.

In case of the emergence of new or evolving risk factors, the case coordinator re-conducts the assessment to define the emergency needs and the risk factors, and based on that:

1. .Makes the needed amendments on the immediate response plan according to the case developments.
2. .Coordinates with the concerned partners to provide the services.

2. Based on the comprehensive assessment of the risks and needs, the case coordinator calls all concerned partners to hold the "Case meeting" according to the "Case conference form" (Form (6-1)).
3. The case coordinator documents the proceedings of the case conference and the articles of the agreed plan, and ensures it is ratified and signed by all partners.
4. The case coordinator prepares a case brief in addition to a detailed action plan and shares it with the partners according to the "Case conference form" (Form 6-a).

The case coordinator and the case management team prepare the comprehensive intervention plan with all its details by completing the Case Conference Form (Form 6-a) and shares it with the partners.

5. The case coordinator documents the case conference details and the agreed-upon intervention plan procedures, insuring endorsement and signatures of all partners.

The time frame allocated to implement the activities of the comprehensive intervention plan should be documented, and the priorities of the procedures should be considered according to the case's needs, while ensuring that the appointments between the partners and the provided services do not conflict.

The case coordinator includes the case and his/her family in the comprehensive intervention plan, the case cordinator includes dures and available options, and the consequences of each as per the best interest and the legislations, laws and the national regulations in force.

6. The case coordinator transfers the case and his/her family to the service providing institutions as recorded in the comprehensive plan according to the "Service providing institutions from" (From 7-a).

Institution	Some examples on the comprehensive intervention plan procedures
The Family Protection Department-Judiciary Division	1. **The police procedures:** a. The case coordinator follows up with the case investigator. b. Coordination with the judicial division to take the police procedures and agree on the due dates of those procedures, such as follow up on the litigation procedures. c. Prepare a report with the implemented procedures and recommendations and send it to the case coordinator. d. The case coordinator follows up on the implementation of the recommendations. 2. **Procedures related to the judiciary system and the Prosecutor General:** a. The case coordinator with the magistrate/Prosecutor General coordinates regarding the case and provides the latter with all information and risk factors. b. The case coordinator receives the Prosecutor General's decision. c. The case coordinator documents the decision in the case file and follows up on its enforcement. d. Following up on the judicial procedures. 3. **Procedures of the forensic judiciary system/ public prosecution** a. The case coordinator follows up with the Sharia Public Prosecution and the family reconciliation office, and follows up on the required procedures according to the case assessment and its needs regarding everything related to the personal status; such as divorce, alimony and custody, etc.... b. The family reconciliation offices follow up on the case and provide the legal, sharia and judicial consultation. c. The case coordinator follows up on the implementation of the recommendations and procedures.
Forensic clinic	1. Conducting examinations and procedures according to the comprehensive intervention plan for the perpetrator and the case or any other parties, when required, such as: • Forensic consultations. • Consequential or deterministic forensic reports. • Provision of clinical management of sexual violence. 2. Preparing reports: • A summary of the report and recommendations. • The detailed forensic report. 3. The case coordinator follows up on the implementation of the recommendations.
Ministry of health/Hospitals & Health Centers	1. The case is transferred to medical services if needed. 2. Conducting a comprehensive medical assessment and providing the required medical services, such as: • Medical consultations. • Visits to the general and specialized medicine clinics and the follow up. • Provision of clinical management of sexual violence. 3. Prepare medical reports and recommendations. 4. The case coordinator follows up on the implementation of the recommendations.

Psychiatric clinics	1. Interview the survivor and conduct the comprehensive psychiatric examination (family members and the case are sometimes interviewed if it needed). 2. Provide the medical psychiatric services, such as: • Psychiatric consultations. • Visits to the psychiatric clinics for follow up. 3. Prepare the medical psychiatric report and its recommendations then send it to the case coordinator. 4. The case coordinator follows up on the recommendations.
The Social Service Office	1. The head of the office receives the case form from the case coordinator. 2. The head of the office follows up with the case via a social expert. 3. The social expert takes the following procedure(s), such as: • Shelter-care/ temporary protection. • Enabling, rehabilitation and re-integration programs. • Social follow up visits. • Family consultation sessions. • Monthly aid. • Behavior treatment. 4. The social expert prepares a report on the case and sends it to the head of the office. 5. The head of the office endorses the report and sends it to the case coordinator. 6. The case coordinator follows up on the implementation of the recommendations.
Ministry of Interior-Family violence Protection Division	1. The case coordinator coordinates with the Family violence Protection Division and provides it with the information and the risk factors. 2. The Family violence Protection Division follows up with the governor to take the administrative decisions and the required bails according to the legislation in force including the conciliation and ensuring protection. 3. The case coordinator receives the governor's decision and documents it in the case file. 4. The case coordinator follows up on the implementation of the recommendations.
Ministry of Education	1. The case coordinator coordinates with the department of counseling and guidance in the Ministry of Education. 2. Take the agreed upon procedures, such as: • School transfers. • Student consultation services (school counselor). • Educational and exam services. • Facilitating the mission of the social expert to meet the children at schools, in condition that the allowed authorities to interview the students are identified. They are preferred to be a social researcher from the Family Protection Department. 3. The Department of counseling and guidance prepares the report and the recommendations and send them to the case coordinator. 4. The case coordinator follows up on the implementation of the recommendations.
Other institutions according to the needs of the case	1. The case coordinator coordinates with the institution. 2. The agreed procedures are taken. 3. Reports and recommendations are prepared and sent to the case coordinator.

7. The service providers fill out the Service Provision Report (Form 8-a) and sends it to the case coordinator as per the agreed-upon methodology.
8. The case coordinator follows up the implementation of the comprehensive intervention plan as agreed during the case conference according to the referral forms. This is to ensure the implementation of the comprehensive intervention plan as mentioned in the agreed articles and recommendations and within the specified time frame. The case coordinator monitors the implementation of the articles of the comprehensive intervention plan according to the "Follow-up Registry Form", (Form 9-a) and follows up with the survivor.

The case coordinator notifies the case and his/her family with the outcomes of the case follow up conferences, the procedures and available options and the consequences of each according to the best interest and the legislations, laws and the national regulations in force.

9. Based on the follow up registry of the comprehensive intervention plan, a case conference is held with the participation of all the case management team members to present the outcomes of the implementation of the comprehensive intervention plan. Based on the discussions of the case conference, one of the following recommendations is undertaken:
   a. Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team, evaluates that the goals of the immediate response plan of the case have been realized, all of its activities have been implemented, the Life Threatening risk factors have been eliminated, in addition to the absence of the need for any other services, and the case team decides to close the case file - the case coordinator moves to the closure procedures of the case file, and the case coordinator notifies the case and his/her family with the required instructions to protect him/her in case he/she needed any additional support in the future. The case coordinator documents that in the file.
   b. Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team evaluates that the goals of the immediate response plan of the case have not been realized nor its activities implemented, and the case needs additional services and interventions - services and procedures are agreed to provided according to the case needs and they are translated into an action plan which is followed up by the case coordinator and the work team (restart the comprehensive intervention steps starting with the Comprehensive Needs Assessment Form "Form 5-a" and coordinating for a case conference called "Follow-up Case Conference").
      - In case of the emergence of new or recurring risk factors, the case coordinator re-conducts the assessment to determine any urgent needs and risk factors, in addition to take the necessary emergency response steps in coordination with the partners.

The case coordinator holds case conferences (follow up case conferences) repeatedly as long as there are risk factors or additional needs and interventions required, based on the comprehensive needs assessment in coordination with the partners.

The case coordinator notifies the case and his/her family with the outcomes of the case follow up conferences, the procedures and the available options in addition to the consequences of each according to the best interest, the legislations, laws and the national regulations in force.

The case coordinator notifies the case coordinators supervisor of the case developments and the implementation of the comprehensive intervention plan and obtains the supervisor's endorsement on the procedures.

File Closure Procedures

The case file closure is more effective when it happens as part of the agreed plan of operation among the service providers, after ensuring that the goals of the intervention plan or the immediate response plan of the case and his/her family are realized. And the progress is followed up and revised regularly.

The decision of the case file closure is taken according to justifications and standards pertaining to the file closure, and with a consensus among the concerned partners, in addition to the majority opinion of all the concerned institutions to provide their services to the case and his/her family, with the emphasis on the involvement of the case or his/her (legal representative) and his/her family in the case file closure. All concerned parties and service providers should take part in the decision-making process and discussing any necessary measures as a part of the closure process. A comprehensive revision must always be conducted for the risk factors affecting the survivor and his/her family prior to file closure ensuring overall documentation of all the services provided to the case and his/her family.

1. The case coordinator moves to the case file closure based on the case conference which comprises the following:
   - The implementation of the immediate response plan with its activities altogether, and the roles and responsibilities assigned to all partners with the elimination of risk factors and the absence of any additional needs of the case.
   - The implementation of the comprehensive intervention plan with its activities altogether, the roles and responsibilities assigned to all partners with the elimination of risk factors and the absence of any additional needs of the case.
   - The presence of one of the justifications of the file closure approved in the case management approach (Table 10).
2. The case coordinator arranges to hold a case conference. The closure is based on the conference recommendations according to the "Case file closure form" (From 10-a).

Table (10): Regulations and justifications of the case file closure.

Regulations of the case file closure	1. The attendance of service providing representatives who deal with the case. 2. The documentation of justifications and closure standards. 3. The written documentation of any reservation if present. 4. Based on the majority decision, the case management team takes a closure decision. 5. The signature and endorsement of the case management team members on the proceedings of the case conference which resulted in the file closure decision. 6. The case and his/her family are notified with the required instructions for future follow up, in addition to the safety plan to prevent the recurrence of violence.
Justifications of file closure	1. Realizing the goals of the immediate response plan, eliminating the risk factors and ensuring they don't recur. 2. Realizing the comprehensive intervention plan, eliminating the risk factors and ensuring they don't recur. 3. Moving abroad for residency or immigration. 4. The death of the survivor; and the procedures regarding the protection of the other family members. 5. The refusal of the case to receive the multiple services. If the case was incompetent or a child, and if the legal representative refuses to pursue the procedures of the case management, the best interests should be taken into account while ensuring the completion and the continuity of the legal and administrative procedures according to the regulations, instructions, and laws regarding the nature of the case and the procedures related to the protection of the other family members.

3. The case coordinator ensures the documentation of the case conference results and the endorsement and signature of all partners, in addition to the approval and endorsement of the case coordinators supervisor.

The case coordinator notifies the case and his/her family with the results of the file closure conference and provides him/her with the necessary instructions to prevent the recurrence of violence, in addition to follow up guidelines in case of the need for any additional support in the future (safety plan) and documents that in the file.

4. The case coordinator closes the file and saves it according to the file saving policy in the Family Protection Department, and the file is opened again in case of any new complaint in the future.

The case coordinator completes the case file closure procedures within a maximum period of 24 hours.

c.Forms used in the Family Protection Department and its branches Form (1-a): Reception Form

Date:	Time:
Case Identification:	
☐ Disclosure / complaint by the survivor or family member ☐ Identification by service provider ☐ Report by service providing institution (identification) ☐ Other	
Violence Incident:	
Location of the Incident: ☐ Home ☐ Street ☐ School ☐ Work Place ☐ Other (Specify) _____ Type of Violence ☐ Physical ☐ Sexual ☐ within family ☐ outside of family ☐ Neglect ☐ Psychological/ verbal ☐ Other Family members affected by the incident ☐ Wife ☐ Child/children ☐ Both, wife and children ☐ Others	

Survivor Information:		
Full Name:		
Date of Birth:	**Sex:** ☐ **Male** ☐ **Female**	**Nationality:**
National ID # for Jordanian	**Type and Number of ID Document (for non-Jordanian)**	
Social Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	**Education** ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-Graduate Studies	
Land Phone	**Mobile Phone**	
Address		
Profession	**Place of Work**	**Work Phone**
Work Address		
In case of children or incapacitated: **Name of Guardian /Legal Representative** **Phone Number**		

Perpetrator Information (repeat for multiple perpetrators):		
Perpetrator Name:		
Nationality	**Sex:** ☐ **Male** ☐ **Female**	Birth of date:
National ID # for Jordanian	Type and Number of ID Document (for non-Jordanian)	
Social Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Education ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-graduate Studies	
Mobile phone	Land phone	
Address		
Profession	**Work place**	Work phone
Work address		
Relation to the survivor: ☐ Family member (except husband) ☐ Husband ☐ Other (specify):		

Primary Risk Indicators
Does the survivor suffer from acute physical injuries? ☐ Yes ☐ No
Does the survivor suffer from mental instability? (shouting, crying, shock, etc.) ☐ Yes ☐ No
Is the survivor afraid of the perpetrator or family members? ☐ Yes ☐ No
Is the violence incident taking place now? (during reporting) ☐ Yes ☐ No
Reception officer name and signature
Case coordinators supervisor explanations:
Specialization Within FPD qualitative specialization ☐ Yes ☐ No Within FPD geographic specialization ☐ Yes ☐ No Case classifications ☐ High priority ☐ Low priority
Assigned Case Coordinator:
Date: Time:
Case Coordinator Name:
Alternative Case Coordinator Name:
Case Coordinators Supervisor Signature

Form (2-a): Initial Assessment Form

Day:	Date:	Time:
Survivor Name:		File #:

Survivor Information:

Identification of violence case:

- ☐ Disclosure / complaint by the survivor or family member
- ☐ Identification by service provider
- ☐ Report by service providing institution (identification)
- ☐ Other

Does the survivor suffer of any disabilities?

☐ Yes ☐ No

If yes, please specify:

☐ Mental ☐ Physical

- ☐ Audio
- ☐ Visual
- ☐ Mobility
- ☐ Others

Does the survivor suffer any chronic diseases?

☐ **Yes** ☐ **No**

If yes, please specify type of disease:

☐ **Diabetes** ☐ **Hypertension** ☐ **Heart Disease** ☐ **Kidney Disease** ☐ **Other**

Violence Incident:

Location of the Incident:	**Time of Incident:**
☐ Home ☐ Street ☐ School ☐ Work Place ☐ Other (Specify)	**Date: (Day)** **Time:**

Type of Violence:

- ☐ Sexual:
  - ☐ Within family
  - ☐ Outside of family
- ☐ Physical
- ☐ Psychological / Verbal
- ☐ Neglect
- ☐ Other

Has the survivor been previously abused?

☐ Yes ☐ No

If yes please describe in brief.

1. Life-threatening Risk Factors:

- ☐ The presence of serious physical injuries that require an immediate medical care.
- ☐ The use of weapons or sharp tools in the assault.
- ☐ Sexual assaults within the past 72 hours to receive a preventive treatment after being subjected to the sexual violence (emergency contraceptives, preventing the transmission of sexually transmitted diseases, and preventing the transmission of HIV).
- ☐ The threat to end the life the case from the perpetrator or one of the family members (fear of honor crimes).
- ☐ In case the case suffers from one of the following symptoms; severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety.
- ☐ Suicide attempts or planning for or threatening to hurt others by the Case.
- ☐ Other (specify):

2. Immediate Needs:

- ☐ Medical/health services
- ☐ Psychosocial
- ☐ Safety and security

Perpetrator Information (repeat for multiple perpetrators):
Perpetrator name:
Does the perpetrator suffer from psychological problems? ☐ Yes, specify ☐ No
Does the perpetrator suffer from addiction to alcohol or drugs? ☐ Yes, specify ☐ No
Does the perpetrator have a criminal record? ☐ Yes, specify ☐ No
Did the perpetrator threaten the survivor or any family member? ☐ Yes, specify ☐ No

Procedures undertaken by the survivor following the incident:
Did the survivor report the incident? ☐ Yes (Reported to:) ☐ No
What procedures have been carried out (in case of reporting)?
Recommendations:
Need for services: ☐ The survivor needs urgent services: ☐ The survivor needs non-urgent services. ☐ Medical ☐ Psychological ☐ Forensic ☐ Protection & Security ☐ Referral to institution providing other services

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Note: In the FPD case management pathway, there is no "Form 3-a", because this form is the Reporting Form sent by other institutions to the FPD when reporting a violent incident.

Form (4-a): Immediate Response Plan Form- Family Protection Department

Day:	Date:	Time:
		Response meeting number:

Survivor Name:	File #:
Case coordinator:	FPD Branch:

Case summary:

Summary of initial Assessment (including urgent needs and priorities):

Case Management Team (Immediate Response Phase):				
#	Members invited/ contacted	Institution	Job title	Contact mechanism
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Immediate Response Plan		
Implementing agency	List of potential immediate intervention tasks	Implementation time-frame
Judicial Branch at FPD	☐ Personal identification papers ☐ Interview the: perpetrator / witnesses / guardians ☐ Bringing the involved parties ☐ Circulate a circular for bringing the perpetrator ☐ Collect evidence – Moving to the event scene ☐ Custody of samples and send them to the criminal evidence laboratory ☐ Recording interviews using video (for children) ☐ Scrutinizing the records and preparing a list of precedence, if any ☐ Filing the case for court ☐ Investigation procedure (interview with the survivor) ☐ Immediate transfer of the victim to emergency shelter ☐ Immediately notifying the doctor of the presence of a case of medical emergency. ☐ Refer to the Governor for administrative procedures ☐ Ensuring protection measures ☐ Other: (specify)	
Forensic Clinic at FPD	☐ Conduct a forensic examination ☐ Write forensic preliminary report ☐ Custody of evidence samples ☐ Other: (specify)	
Hospitals/health centers	☐ Emergency Medical treatment (including CMR) ☐ Other: (Specify)	
Psychiatric Clinic at FPD	☐ Initial mental health assessment of the case and the perpetrator ☐ Admission to the National Center for Mental Health ☐ Transfer to psychiatric rehabilitation centers (for children) ☐ Other: (Specify)	
Social Services Office at FPD	☐ Initial home visit ☐ Case interview/Study ☐ Shelter / temporary protection ☐ Emergency financial aid ☐ Other: (Specify)	

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date: Time:	Date: Time:

Form (5-a): Comprehensive Needs Assessment Form

Day:	Date	Time:

Survivor Name:	File #:
	Type of Assessment:

Case Summary:
Comprehensive Risk Factors

1. Life-threatening Risk Factors:
   - ☐ The presence of serious physical injuries that require an immediate medical care.
   - ☐ The use of weapons or sharp tools in the assault.
   - ☐ Sexual assaults within the past 72 hours to receive a preventive treatment after being subjected to the sexual violence (emergency contraceptives, preventing the transmission of sexually transmitted diseases, and preventing the transmission of HIV).
   - ☐ The threat to end the life the case from the perpetrator or one of the family members (fear of honor crimes).
   - ☐ In case the case suffers from one of the following symptoms; severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety.
   - ☐ Suicide attempts or planning for or threatening to hurt others by the Case.
   - ☐ Other (specify):

2. Comprehensive needs:

Types of Needs	Details	
Medical	1	
	2	
	3	
	4	
	5	
Forensic	1	
	2	
	3	
	4	
	5	
Psychiatric	1	
	2	
	3	
	4	
	5	
Psychosocial	1	
	2	
	3	
	4	
	5	

Legal	1	
	2	
	3	
	4	
	5	
Judicial	1	
	2	
	3	
	4	
	5	
Administrative Procedures	1	
	2	
	3	
	4	
	5	
Pedagogical/Educational	1	
	2	
	3	
	4	
	5	
Economic Empowerment	1	
	2	
	3	
	4	
Police	1	
	2	
	3	
	4	
	5	
Other	1	
	2	
	3	
	4	
	5	

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Form (6-a): Case Conference Form

Day:	Date:	Time:

Survivor Name:	File #:
Case coordinator:	Institution:

Conference #:	Conference type: ☐ Case Conference ☐ Follow-up Conference	Conference location:

Case Summary:
Summary of Comprehensive Needs:
Conference Summary:
Conference Decision:
Provision of services based on comprehensive needs assessment (please fill comprehensive intervention plan below) Case file closure (please fill Form 10-a, File Closure Form)

Comprehensive Intervention Plan			
Type of service	Procedures	Implementing agency	Timeframe
Medical	1		
	2		
	3		
	4		
	5		
Forensic	1		
	2		
	3		
	4		
	5		
Psychiatric ☐	1		
	2		
	3		
	4		
	5		
Psychosocial ☐	1		
	2		
	3		
	4		
	5		
Legal	1		
	2		
	3		
	4		
	5		
Judicial	1		
	2		
	3		
	4		
	5		
Administrative Procedures	1		
	2		
	3		
	4		
	5		
Pedagogical/Educational	1		
	2		
	3		
	4		
	5		

Economic Empowerment	1			
	2			
	3			
	4			
	5			
Other	1			
	2			
	3			
	4			
	5			

Case Management Team Members				
#	Members invited/ contacted	Institution	Job title	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date: Time:	Date: Time:

Form (7-a): Referral Form

Day:	Date:	Time:

Survivor Information:		
Survivor Name:	File #:	
Type of response: ☐ Immediate ☐ Comprehensive Intervention		
Date of birth:	Gender: ☐ Male ☐ Female	Nationality:
National ID: (for Jordanians)		Type and Document #: (for non-Jordanians)
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		Educational level: ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-Graduate Studies
Phone number		Mobile Number
Address		
In case of child or incapacitated: Name of Guardian: Phone Number: Name of Legal Representative: Phone number:		
Job	Work place	Work phone
Work address		

Case Type:			
☐ High Priority		☐ Low Priority	
Referral Mechanism:			
☐ Telephone (urgent cases)	☐ Fax	☐ E-mail	☐ Personal

Referring Institution:	
Institution:	Case coordinator name:
phone:	E-mail:
Address:	

Institution Referred to:	
Name:	Person referred to:
Phone:	E-mail:
Address:	
Case Summary:	

Referral details: 1. Needed services: 2. Preferred contact mechanism with the survivor:

Name & Signature of Case Coordinator:	
Date: Time:	Date: Time:

Approval of the referral and information disclosure between partners (read the information with survivor and answer any question that might be raised before examiner signs below)	
I, the undersigned, _____ (case name), understand that the purpose of the referral and the disclosure of this information for (the organization referred to)---------- is to ensure the provision of care and continuity between the service providers who seek to provide me with services, and _____ (referring institution) have worked to explain referral procedures to me clearly, and identified the information that will be disclosed. And by signing on this form, I agree on the exchange of this information.	
Signature of the responsible party (survivor, parent, or legal representative):	Date:

Form (8-a): Service Provision Report

Day:	Date:	Time:

Institution name:	Sector:
Phone	Email

Survivor Name:	File #:
Age:	Date Received:

Services provided:

☐ Medical ☐ Psychiatric ☐ Forensic ☐ psychosocial

☐ Legal ☐ Judicial ☐ Administrative procedures

☐ Pedagogical/Educational ☐ Economic empowerment ☐ Other

Summary of services/ procedures provided:		
#	Service/Procedure	Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Service Provider Recommendations:

Name & Signature of Service Provider	Official Stamp	Date and time of Report Receipt	Name & Signature of Case Coordinator

Form (9-a): Follow-up Registry Form

Survivor Name:	File #:
Type of response: ☐ Immediate ☐ Comprehensive Intervention	
Case coordinator:	

#	Procedure	Implementing agency	Time Frame	Implementation status
1				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
2				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
3				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
4				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
5				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

6				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
7				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
8				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
9				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
10				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
11				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
12				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

13				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
14				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
15				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
16				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
17				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
18				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
19				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
20				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

Form (10-a): File Closure Form

Day	Date	Time:

Case Conference #: Type of conference: ☐ Response Meeting ☐ Case Conference Case coordinator:	Case conference location: Institution:

Survivor Name: Case Summary:

Summary of Implemented Procedures	
Medical ☐ Treatment ☐ Psychiatric ☐ Forensic	
Psychosocial	
Safety and Protection	

Legal/ Judicial/ Administrative Procedures	
Other	

File Closure Justifications
☐ Achieving Immediate response plan goals, demise of risk factors ☐ Achieving Intervention plan goals, demise of risk factors ☐ Survivor moves / immigrates to another country, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case ☐ The death of the survivor, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case ☐ The case denied continuation of case management procedures, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case. ☐ In case of a child or incapacitated (denial of the guardian), take into consideration the best interest determination and make appropriate decision based on it. ☐ Other (specify)
Case Coordinator tasks: ☐ The survivor was notified about file closure procedure ☐ Informed consent was obtained from the survivor (or in case of a child or incapacitated, the guardian) ☐ The survivor was provided with clear instructions on how to prevent further violence and a safety plan

Case management team members				
#	Members invited/ contacted	Institution	Job title	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Name and signature of case coordinator			Name and signature of case coordinator supervisor	
Date:	Time:		Date:	Time:

Second: Cases that do not require mandatory reporting to the Family Protection Department

If the act of violence committed does not require mandatory reporting based on the laws and legislation in force and the mandatory reporting criteria mentioned previously in this manual, then the service providing institutions that receive the survivor handle the case according to the case management approach, and are responsible for all case management procedures; assessment, coordination, planning, referral, and follow-up, through to case file closure.

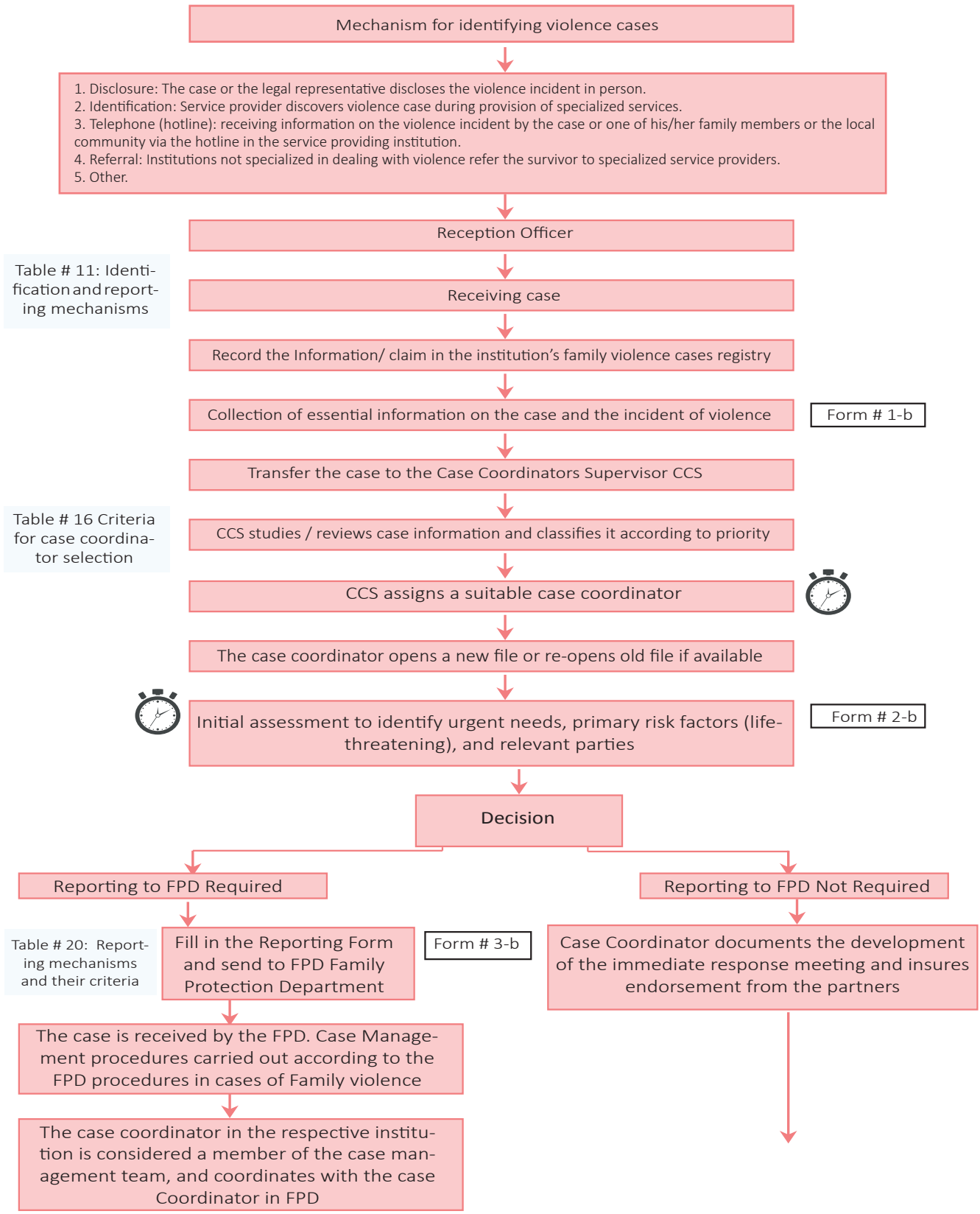
Case Management Approach for Service Providing Institutions for Family Violence Cases:

a. Detailed procedures workflow
b. Explanation of the detailed procedures workflow
c. Case management forms

Reservations (if applicable):

a. Detailed Working Procedure Workflow

Identification and Reporting Phase in Service Provider Institutions



Example on Immediate Response Plan in Service Providing Institutions					
Medical Services		**Psychosocial Services**	**Legal Services**	**Pedagogical/Educational Services**	**Other Services**
Health Services	**Psychiatric Clinic**				
The case coordinator, coordinates with the Medical regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately	The case coordinator, coordinates with the Psychiatric regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately.	The case coordinator, in case of need transfers the case to the Social Service Office	The case coordinator, coordinates with Legal Services	Case Coordinator, coordinates with pedagogical/educational services	The case coordinator, coordinates with any institution needed for the case providing all information
Medical cadre carry necessary medical checks and deliver the needed treatment services	Psychiatric interviews the case and carry Psychiatric check (including family members and perpetrator if needed)	The Psycho/social specialist carries necessary needed actions	Legal Services Provides necessary legal services	Pedagogical/educational service provider carries all agreed actions	Service provider interviews the case and deliver the required services
Medical cadre Prepare medical reports and recommendations, send to Case Coordinator	The Psychiatric prepares the report on the case with the recommendations	The Psycho/social Specialist, prepares Case report and send to Case Manager	Legal Services prepares case report and sends it to case coordinator	Pedagogical/educational service provider prepares Case report and send to Case Coordinator	Service Provider prepares report on provided services including recommendations
Case Coordinator attach the repot to case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file
Case Coordinator follows the implementation of the recommendation	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations
Official implementation body MoH or any other health service provider	**Official implementation body** Psychiatry clinic at MoH or any other psychiatric service provider	**Official implementation body** Any social service provider	**Official implementation body** Any legal service provider	**Official implementation body** MoE, Education guidance division	**Official implementation body** Any institution providing services to the survivors and their families based on the needs assessment

Immediate Response Phase

Case Coordinator includes the case and his/her family in the immediate response plan, procedures, available options, and the consequences of each, in accordance with the best interests, legislation, laws and national regulations in force.

Convening the Immediate Response meeting

Table # 21 Mechanisms of holding immediate response meeting

Case Coordinator documents the development of the immediate response meeting and insures endorsement from the partners

Immediate Response Plan

Case coordinator documents case summary and the immediate response plan including:

d- The planned activities

e- Roles and responsibilities of partners

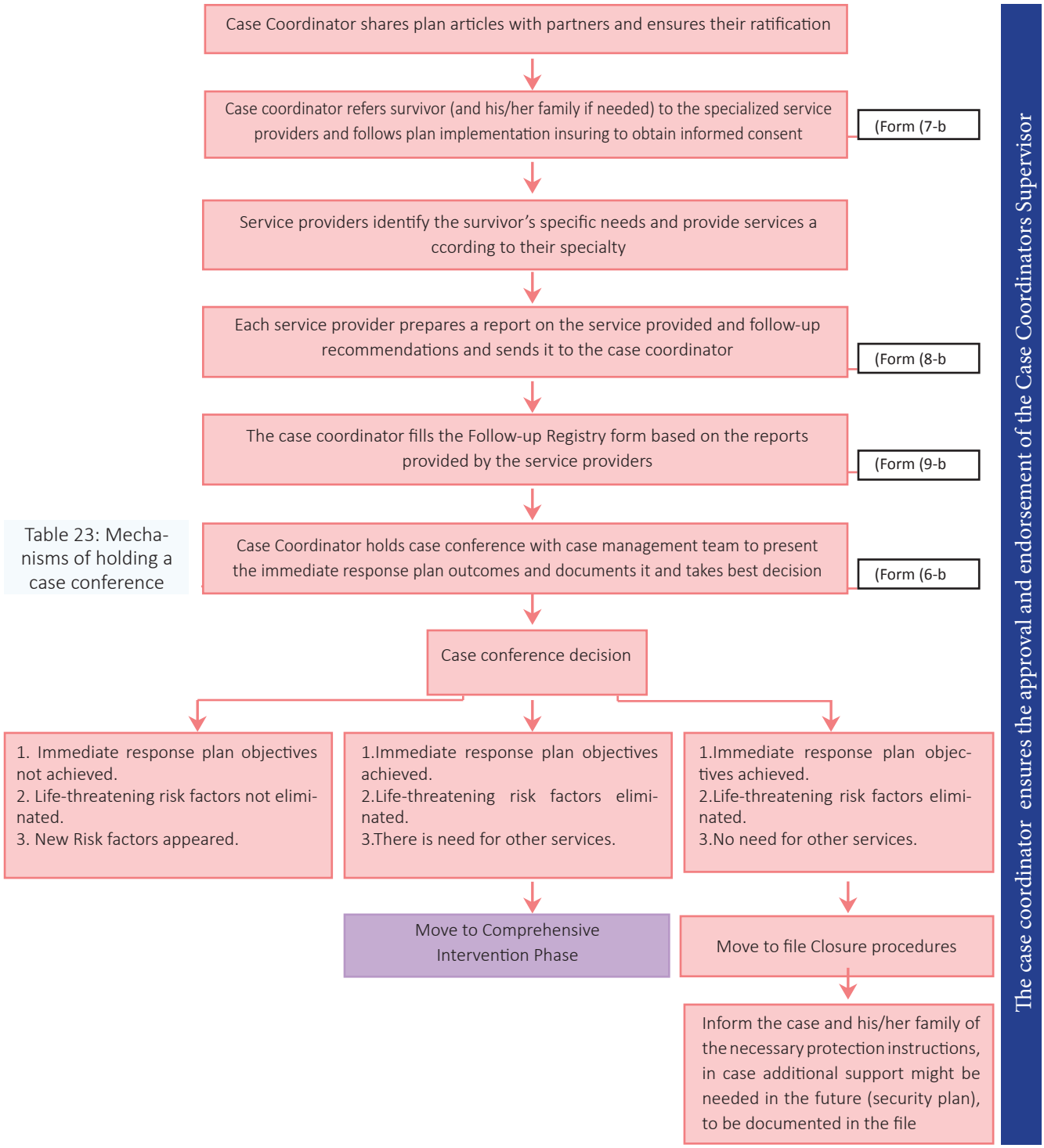
f- Time frame (ensuring that the appointments between the partners and the provided services do not conflict)

Form # 4-b

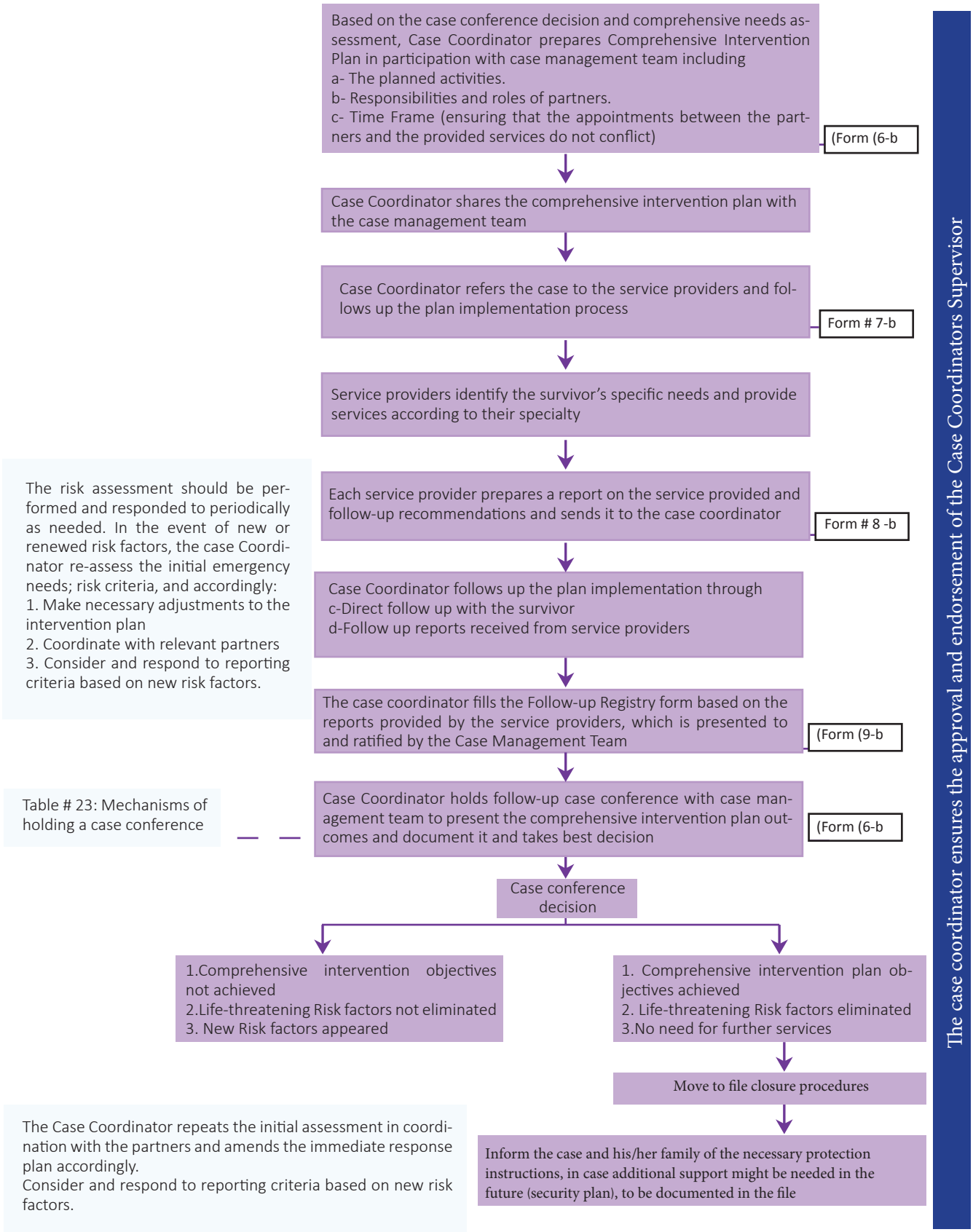
The case coordinator ensures the approval and endorsement of the case coordinators supervisor and carries regular assessment of risk factors

Example on Comprehensive Intervention Plan in Service Providing Institutes					
Medical Services		Psychosocial Services	Legal Services	Pedagogical/ Educational Services	Other Services
Health Services	Psychiatric Clinic				
The case coordinator, coordinates with the Medical regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately	The case coordinator, coordinates with the Psychiatric regarding the case and provides all information and risk factors. The case coordinator, in case of need transfers the case to Medical Treatment immediately.	The case coordinator, in case of need transfers the case to the Social Service Office	The case coordinator, coordinates with Legal Services	Case Coordinator, coordinates with pedagogical/educational services	The case coordinator, coordinates with any institution needed for the case providing all information
Medical cadre carry necessary medical checks and deliver the needed treatment services	Psychiatric interviews the case and carry Psychiatric check (including family members and perpetrator if needed)	The Psycho/social specialist carries necessary needed actions	Legal Services Provides necessary legal services	Pedagogical/ educational service provider carries all agreed actions	Service provider interviews the case and deliver the required services
Medical cadre Prepare medical reports and recommendations, send to Case Coordinator	The Psychiatric prepares the report on the case with the recommendations	The Psycho/social Specialist, prepares Case report and send to Case Manager	Legal Services prepares case report and sends it to case coordinator	Pedagogical/ educational service provider prepares Case report and send to Case Coordinator	Service Provider prepares report on provided services including recommendations
Case Coordinator attach the repot to case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file	Case Coordinator attaches the report in the case file
Case Coordinator follows the implementation of the recommendation	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations	Case Coordinator follows the implementation of recommendations
Official implementation body The case coordinator ensures continuous follow-up based on the reports and procedures, and responds immediately.					

Table 23: Mechanisms of holding a case conference



Comprehensive Intervention Phase



Application of Case Management

b. Explanation of the detailed procedures of the case management approach in the service providing institutions

Identification and Reporting Phase

General criteria for all the workers in the case management
1. The absolute belief in the importance of dealing with the Family violence cases and providing protection for them. 2. Ensuring confidentiality in dealing with the data of the survivor. 3. Respect. 4. Professionalism and neutralism in dealing with the violence cases. 5. Adherence to the code of conduct and the moral principles and values.

Mechanisms of identifying the violence cases:

1. Disclosure: the case or his/her legal representative discloses the violence incident in person.
2. Identification: the service provider discovers violence case during provision of specialized services
3. Telephone (hotline): receiving information on the violence incident by the case or one of his/her family members or the local community via the hotline in the service providing institution.
4. Referral: Institutions not specialized in dealing with violence refer the survivor to specialized service providers.
5. Others.

Procedures of dealing with Family violence cases inside the institutions concerned with Family violence:

a. The reception officer in the service providing institution receives the family violence case according to the sources of identification mentioned above, and deals with it based on the following (taking into account the policies and the internal procedures of his/her institution):

Case File Closure Procedures

Table # 24 Regulations and justifications of the case file closure requirements

- Case Coordinator closes the file according to follow-up case conference results based on:
- Immediate response plan achieved, and risk factors eliminated
- Comprehensive intervention plan achieved, and risk factors eliminated

Form # 10-b

File Closure Justification:
a. Realizing the goals of the immediate response plan, eliminating the risk factors and ensuring they don't recur.
b. Realizing the comprehensive intervention plan, eliminating the risk factors and ensuring they don't recur.
c. Moving abroad for residency or immigration.
d. The death of the survivor; and the procedures regarding the protection of the other family members.
e. The refusal of the case to receive the multiple services.

If the case was incompetent or a child, and if the legal representative refuses to pursue the procedures of the case management, the best interests should be taken into account while ensuring the completion and the continuity of the legal and administrative procedures according to the regulations, instructions, and laws regarding the nature of the case and the procedures related to the protection of the other family members.

File Closure Regulations:
1. The attendance of service providing representatives who deal with the case.
2. The documentation of justifications and closure standards.
3. The written documentation of any reservation if present.
4. Based on the majority decision, the case management team takes a closure decision.
5. The signature and endorsement of the case management team members on the proceedings of the case conference which resulted in the file closure decision.
6. The case and his/her family are notified with the required instructions for future follow up, in addition to the safety plan to prevent the recurrence of violence.

The case coordinator ensures that the decision of file closure conference is documented, endorsed and signed by all the partners.

The case coordinator closes the file and saves it according to filing policy in the institution

Inform the case and his/her family of the necessary protection instructions if additional support needed in the future (security plan) and document it in the file

The file is re-opened if any new future complaints are received

The case coordinator notifies the case and his/her family with the results of the file closure conference and provides him/her with the necessary instructions to prevent the recurrence of violence, in addition to follow up guidelines in case of the need for any additional support in the future (safety plan) and documents that in the file.

Table (11): Mechanisms of identification and reporting of family violence and procedures to deal with them in the service providing institutions	
Mechanisms of violence incident identification	Procedures of dealing with the cases inside the institutions concerned with the family violence services
Disclosure	The reception officer fills out the Reception Form (Form 1-b) and internally refers the case to the case coordinators supervisor to assign a case coordinator to start with case management procedures.
Identification	If one of the service providers discovers or suspects a Family violence case, the service provider should document all the notes and information in the case file and transfer it internally to the case coordinators supervisor to assign one and initiate the case management procedures.
Telephone (The hotline)	In case the information is received via the hotline of the institution, the internal procedures and policies are taken into account when assessing the case, its severity and the mechanisms to dealing with it, accordingly the following should be done: a. Directly report it to the Family Protection Department, or b. Transfer it internally to the case coordinators supervisor.
Referral	Institutions not specialized in dealing with violence refer the survivor to specialized service providers. a. If the case reaches directly to the receptionist, the reception officer starts the case management procedures directly. b. If the case reaches directly to the case coordinators supervisor specializing in family violence cases (via phone or fax or the email), the supervisor checks whether there is a previous file for the case or opens a new one then initiates the case management procedures.
others	

b. The reception officer logs the case in the family violence cases registry in the institution.
c. The reception officer fills in the available information and data regarding the case and his/her family in the special form for it, the "Reception Form" (Form 1-b).

Table (12): Criteria for the reception officer
1. To have sufficient knowledge and experience in receiving the Family violence cases and the mechanisms to deal with them. 2. To have high communication skills in addition to the ability to provide the needed support to the case and his/her family. 3. To have the ability to identify the priority cases which require immediate intervention and the mechanisms to deal with them.

d. The reception officer transfers the case to the case coordinators supervisor to initiate the case management procedures.

Table (13): Criteria for the case coordinators supervisor
1. To have sufficient knowledge and experience in the classification of the cases and the mechanisms to deal with them. 2. To be familiar with the expertise of the case coordinators and the ability to allocate the cases accordingly. 3. To have administrative and organizational skills that enables him/her to allocate the cases to the case coordinators fairly and follow up with the all cases in coordination with them. 4. To have high communication skills and the ability to provide the required technical and administrative support to the case coordinators. 5. To have the ability to identify the priority cases that require immediate intervention and the mechanisms to deal with them.

f. The case coordinators supervisor receives the transferred case from the reception officer or from the institutions not specialized in dealing with violence cases.

g. The case coordinators supervisor studies the data and classifies it to priority into high or low priority, (Table (14)), and assigns the suitable case coordinator for it based on the case coordinator selection criteria (Table (16)) who continues with the case management procedures.

Table (14): Examples of high priority cases
A case coordinator is assigned in a maximum period of one hour from receiving the case, and the case management procedures are initiated within 3 hours. Services are then provided according to the preliminary assessment of the case.
1. The presence of serious physical injuries that require an immediate medical care. 2. The use of weapons or sharp tools in the assault. 3. Sexual assaults within the past 72 hours to receive a preventive treatment after being subjected to the sexual violence (emergency contraceptives, preventing the transmission of sexually transmitted diseases, and preventing the transmission of HIV). 4. The threat to kill the case from the perpetrator or one of the family members (fear of honor crimes). 5. In case the case suffers from one of the following symptoms; severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety. 6. Cases that require mandatory reporting according to laws and legislation.

h. The case coordinators supervisor completes the reception form/ the case coordinator assigning field (including the name of the case coordinator and the alternative coordinator).

The case coordinators supervisor assigns a case coordinator within a maximum period of one hour after the case is received.

i. The case coordinators supervisor provides technical support to the case coordinators, follows up on the case, endorses and checks all the procedures and intervention plans.

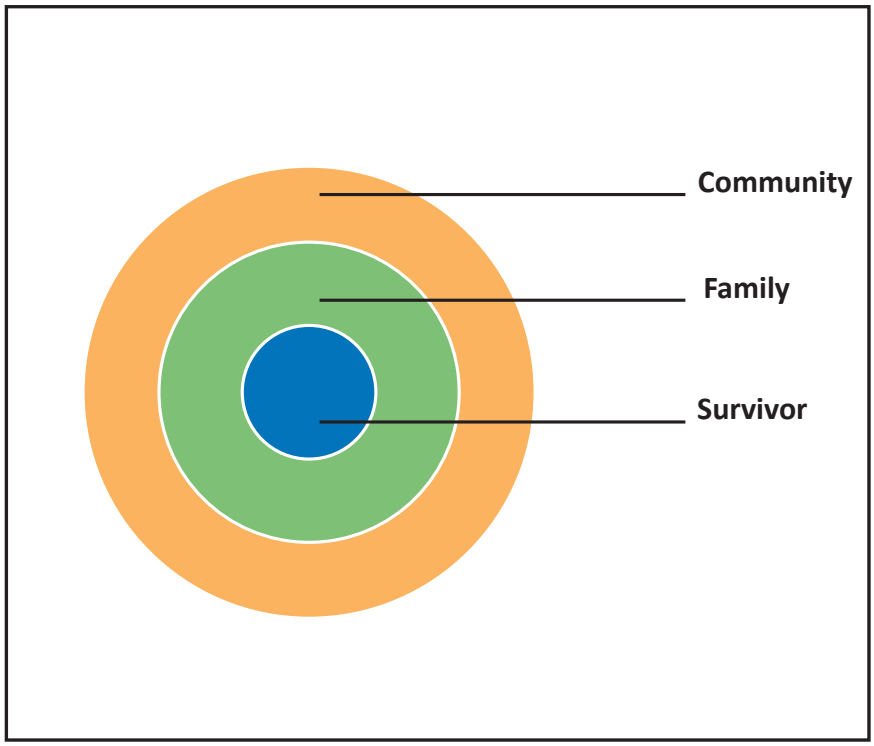
Table (15): Criteria for the case coordinator
1. To have sufficient knowledge and experience in classifying the cases and the mechanisms to deal with them. 2. To have high communication skills and the ability to provide the required services for the case. 3. To have the ability to identify risk factors which require immediate intervention and mechanisms to deal with them. 4. To have coordination, follow up, assessment and documentation skills. 5. To have a practical experience and specialized technical training in the area of case management.

Table (16): Criteria for case coordinator selection
1. Taking into account the gender of the case when allocating the cases to the case coordinators.
2. Taking into account the severity of the case and the experience of the case coordinators when allocating cases.
3. Taking into account the jurisdiction of the case coordinators when allocating the cases.
4. Providing clear grounds to identify the cases where there is an interest confliction among the case coordinator, the case and the service provider.
5. Taking into account that the number of cases wouldn't exceed 50 cases at a time for each case coordinator.

Based on the risk factors and needs assessment, the case coordinator starts the procedures of case management within one hour of receiving the case for high priority cases and within three hours for other cases.

j. The case coordinator conducts the following procedures once he/she receives the case:
   - Opening a new file or reopening an old file (if applicable).
   - Receiving the case and checking all his/her documents and the reports if available.
   - The case coordinator conducts a preliminary assessment based on the "Initial Assessment Form" (Form 2-b), and according to the information he/she acquired from the same case or from the transferring authority in order to identify the emergency needs (physical, psychological/social, safety and protection) including the preliminary life-threatening risk factors.

Life-threatening risk factors are assessed based on three levels: individual (the survivor / Case, family, community)



Preliminary Risk Factors	
Definition	Is a set of indicators and characteristics of the survivor, or the perpetrator, or the family or the community, which lead, individually and / or combined, to a direct threat to the life of the sruvivor and / or his/her family.
Classification	• These indicators may be: 1. Imminent danger and life threat to the case or his/her family, which requires provision of a safe place for the case until it is eliminated. 2. Frequent threat of family violence towards the case or any of her/is family members. • These indicators can be permanent or temporary, therefore a case periodic review is necessary. • Assessment of these indicators (dangers and threats) requires a specialized study by the case coordinator and service providers to identify and deal with. • Can be classified according to: 1. Level of influence on case, perpetrator or the family) as shown in the model below (risk assessment: probability of occurrence / impact), accordingly, intervention priorities can be identified. 2. Type of indicators: physical, psycho / social, economic, legal and other
Response	Response to risk factors Requires 1. Categorize factors into a permanent or temporary to develop appropriate response plan 2. Linking the risk factors to the multiple needs of the case and / or the family, and services required for the intervention.

Examples of factors that pose a risk to the life of the case or any of the family members and require reporting		
Survivor	**Family**	**Community**
– A severe psychological state and a low self-esteem by the case that may increase the probability of suicide – A previous suicide attempts. – Sexual violence on the case, whether from inside or outside the family. – The recurrence of any form of violence in a manner that may affect the life and physical integrity of the individual.	– The case lacks a social support network of parents and relatives- – The culture of the family may not tolerate reporting any case of violence by any of its members, therefore there is possibility of serious action against the case or family members. – A direct threat from the perpetrator in the event that the offender and the case remain together within the family – Previous security records for any family member may pose risk to the lives of individuals – Use of weapons by family members.	– The surrounding social environment accepts violence and can't tolerate the request by the case for assistance, and considers the survivor / the case as a stigma, that must get rid of by killing

Risk Assessment: Probability and impact Severity

Based on the available information, the case management team investigates the circumstances and conditions of the case to identify and assess the potential risks as per the attached matrix. Based on the comprehensive assessment of the overall risk factors and needs of the case, the environmental conditions of the case, the service provision reports of the survivor, his/her family and the perpetrator.

Usually the orange squares are taken into serious consideration, pink squares are considered risky, while the red squares are considered high risk. The case is categorized according to the assessment by the case management team.

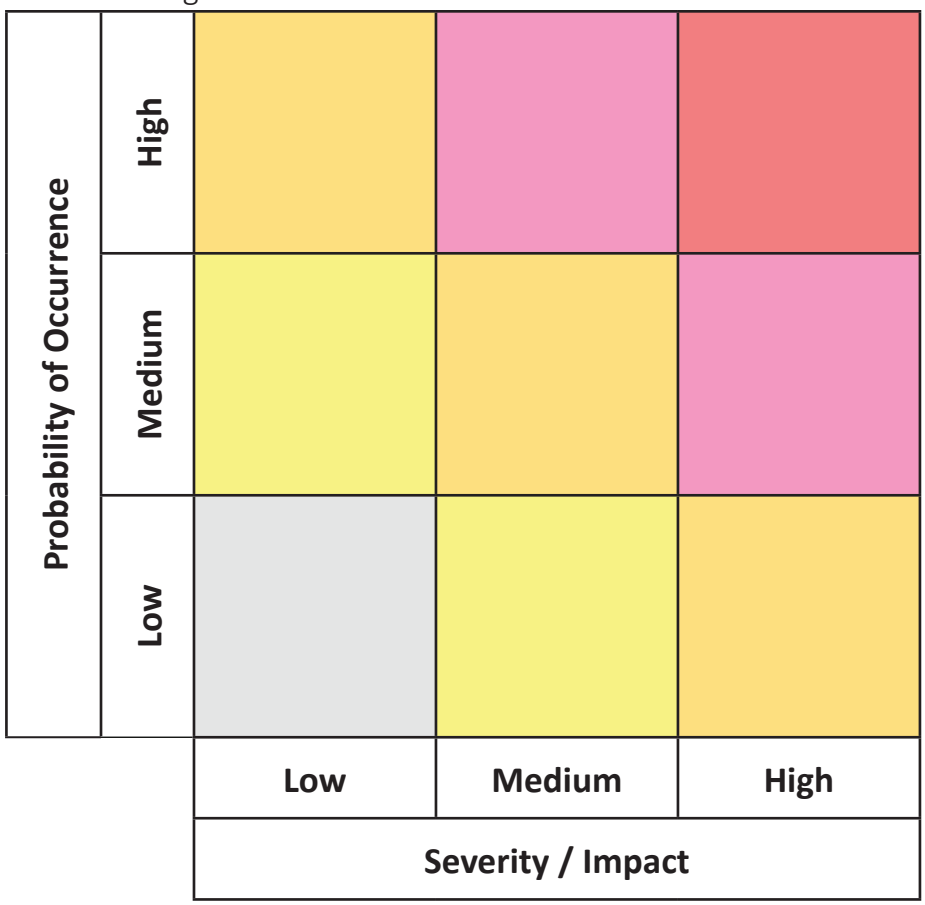


Table (17): Reporting criteria which entail legal liability
The case coordinator and / or the service providers shall take into consideration the cases where the mandatory notification is legally required. Failure to report shall result in legal Liability: 1. In case of any sexual violence or suspecting a sexual violence. 2. In case of any violence being on a child or an incompetent. 3. If there is a life threat on the case from the perpetrator or the family or from the case him/ herself. 4. If weapons or sharp tools are used in the violence incident. 5. Crimes that are classified as felonies. 6. Other: ……

Table (18): Reporting criteria which do not entail legal liability
Are criteria that depend on case assessment based on life-threatening risk factors to the survivor and his/her family (psychological, social, safety and security, etc.), which require reporting by the case coordinator or service providers, **in case of at least one of the following factors, in which not reporting does not result in any legal liability:** • If the case suffers from physical injuries that require immediate medical intervention. • If the case has been subjected to assault by multiple perpetrators. • If the case suffers from the following symptoms: severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety. • If the case is suicidal or threatens to commit suicide. • If the case is deemed a danger on the lives of others and their safety. • If the case fears for her life or for his/her family members' lives. • If the violence incidence is recurring within the family (against the survivor or any family member of the family).

The case coordinator notifies the case and his/herfamily with the details of the assessment and the available options, in addition to the consequences of each according to the best interest, the legislations, laws and the national regulations in force.

Table (19): Procedures of dealing with the cases that require reporting and others that do not require reporting	
Cases that require reporting	Cases that do not require reporting
If the case requires reporting, the case coordinator fills the «Reporting Form» (Form 3-b) and sends it to the Family Protection Department according to the approved reporting mechanism among institutions.	If the case does not require reporting, the case coordinator moves to the Immediate Response Phase based on the preliminary assessment and the emergency needs then he/she completes the case management procedures internally.

Table (20): Reporting mechanisms and their criteria	
Approved mechanism	**Criteria**
Phone (Attached to the reporting form)	- Use an official phone number that operates 24 hours throughout the week. - The phone is linked to a specific job title and not a particular person, so the phone would be circulated among employees on duty. - The use of the official phone is confined on official calls and reporting only, and not for personal purposes.
Fax	- Use an official fax number designated for receiving reporting forms. - Ensuring the readiness of the device for work, and continuously supply it with ink and paper, in addition to a regular maintenance. - Put the device in a secure place and only available for the person allowed to receive the reporting forms to maintain confidentiality. - Keep the reception and sending receipts.
Email (deemed the best method)	- Use an official email address for reporting and receiving mechanisms. - Commit to using the official email to send the reporting forms and not the personal emails. - The password should only be known to the person responsible to receive or send the reporting. - Scan the Reporting Form and send via email to the Family Protection Department according to the approved electronic system. - Use the official website of the Family Protection Department to report (put the link/ address here).

k. The case coordinator moves to the Immediate Response Phase according to the information received from the case file, the case and his/her family. The case coordinator is responsible for the entire documentation procedures and the follow up with all the partners up to the file closure procedures.

Immediate Response Phase

This phase is for cases that require immediate response services but do not require mandatory reporting.

- ❖ The possibility of the emergence of new risk factors should be taken into account at any time during this phase which could require reporting, accordingly, the required reporting procedures are taken (Table (18)).

1. Based on the initial assessment results and the preliminary evaluation of urgent needs, the case coordinator arranges to hold **"the immediate response meeting"** with the institutions and the partner bodies to draft "the immediate response plan" according to "Immediate Response Plan Form for Service Providers" (Form 4-b).

After completing the initial needs assessment, the case coordinator begins referring the survivor, within a maximum of one hour, to the service providers based on the coordination with the partners and the sequence of needs.

Table (21): Mechanisms of holding immediate response meeting	
What?	It is a consultative meeting held by the case coordinator jointly with the concerned institutions to put the immediate response plan to deal with the case and his/her family.
Who?	The case coordinator calls the concerned partners (if applicable) a. The health sector. b. The social sector, that is concerned with the study of the initial social status of the case and his/her family to provide any needed social, psychological and shelter-care services. c. Others: according to the evaluation and assessment of the case needs.
When?	Within 24 hours from receiving the case.
How?	Through direct phone call with the concerned bodies or via holding a meeting with the presence of the concerned bodies if possible.
Why?	To have an immediate response plan in place, while defining the following: a. The plan activities. b. The responsibilities and roles of the executive partners. c. The time frame: while ensuring that appointments are not conflicting, and according to the procedures' priorities needed by the case. Accordingly, each partner starts providing services and sends a follow up report to the case coordinator elaborating the emergency sectoral response plan.
Documentation, endorsement and follow up	a. Documentation of all the immediate response meeting proceedings. b. Ensuring that the partners abide by the articles of the immediate response plan. c. Ensuring the thorough follow up by the case coordinators to implement the articles of the immediate response plan.

2. The case coordinator documents the developments of the immediate response meeting, the agreed procedures, the action plan with all its details including (including the activities of the immediate response plan, responsibilities and roles of the service providing partners, and the

time frame) in the Immediate Response Plan Form of the Service Providers" (Form 4-b); in addition, he/she ensures its endorsement from the partners.

The case coordinator notifies the case and his/her family in the immediate response plan and the available options, in addition to the consequences of each according to the best interest, legislations, laws and the national regulations in force.

The time frame allocated to apply the activities of the immediate response plan should be documented, and the priorities of the procedures should be taken into consideration according to the needs of the case while ensuring that the appointments between the partners and the provided service do not conflict.

Institution	Immediate response plan procedures
Health services	1. Based on the assessment of the case coordinator, the case is immediately transferred to medical services in case it needed. 2. Clinical examinations are conducted and providing the required medical services, such as: • Treatment and medical consultations. • Provide clinical management of sexual violence. 3. Prepare the medical reports and recommendations then send the report to the case coordinator.
Psychiatric medical services	1. Interview the case and conduct the psychiatric examination (the family members and the perpetrator are interviewed sometimes if required), such as: • Conduct the preliminary psychiatric assessment for the case and the perpetrator. 2. Prepare the psychiatric report and its recommendations then send it to the case coordinator.
Psychosocial services	1. The social expert takes the required procedure(s), such as: • Preliminary house visit. • Study the case and conduct interviews with the survivor, his/her family and the perpetrator. • Emergency aid. 2. The social expert prepares a report on the case and sends it to the case coordinator.
Others (according to the case needs)	1. The Case coordinator shall coordinate with the Service Provider institution. 2. Implement agreed actions/ procedures. 3. The recommendations are prepared and sent to the Case Coordinator.

3. The case coordinator shares the articles of the plan with the partners and follows up on its implementation with them. Each service provider is considered a member of the case management team.

4. The case coordinator refers the case (and his/her family if the case needed) to the specialized service providers according to the immediate response plan, "Referral Form" (Form 7-b) making sure to acquire informed consent.

The case coordinator refers the survivor to the service providers based on the sequence of needs, wherein the case is referred within a maximum of one hour after completing each service.

Table (22): Criteria for the case management team member
1. To have a sufficient knowledge and experience in assessing the cases and the mechanisms of dealing with them.
2. To have high communication skills and the ability to provide the necessary technical support to the cases.
3. To be directly concerned with dealing with the cases within his/her institution and possesses the full authority to be familiarized with the work procedures with them.
4. Ensuring the commitment to attend all the meetings and the conferences related to the case.

5. The service providers (from inside the institution and/or outside it) identify the case's special needs, each according to their specialty, and commence in service provision. Then the Service Provision Report is completed (Form 8-b) listing the undertaken services and follow up recommendations according to the regulations and internal instructions for each partner institution. In addition to sharing the report with the case coordinator via the agreed follow up mechanism.

The risk assessment procedures should be conducted periodically according to the needs of the case and the response should be implemented accordingly.

In case of the emergence of new and evolving risk factors, the case coordinator re-conducts the preliminary assessment to define the urgent needs and the risk standards, and accordingly:

1- Conduct the required amendments on the intervention plan.

2- Coordinate with the relevant partners.

6. The case coordinator fills the Follow-up Registry Form (Form 9-b) based on the service provision reports submitted by the partners and shares it with the partners ensuring the endorsement of the case coordinators supervisor.
7. Based on the follow up registry report of the implementation of the immediate response plan, and the notes and recommendations of the concerned partners, the case coordinator briefs the supervisor on the course of the case and the implementation of the immediate response plan, in addition to having the latter's endorsement on the procedures.

Within a maximum period of 24 hours following the receipt of the final service provision report, the case coordinator completes the Follow-up Registry Form for the implementation of the immediate response plan and the comprehensive risk factors assessment, shares it with the service providers, and sets an appointment for the case conference within a maximum period of two weeks based on the case priority and nature.

Table (23): Mechanisms of holding a case conference	
What?	It's a meeting that the case coordinator calls for with the participation of all the representatives of the concerned institutions to deal with the case and his/her family, in order to study all of its aspects (health, psychological/social, legal, judicial, administrative, pedagogical, and any other services he/she might need). In addition to putting intervention plans that identifies the required procedures to support and help the case and his/her family, and the perpetrator if needed. The case conference reflects the efficiency of the multi-sectoral collaborative approach in responding to the Family violence cases, and in providing the appropriate comprehensive services to the case and his/her family.
Who?	The case coordinator calls the concerned partners: - The health sector including the psychiatric and forensic when needed. - Psychosocial services: shelter-care. - Legal service. - Pedagogical service: administrative procedures might be required or providing technical services from the Ministry of Education. - Economical enabling service. - Other services according to the assessment of the case needs. The concerned partners who provide service are called the "Case management team members".
When?	After implementing the immediate response plan and based on the work priorities with the survivor, his/her family and the perpetrator. A time frame is set accordingly.
How?	A representative of each of the partners is called (provided that the service is directly provided to the survivor, his/her family or the perpetrator).
Why?	To develop the comprehensive plan, and to identify the following: a. The plan's activities. b. The responsibilities and the roles of the executive partners. c. The time frame of the implementation. d. The follow up mechanism.
Regulations	a. Taking into account the selection of the representative of partnering institutions who is directly concerned, or the selection of the direct service provider to the survivor. b. Ensuring the commitment of the partnering institutions representative as a communication officer between his/her institution and the main case coordinator. c. Ensuring the continuity of the representation by the same person (as long as possible).
Documentation, endorsement and follow up	a. Documentation and endorsement of all case conference proceedings. b. Ensuring that the case management team abides by the articles of the comprehensive intervention plan. c. Ensuring the thorough follow up to implement the articles of the comprehensive intervention plan.

During the case conference and based on the discussion of the case management team, decisions are made to undertake one of the following procedures:

- Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team participating in the conference, evaluates that the goals of the immediate response plan have been realized, the activities have been implemented, the life-threatening risk factors have been eliminated, and in case of the absence of the need to provide any other service, moreover, if the team decides to close the case file, the case coordinator **resorts to the file closure procedures.** The case coordinator notifies the case and his/her family about the required instructions to protect him/her in case he/she needed any additional support in the future in order to prevent the recurrence of violence, and documents that in the case file.
- Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team participating in the conference evaluates that the goals of the immediate response plan of the case have been realized (the case and his/her family), all of the activities have been implemented, the risk factors have been eliminated (the preliminary or comprehensive), and the case management team found the need of the case for other services (the case and his/her family), the case coordinator coordinates with all partners to move to the **comprehensive intervention phase**.
- **Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team participating in the conference evaluates that the goals of the immediate response plan of the case haven't been realized nor its activities have been implemented, and the life-threatening risk factors have not been eliminated (the case and his/her family), the case coordinator re-conducts the preliminary assessment and the preliminary needs in coordination with the case management team. In addition to the amendment of the immediate response plan accordingly, and the commencement of taking the required procedures to provide the immediate services for the case in coordination with the concerned partners.**

The case coordinators supervisor provides technical and administrative support to the case coordinators, follows up on the progress of the case, endorses and controls all the procedures and intervention plans.

The case coordinators supervisor provides technical and administrative support to the case coordinators, follows up the course of the case, endorses and controls all procedures and intervention plans.

The case coordinators supervisor inspects the progress of the cases and endorses the procedures that the case coordinator will undertake within a maximum period of 24 hours.

Comprehensive Intervention Phase

The case coordinator moves to this phase based on the decision of the case conference taken by the case management team to continue with the intervention procedures, and based on realizing the immediate response plan goals, implementing all its activities, elimination of any life-threatening risk factors, and based on the survivor's other services need for.

1. After deciding to move to the Comprehensive Intervention Phase, and during the case conference, the case coordinator coordinates to conduct a comprehensive assessment of the overall risk factors and needs of the case, taking into consideration the multiple needs of the survivor; health, physical, social, economic, etc.) and fills out the "Comprehensive Needs Assessment Form" (Form 5-b) in cooperation with the members of the case management team all within their respective competencies.

   (Ensuring the importance of continuous monitoring of any life-threatening risk factors, or any new factors that require reporting in which the case coordinator informs the case coordinators supervisor who reports to the Family Protection Department)

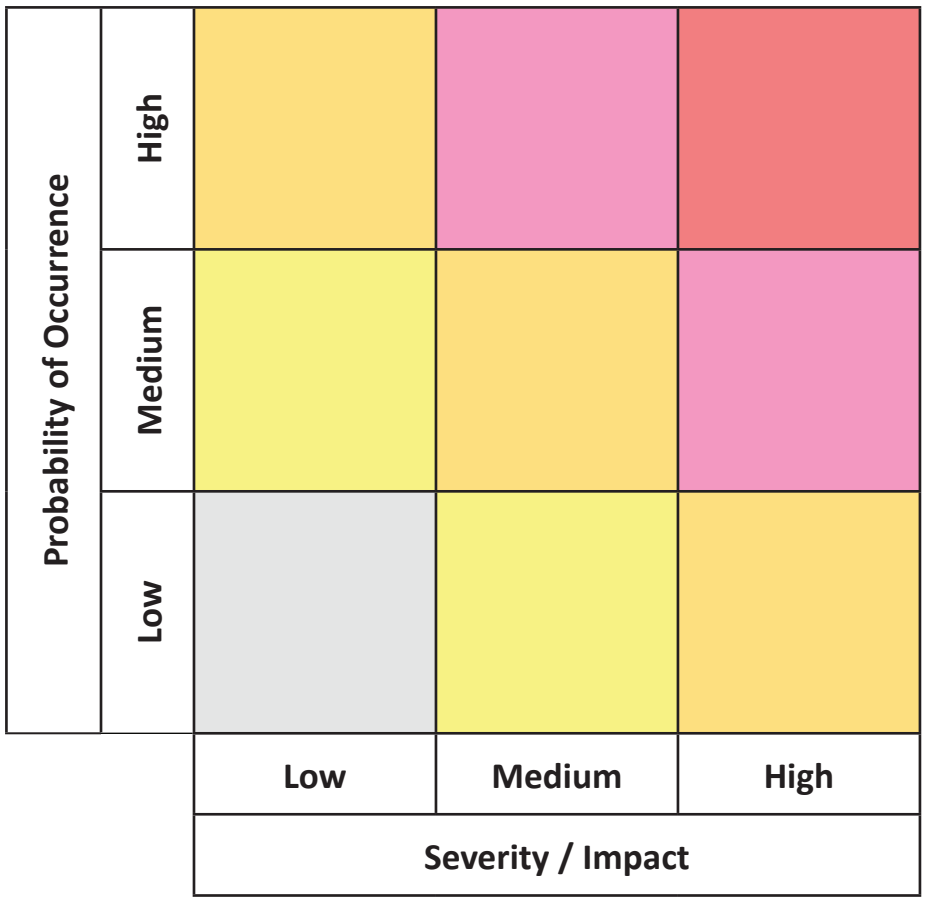
Comprehensive Risk Factors	
Definition	Is a set of indicators and characteristics of the survivor, or the perpetrator, or the family or the community, which lead, individually and / or in combination, to Increase exposure to family violence or increase in incidence frequency.
Classification	• Some of these indicators may indicate imminent danger and pose a threat to the survivor's life or his/her family. In the case of detecting life-threatening factors during the comprehensive assessment procedures carried out periodically by the case coordinator and the case management team, reporting to the FPD is required. • Assessment of these indicators requires a specialized study by the case coordinator and service providers to identify and deal with. • Can be classified according to: 1. Level of effect on case, perpetrator or the family as shown in the model below (risk assessment: probability of occurrence / impact), and accordingly, intervention priorities can be identified. 2. Type of indicators: physical, psychosocial, economic, legal and other.
Response	Response to comprehensive risk factors requires • A specialized comprehensive assessment and study on the life aspects of the case and perpetrator to determine the extent to which the risk indicators affect the case life or his/her family members or increase the intensity of the practiced violence. • Linking the risk factors to the multiple needs of the case and / or the family, and services required for the intervention. • Taking into consideration the reporting criteria mentioned in tables 17 and 18 and the legislation in force.

Examples of factors that pose life-threatening risk to the survivor or any of the family members and require reporting		
Survivor	**Family**	**Community**
– A severe psychological state and a low self-esteem by the case that may increase the probability of suicide – A previous suicide attempt – Sexual violence on the case, whether from inside or outside the family – The recurrence of any form of violence in a manner that may affect the life and physical integrity of the individual	– The survivor lacks a social support network of parents and relatives- – The culture of the family may not tolerate reporting any case of violence by any of its members, therefore there is possibility of serious action against the case or family members. – A direct threat from the perpetrator in the event that the offender and the case remain together within the family – Previous security records for any family member may pose risk to the lives of individuals – Use of weapons by family members.	– The surrounding social environment accepts violence and can't tolerate the request by the case for assistance, and considers the survivor / the case as a stigma, that must get rid of by killing
– Exposure to frequent physical violence that did not result in acute injuries that requires urgent health care, with the possibility of recurrence – Addiction to sedatives, or alcohol. – The inability to protect oneself from violence due to disability or chronic illness – Current or previous psychiatric disorders	– Family Disintegration. – Tension among family members. – The family needs urgent / ongoing financial assistance to meet their living obligations – Presence of family members who may repeat the violence. – Having more than one individual exposed to violence – perpetrator Addicted to drug or alcohol. – Possibility of the offender reaching the case within the family space. – Absence of a reliable person to care and or protect the case within the family.	– The Community culture renounces violence in general but considers it normal if it occurs within the family and can be dealt with within the family and does not require the intervention of parties outside the family.

Risk Assessment: Probability and impact Severity

Based on the available information, the case management team investigates the circumstances and conditions of the case to identify and assess the potential risks as per the attached matrix. Based on the comprehensive assessment of the overall risk factors and needs of the case, the environmental conditions of the case, the service provision reports of the survivor, his/her family and the perpetrator.

1. Usually the orange squares are taken into serious consideration, pink squares are considered risky, while the red squares are considered high risk. The risk level is categorized based on the case management team's assessment.



A risk assessment should be conducted periodically and the response is implemented accordingly.

In case of the emergence of new or evolving risk factors, the case coordinator re-conducts the assessment to define the emergency needs and the risk factors, and based on that:

3- Conduct the needed amendments on the immediate response plan according to the case developments.

4- Coordinate with the concerned partners to provide the services.

2. The case coordinator and the case management team prepare the comprehensive intervention plan with all its details by completing the Case Conference Form (Form 6-b) and share it with the partners.
3. The case coordinator documents the case conference details and the agreed-upon intervention plan procedures insuring endorsement and signatures of all partners.

The time frame allocated to implement the activities of the comprehensive intervention plan should be documented, and the priorities of the procedures should be considered according to the case's needs, while ensuring that the appointments between the partners and the provided services are not conflicted.

The case coordinator notifies the case and his/her family with the comprehensive intervention plan, the procedures and available options and the consequences of each according to the best interest and the legislations, laws and the national regulations in force.

4. The case coordinator transfers the case and his/her family to the service providing institutions as recorded in the comprehensive plan according to the "Service providing institutions from" (From 7-b).

Institution	Comprehensive intervention plan procedures
Health services	1. Based on the assessment of the case coordinator, the case is immediately transferred to medical services in case it needed. 2. Clinical examinations are conducted and providing the required medical services, such as: • Medical consultations including clinical management of sexual violence. • Visits to the general and specialized medicine clinics and the follow up. 3. Prepare the medical reports and recommendations then send the report to the case coordinator.
Psychiatric services	1. Interview the case and conduct the psychiatric examination (the family members and the perpetrator are interviewed sometimes if required), such as: • Psychiatric consultations. • Visits to the psychiatric clinics for follow up. 2. Prepare the medical psychiatric report and its recommendations then send it to the
Psychosocial services	3. The social expert takes the required procedure(s), such as: • Shelter-care/ temporary protection. • Enabling, rehabilitation and re-integration programs. • Social follow up visits. • Family consultation sessions. • Monthly aid. • Behavior treatment. 4. The social expert prepares a report on the case and sends it to the case coordinator.
Legal services	1. The case coordinator coordinates with the legal service provider. 2. Take the agreed procedures. 3. The reports and recommendations are prepared and sent to the case coordinator.
Pedagogical services	1. The case coordinator coordinates with the Ministry of Education. 2. Take the agreed upon procedures, such as: • School transfers. • Student consultation services (school counsellor). • Facilitating the mission of the social expert to meet the children at schools. 3. The reports and recommendations are prepared and sent to the case coordinator.
Other services according to the case needs	1. The case coordinator coordinates with institution. 2. Take the agreed upon procedures. 3. The reports and recommendations are prepared and sent to the case coordinator.

5. The service providers fill out the Service Provision Report (Form 8-b) and send it to the case coordinator according to the agreed-upon methodology.
6. The case coordinator follows up the implementation of the comprehensive intervention plan as agreed during the case conference according to the referral forms. This is to ensure the implementation of the comprehensive intervention plan as mentioned in the agreed articles and recommendations and within the specified time frame.
7. The case coordinator monitors the implementation of the articles of the comprehensive intervention plan according to the "Follow-up Registry Form", (Form 9-b) and follows up with the survivor.

The case coordinator notifies the case and his/her family with the outcomes of the case follow up conferences, the procedures and the available options in addition to the consequences of each according to the best interest, the legislations, laws and the national regulations in force.

8. Based on the follow up registry of the comprehensive intervention plan, a case conference is held with the participation of all the case management team members to present the outcomes of the implementation of the comprehensive intervention plan. Based on the discussions of the case conference, one of the following recommendations is undertaken:
   a. Based on the multi-sectoral and multidisciplinary comprehensive needs assessment, and if the case management team, evaluates that the goals of the immediate response plan of the case have been realized, all of its activities have been implemented, the risk factors have been eliminated, in addition to the absence of the need for any other services, and the case team decides to close the case file, the case coordinator moves to the closure procedures of the case file, and the case coordinator notifies the case and his/her family with the required instructions to protect him/her in case he/she needed any additional support in the future. The case coordinator documents that in the file.
   b. Based on the multi-sectoral and multidisciplinary comprehensive assessment, and if the case management team evaluates that the goals of the immediate response plan of the case haven't been realized nor its activities have been implemented, and the case needs additional services and interventions, services and procedures are agreed to be taken according to the case needs and they are translated into an action plan which is followed up by the case coordinator and the work team (reconduct the preliminary assessment and urgent needs in coordination with the partners and ament the immediate response plan accordingly).

- **The case coordinator holds case conferences (follow up case conferences) repeatedly as long as there are risk factors or additional needs and interventions required, based on the comprehensive needs assessment in coordination with the partners.**

The case coordinator notifies the case and his/her family with the outcomes of the case follow up conferences, the procedures and the available options, in addition to the consequences of each according to the best interest, the legislations, laws and the national regulations in force.

The case coordinator notifies the case coordinators supervisor of the case developments and the implementation of the comprehensive intervention plan and obtains the supervisor's endorsement on the procedures.

The case coordinator notifies the case coordinators supervisor within a maximum of 24 hours of the case developments and the implementation of the comprehensive intervention plan and obtains the supervisor's endorsement on the procedures. And obtains endorsement on the Reporting Form for cases that require reporting within one hour.

File Closure Procedures

Case file closure:

The case file closure is more effective when it happens as a part of the agreed plan operation among the service providers, and that is after ensuring that the goals of the intervention plan or the immediate response plan of the case and his/her family are realized. And the progress is followed up and revised regularly.

The decision of the case file closure is taken according to justifications and standards pertaining to the file closure, and with a consensus among the concerned partners, in addition to the majority opinion of all the concerned institutions to provide their services to the case and his/her family, with the emphasis on the involvement of the case or his/her (legal representative) and his/her family in the case file closure. There should be an opportunity available to all concerned parties to provide the services in taking part in the decision-making process and discuss any necessary measures as a part of the closure process. A comprehensive revision must always be conducted for the risk factors on the case and his/her family prior to the file closure with an overall documentation of the entire services provided to the case and his/her family.

1. The case coordinator moves to the case file closure based on the case conference which comprises the following:
   - The implementation of the immediate response plan with its activities altogether, and the roles and responsibilities assigned to all partners with the elimination of risk factors and the absence of any emergency needs of the case.
   - The implementation of the comprehensive intervention plan with its activities altogether, the roles and responsibilities assigned to all partners with the elimination of risk factors.
   - The presence of one of the justifications of the file closure approved in the case management approach (Table 10).
2. The case coordinator arranges to hold a case conference and the closure is based on the recommendations of the conference according to the "File Closure Form" (Form 10-b).

Table (24): Regulations and justifications of the case file closure	
Regulations of the case file closure	1. The attendance of service providing representatives who deal with the case. 2. The documentation of justifications and closure standards. 3. The written documentation of any reservation if present. 4. Based on the majority decision, the case management team takes a closure decision. 5. The signature and endorsement of the case management team members on the proceedings of the case conference which resulted in the file closure decision. 6. The case and his/her family are notified with the required instructions for future follow up, in addition to the safety plan to prevent the recurrence of violence.
Justifications of file closure	1. Realizing the goals of the immediate response plan, eliminating the risk factors and ensuring they don't recur. 2. Realizing the comprehensive intervention plan, eliminating the risk factors and ensuring they don't recur. 3. Moving abroad for residency or immigration. 4. The death of the survivor; and the procedures regarding the protection of the other family members. 5. The refusal of the case to keep receiving the multiple services. 6. If the case was incompetent or a child, and if the legal representative refuses to pursue the procedures of the case management, the best interest should be taken into account while ensuring the completion and the continuity of the legal and administrative procedures according to the regulations, instructions, and laws regarding the nature of the case and the procedures related to the protection of the other family members.

3. The case coordinator ensures the documentation of the case conference results and the endorsement and signature of all partners, in addition to the approval and endorsement of the case coordinators supervisor.

The case coordinator notifies the case and his/her family with the results of the file closure conference and provides him/her with the necessary instructions to prevent the recurrence of violence, in addition to follow up guidelines in case of the need for any additional support in the future (safety plan) and documents that in the file.

4. The case coordinator closes the file and saves it according to the file saving policy in his/her institution, and the file is opened again in case of any new complaints in the future.

The case coordinator completes the case file closure procedures within a maximum period of 24 hours.

C. Forms used by service providing institutions

Form (1-b): Reception Form

Date:	Time:
Case Identification:	
☐ Disclosure / complaint by the survivor or family member ☐ Identification by service provider ☐ Referral by institution not specialized in violence cases ☐ Other	
Violence Incident:	
Location of the Incident: ☐ Home ☐ Street ☐ School ☐ Work Place ☐ Other (Specify) Type of Violence ☐ Physical ☐ Sexual ☐ within family ☐ outside of family ☐ Neglect ☐ Psychological/ verbal ☐ Other Family members affected by the incident ☐ Wife ☐ Child/children ☐ Both, wife and children ☐ Others	

Survivor Information:		
Full Name:		
Date of Birth:	Sex: ☐ Male ☐ Female	Nationality:
National ID # for Jordanian	Type and Number of ID Document (for non-Jordanian)	
Social Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Education ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-Graduate Studies	
Land Phone	Mobile Phone	
Address		
Profession	Place of Work	Work Phone
Work Address		
In case of children or incapacitated: Name of Guardian /Legal Representative Phone Number		

Perpetrator Information (repeat for multiple perpetrators):		
Perpetrator Name:		
Nationality	Sex: ☐ Male ☐ Female	Birth of date:
National ID # for Jordanian	Type and Number of ID Document (for non-Jordanian)	

Social Status	Education
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-graduate Studies
Mobile phone	Land phone
Address	

Profession	Work place	Work phone
Work address		

Relation to the survivor:

☐ Family member (except husband)

☐ Husband

☐ Other (specify):

Primary Risk Indicators
Does the survivor suffer from acute physical injuries? ☐ Yes ☐ No
Does the survivor suffer from mental instability? (shouting, crying, shock, etc.) ☐ Yes ☐ No
Is the survivor afraid of the perpetrator or family members? ☐ Yes ☐ No
Is the violence incident taking place now? (during reporting) ☐ Yes ☐ No
Reception officer name and signature

Case coordinators supervisor explanations:
Specialization Within FPD qualitative specialization ☐ Yes ☐ No Within FPD geographic specialization ☐ Yes ☐ No Case classifications ☐ High priority ☐ Low priority
Assigned Case Coordinator:
Date: Time:
Case Coordinator Name:
Alternative Case Coordinator Name:
Case Coordinators Supervisor Signature

Form (2-b): Initial Assessment Form

Day:	Date:	Time:
Survivor Name:		File #:

Survivor Information:

Identification of violence case:

- ☐ Disclosure / complaint by the survivor or family member
- ☐ Identification by service provider
- ☐ Referral by institution not specialized in violence cases
- ☐ Other

Does the survivor suffer of any disabilities?

☐ Yes ☐ No

If yes, please specify:

☐ Mental ☐ Physical

☐ Audio

☐ Visual

☐ Mobility

☐ Others

Does the survivor suffer any chronic diseases?

☐ Yes ☐ No

If yes, please specify type of disease:

☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Kidney Disease

☐ Other

Violence Incident:

Location of the Incident:

- ☐ Home
- ☐ Street
- ☐ School
- ☐ Work Place
- ☐ Other (Specify)

Time of Incident:

Date: (Day)

Time:

Type of Violence:

Sexual:

- ☐ Within family
- ☐ Outside of family

- ☐ Physical
- ☐ Psychological / Verbal
- ☐ Neglect
- ☐ Other

Has the survivor been previously abused?

☐ Yes ☐ No

If yes please describe in brief.

Perpetrator Information (repeat for multiple perpetrators):
Perpetrator name:
Does the perpetrator suffer from psychological problems? ☐ **Yes, specify** ☐ **No**
Does the perpetrator suffer from addiction to alcohol or drugs? ☐ **Yes, specify** ☐ **No**
Does the perpetrator have a criminal record? ☐ **Yes, specify** ☐ **No**
Did the perpetrator threaten the survivor or any family member? ☐ **Yes, specify** ☐ **No**

Procedures undertaken by the survivor following the incident:
Did the survivor report the incident? ☐ Yes ☐ No ☐ Other
What procedures have been carried out (in case of reporting)?

1. Mandatory Reporting Criteria

The case coordinator and / or service providers must take into account cases where reporting is legally mandatory, and :not reporting entails legal liability

- ☐ In case of any sexual violence or suspecting a sexual violence.
- ☐ In case of any violence being on a child or an incompetent.
- ☐ If there is a life threat on the case from the perpetrator or the family or from the case him/ herself.
- ☐ If weapons or sharp tools are used in the violence incident.
- ☐ Crimes that are classified as felonies.
- ☐ Other: ……

Less than that, depends on the case assessment based on preliminary risk indicators that require reporting in the event of at least one of the following factors, (the case coordinator / service providers are not legally liable for non-reporting, for example:

- ☐ If the case suffers from physical injuries that require immediate medical intervention.
- ☐ If the case has been subjected to assault by multiple perpetrators.
- ☐ If the case suffers from the following symptoms: severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety.
- ☐ If the case is suicidal or threatens to commit suicide.
- ☐ If the case is deemed a danger on the lives of others and their safety.
- ☐ If the case fears for her life or for his/her family members' lives.
- ☐ If the violence incidence is recurring within the family (against the survivor or any family member of the family).

Other:

2. Immediate Needs:

- ☐ Medical/health services
- ☐ Psychosocial
- ☐ Safety and security

Case Coordinator's Recommendations:	
Reporting to FPD:	
☐ Requires reporting	☐ Does not require reporting
Need for services:	
☐ The survivor needs urgent services:	☐ The survivor needs non-urgent services.
☐ Medical	☐ Continue providing services in the institution
☐ Psychological	☐ Referral to institutions providing other services
☐ Forensic	
☐ Protection & Security	
☐ Referral to institution providing other services	

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Form (3-b): Reporting Form

Day:	Date:	Time:

Reporting Information:
Reporting Institution: ☐ Institution specializing in family violence ☐ Service providing institution ☐ Qualified service provider (specify): ☐ Other

Type of Violence
☐ Physical
☐ Sexual
☐ within family
☐ outside of family
☐ Neglect
☐ Other

Information of the Reporting Institution:	
Name of the reporting institution:	
Job title of the reporter:	Name of the reporting person:
e-mail:	Telephone no:
Address:	

FPD Branch Reported to:
Office / Branch:
Governorate:
Reporting Mechanism: ☐ phone ☐ fax ☐ e-mail ☐ by hand ☐ other

Survivor Information:	
Survivor Name:	
Nationality:	Age:
National ID number (for Jordanian): Type and number of ID (for non-Jordanian):	Sex: ☐ Male ☐ Female

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	
Level of education: ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-Graduate studies	
Address:	
In case of children or incapacitated: Name of Guardian /Legal Representative Phone Number	

Profession	Work place	Work phone
Work address		

Description of the Violence Incident

Services Provided to the Survivor by the Reporting Institution
☐ Medical services _____ _____ ☐ Psychosocial services _____ _____ ☐ Shelter services _____ _____ ☐ Legal services _____ _____ ☐ Others _____ _____ _____

Name and Signature of Person Who Reported the Case	Name and Signature Report Recipient
Date: Time:	Date: Time:

Form (4-b): Immediate Response Plan Form- Service Providers

Day:	Date:	Time:
Response meeting number:		

Survivor Name:	File #:
Case coordinator:	Institution:

Case summary:

Summary of initial Assessment (including urgent needs and priorities):

Case Management Team (Immediate Response Phase):				
#	**Members invited/ contacted**	**Institution**	**Job title**	**Contact mechanism**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Immediate Response Plan				
Needs/sector		**Tasks**	**Implementing agency**	Timeframe
Medical	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
Psychiatric	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
Psychosocial	1			
	2			
	3			
	4			
	5			
	6			
	7			
	8			
Others	1			
	2			
	3			
	4			
	5			

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Form (5-b): Comprehensive Needs Assessment Form

Day:	Date	Time:

Survivor Name:	File #:
	Type of Assessment:

Case Summary:
Comprehensive Risk Factors

1. Mandetory Reporting Criteria:

The case coordinator and / or service providers must take into account cases where reporting is legally mandatory, and not reporting entails legal liability:

- ☐ In case of any sexual violence or suspecting a sexual violence.
- ☐ In case of any violence being on a child or an incompetent.
- ☐ If there is a life threat on the case from the perpetrator or the family or from the case him/herself.
- ☐ If weapons or sharp tools are used in the violence incident.
- ☐ Crimes that are classified as felonies.
- ☐ Other: ……

Less than that, depends on the case assessment based on preliminary risk indicators that require reporting in the event of at least one of the following factors, (the case coordinator / service providers are not legally liable for non-reporting, for example:

- ☐ If the case suffers from physical injuries that require immediate medical intervention.
- ☐ If the case has been subjected to assault by multiple perpetrators.
- ☐ If the case suffers from the following symptoms: severe crying seizures, aggression tendencies, dazedness, confusion, disorientation, inability to focus, fear, trembling and anxiety.
- ☐ If the case is suicidal or threatens to commit suicide.
- ☐ If the case is deemed a danger on the lives of others and their safety.
- ☐ If the case fears for her life or for his/her family members' lives.
- ☐ If the violence incidence is recurring within the family (against the survivor or any family member of the family).
- ☐ Other:

2. Comprehensive Needs:

Types of Needs	**Details**	
Medical	1	
	2	
	3	
	4	
	5	

Psychiatric	1	
	2	
	3	
	4	
	5	
Psychosocial	1	
	2	
	3	
	4	
	5	
Legal	1	
	2	
	3	
	4	
	5	
Pedagogical/Educational	1	
	2	
	3	
	4	
	5	
Economic Empowerment	1	
	2	
	3	
	4	
Other	1	
	2	
	3	
	4	
	5	

Conduct a periodic risk assessment and response accordingly
In case of identifying new or recurring risk factors, the case coordinator should conduct the initial assessment to determine urgent needs and risk factors and legislation in force, and based on this:

1. Report to Family Protection department, if required.
2. Set necessary adjustments to intervention plan.
3. Coordinate with relevant partners.

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Form (6-b): Case Conference Form

Day:	Date:	Time:

Survivor Name: **Case coordinator:**	File #: Institution:

Conference #:	Conference type: ☐ Case Conference ☐ Follow-up Conference	Conference location:

Case Summary:
Summary of Comprehensive Needs:
Conference Summary:
Conference Decision:
☐ Provision of services based on comprehensive needs assessment (please fill comprehensive intervention plan below) ☐ Case file closure (please fill Form 10-b, File Closure Form)

Comprehensive Intervention Plan			
Type of service	**Procedures**	**Implementing agency**	Timeframe

Medical	1			
	2			
	3			
	4			
	5			
Psychiatric	1			
	2			
	3			
	4			
	5			
Psychosocial	1			
	2			
	3			
	4			
	5			
Legal	1			
	2			
	3			
	4			
	5			
Pedagogical/ Educational	1			
	2			
	3			
	4			
	5			
Economic Empowerment	1			
	2			
	3			
	4			
	5			
Other	1			
	2			
	3			
	4			
	5			

Case Management Team Members				
#	**Members invited/ contacted**	**Institution**	**Job title**	**Signature**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Name & Signature of Case Coordinator:	Name & Signature of Case Coordinators Supervisor:
Date:	Date:
Time:	Time:

Form (7-b): Referral Form

☐ Day: ☐ Date: ☐ Time:	Type of response: ☐ Immediate ☐ Comprehensive intervention

Survivor Information:		
Survivor Name:	File #:	
Type of response: ☐ Immediate ☐ Comprehensive Intervention		
Date of birth:	Gender: ☐ Male ☐ Female	Nationality:
National ID: (for Jordanians)		Type and Document #: (for non-Jordanians)
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed		Educational level: ☐ Illiterate ☐ Primary ☐ Secondary ☐ Bachelor ☐ Post-Graduate Studies
Phone number		Mobile Number
Address		
In case of child or incapacitated: Name of Guardian: Phone Number: Name of Legal Representative: Phone number:		

Profession	Work place	Work phone
Work address		

Case Type:	
☐ High Priority	☐ Low Priority
Referral Mechanism:	
☐ Telephone (urgent cases) ☐ Fax ☐ Official E-mail ☐ Personal	

Referring Institution:	
Institution:	Case coordinator name:
Phone:	E-mail:
Address:	

Institution Referred to:	
Name:	Person referred to:
Phone:	E-mail:
Address:	
Case Summary:	

Referral details: 1. Services needed: 2. Preferred contact mechanism with the survivor:

Name & Signature of Case Coordinator:	
Date: Time:	Date: Time:

Approval of the referral and information disclosure between partners (read the information with survivor and answer any question that might be raised before examiner signs below)	
I, the undersigned, _____ (case name), understand that the purpose of the referral and the disclosure of this information for (the organization referred to)---------- is to ensure the provision of care and continuity between the service providers who seek to provide me with services, and _____ (referring institution) have worked to explain referral procedures to me clearly, and identified the information that will be disclosed. And by signing on this form, I agree on the exchange of this information.	
Signature of the responsible party (survivor, parent, or legal representative):	Date:

Form (8-b): Service Provision Report

☐ Day:	Type of response:	
☐ Date:	☐ Immediate	☐ Comprehensive intervention
☐ Time:		

Institution name:	Sector:
Phone	Email
Address	

Survivor Name:	File #:
Age:	Date Received:

Services provided:

☐ Medical ☐ Psychiatric ☐ Forensic ☐ psychosocial

☐ Legal ☐ Judicial ☐ Administrative procedures

☐ Pedagogical/Educational ☐ Economic empowerment ☐ Other

Summary of services/ procedures provided:		
#	Service/Procedure	Date
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Service Provider Recommendations:

Name & Signature of Service Provider	Official Stamp	Date and time of Report Receipt	Name & Signature of Case Coordinator

Form (9-b): Follow-up Registry Form

Survivor Name:	File #:
Type of response: ☐ Immediate ☐ Comprehensive Intervention	
Case coordinator:	

#	Procedure	Implementing agency	Time Frame	Implementation status
1				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
2				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
3				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
4				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
5				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

6				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
7				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
8				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
9				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
10				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
11				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
12				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

13				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
14				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
15				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
16				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
17				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
18				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
19				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up
20				☐ Done ☐ Not yet ☐ Amendments ☐ Follow up

Form (10-b): File Closure Form

Day	Date	Time:

Case Conference #:	Case conference location:
Case coordinator:	Institution:

Survivor Name:	
Case Summary:	

Summary of Implemented Procedures	
Medical ☐ **Treatment** ☐ **Psychiatric** ☐ **Forensic**	

Psychosocial	
Safety and Protection	
Legal/ Judicial/ Administrative Procedures	
Other	

File Closure Justifications

- ☐ Achieving Immediate response plan goals, demise of risk factors
- ☐ Achieving Intervention plan goals, demise of risk factors
- ☐ Survivor moves / immigrates to another country, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case
- ☐ The death of the survivor, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case
- ☐ The case denied continuation of case management procedures, ensure the continuity of legal and administrative procedures based on laws and legislations concerned with the case.
- ☐ In case of a child or incapacitated (denial of the guardian), take into consideration the best interest determination and make appropriate decision based on it.
- ☐ Other (specify)

Reservations (if applicable):

Case management team members				
#	Members invited/ contacted	Institution	Job title	Signature
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Name and signature of case coordinator	Name and signature of case coordinator supervisor
Date: Time:	Date: Time:

Case Management Form Usage and Information Exchange Matrix:

Form Number and Name		Filled out by	Delivered to	Supervised by	Ratified by
1	Reception	Receptionist	CCS		CCS
2	Initial Assessment	CC		CCS	CCS
3	Reporting	SP	CCS		CCS
4 a	Immediate Response Meeting for FPD	CC		CCS	CMT and CCS
4 b	Immediate Response Meeting for Service Providing Institutions	CC		CCS	CMT and CCS
5	Comprehensive Needs Assessment	CC		CCS	CMT and CCS
6	Case Conference	CC		CCS	CMT and CCS
7	Referral to Service Providing Institute	CC	SP		
8	Service Provision	SP	CC		
9	Follow-up Registry	CC		CCS	
10	Case Closure	CC		CCS	CMT and CCS

CC= Case Coordinator, CCS= Case Coordinators Supervisor, CMT= Case Management Team, SP= Service Provider

Thanks List

List of	Nmae
Ministry of Social Development	Mr. Jalal Ghreeb
	Mr. Mo'wiah Masadeh
	Ms. Ibtessam Alzghool
	Ms. Samar Sabha
	Mr. Abd Alsalam Alrawahnah
	Mr. Maher Kloub
	Ms. Hailanah Hammad
	Mr. Ahmad Shhadat
	Ms. Suhad Mobaydeen
Ministry of Health	Dr. Ahmad Bani hani
	Dr. Nael Al Edwan
	Dr. Malak Al Awari
	Dr. Roula Afaneh
	Dr. Eman Shhadeh
	Dr. Esra Al Tawalbeh
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	Ms. Rudaynah Halasa
	Ms. Asma Tabasha
	Dr. Tagreed Al Baddawi
Ministry of Interior	Mr. Hussam Al Gaber
Ministry of Justice	Ms. Alfat Khanfar
Department of the Chief Justice	Dr. Ashraf Al Omari
Judicial Council	Judge Ali Al Masimi
Family Protection Department	Lt. Col. Eyas Daoudieh
	Lt. Col. Sadiq Al Omari
	Captain Ayman Al Rifai
	Captain Mohammed Al hzaima
	Captain Sultan Al Abdullat
Jordan River Foundation	Ms. Ola Al-Omari
	Ms. Iman Al Akrabawi
Family Health Care Institute	Dr. Atef Al Qasim
	Ms. Esraa Shakbouha
	Ms. Haneen Al Zoubi
National Committee for Women's Affairs	Ms. Ma'li Al N'amat

Justice center for legal aid	Ms. Suhad Al Sukari
	Mr. Mutaz Al Douhni
	Ms. Samia Haboub
Union of Jordanian Women	Ms. Najeyah Al Zoubi
United Nations Children's Emergency Fund	Ms. Maha Homsi
	Ms. Suzan Kashet
	Ms. Maryam Al Qasem
United Nations High Commissioner for Refugees	Ms. Zaina Jad'an
United Nations Population Fund	Ms. Yara Al Dair
	Ms. Layali Abo Sair
Arab Renaissance for Democracy and Development	Ms. Suzan Mohareb
Intersos Jordan	Ms. Majedah Mahasneh
Save The Children Jordanian Association	Ms. Sana Al hyari
	Ms. Rawan Iydah
International Medical Corps	Ms. Lama Al As'ad
	Ms. Ibtisam Al Khasawneh
International Rescue Committee	Ms. Samah Al Dmour
National Council for Family Affairs	Mr. Hakam Al Matalkah
	Mr. Faris Al Bashiti
	Mr. Nasser Al Dmour
	Ms. Hadeel Al Hawari
	Ms. Majed Sweiss
Advisory Group	Eng. Jamal Al Salah
	Ms. Troub Malhas
	Dr. Manal Tahtamouni

المجلس الوطني لشؤون الأسرة
NATIONAL COUNCIL FOR FAMILY AFFAIRS

In partnership with

وزارة الصحة

UNFPA

UNHCR
The UN Refugee Agency

unicef

HANDICAP INTERNATIONAL

مركز العدل للمساعدة القانونية

اللجنة الوطنية الأردنية لشؤون المرأة
The Jordanian National Commission for Women

NOOR AL HUSSEIN FOUNDATION
معهد العناية بصحة الأسرة
INSTITUTE FOR FAMILY HEALTH

مديرية الأمن العام

وزارة العدل

وزارة العمل

المجلس القضائي الأردني

Chid Protection
Sub-Working Group

SGBV
Sub-Working Group

International Medical Corps

RESCUE COMMITTEE

INTERSOS

IRD
International Relief & Development

Save the Children

ARDD

جمعية إتحاد المرأة الأردنية
Jordanian Women's Union Association

مؤسسة نهر الأردن
Jordan River Foundation