STANDARD OPERATING PROCEDURES

FOR

RESPONSE TO

GENDER BASED VIOLENCE

and

CHILD PROTECTION

IN

SOMALILAND

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List all NGOs/UN/government institutions that participated in the process

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
BIA	Best Interest Assessment
BID	Best Interest Determination
CAAC	Children Associated with Armed Conflict
CAAG	Children Associated with Armed Groups
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CFS	Child Friendly Space
CMR	Clinical Management of Rape
CP	Child Protection
CRC	Convention on the Rights of the Child
ERW	Explosive Remnants of War
EODs	Explosive Ordinance Disposals
FTR	Family Tracing and Reunification
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IASC	Inter Agency Standing Committee
IDP	Internally Displaced Person
IDTR	Identification, Documentation, Tracing, Reunification
IEDs	Improvised Explosive Device
MCH	Mother and Child Health
MRE	Mine Risk Education
MRM	Monitoring and Reporting Grave Violations of Child Rights
NGOs	Non-Governmental Organizations
PEP	Post-Exposure Prophylaxis
PSEA	Prevention of Sexual Exploitation and Abuse
S/UAM	Separated/Unaccompanied Minors
SOPs	Standard Operating Procedures
STIs	Sexually Transmitted Infections
UN	United Nations
UXOs	Unexploded ordinances
VCT	Voluntary Counselling and Testing

CHAPTER 1. INTRODUCTION and SETTING

Protection of children and women from violence in particular from gender based violence, abuse and exploitation is a high priority for the Government of Somaliland. According to the Convention on the Rights of the Child, the Draft Somaliland Child Act, Child Protection Policy and other international treaties, all children have the right to be protected from harm. Gender based violence (GBV) is a life threatening protection, health, and human rights issue that can have devastating impact on women and children in particular, as well as families and communities. The Government and civil society have duty and responsibility to prevent violation of child protection, gender based violence and respond to such violation ensuring safety, respect to dignity of the survivors, bringing perpetrators to justice.

The vision and approach of the Somaliland gender based violence and child protection standard operating procedures (SOP) is to create a protective environment, where girls, boys, women and men are free from violence, exploitation, and abuses under which services, behaviors and practices minimize vulnerability, address known risk factors, and strengthens resilience through child friendly and human rights based approach. With this vision the Gender-Based Violence (GBV) and Child Protection (CP) Standard Operating Procedures (SOP) are developed to facilitate protection services and joint referral pathway for survivors of violation in Somaliland.

1.1 Purpose of the Standard Operating Procedures:

These Standard Operating Procedures have been developed to facilitate joint action and proper service delivery by all actors to respond to GBV and CP concerns in Somaliland. The SOPs are based on the international and national standards and will be applied in line with those standards. The SOP is developed by representatives of the organisations listed above, and describes clear procedures, roles, and responsibilities for all actors. Furthermore all organisations listed above agree to the same procedures, guiding principles and working together for the best interest of women, men, boys and girls. This SOP covers [Somaliland], which includes both IDP settlements and host communities in an urban setting. Main persons of concern are girls, boys, women and men affected by emergencies, child headed households, separated/unaccompanied children, children with disability, female headed households, survivors of gender based and other violence, IDPs, poor and vulnerable host community members.

1.2 Multi-sectoral response to GBV and CP

The SOPs take into consideration that GBV and CP requires multi-sectoral response as listed below at the minimum:

- Health (nutrition, medical response to sexual and other physical violence, and any other services needed, disabilities, children born from rape)
- Psycho-social (trauma counselling, emotional support, children formerly associated with armed conflict/groups, youth/children at risk, livelihood, education, recreation, sexual exploitation and abuse, and child abuse, disabilities, mine risk education)
- Protection/Security (safe spaces, police)
- Legal aid (legal response to GBV and children in contact with the law, child abuse, child friendly legal support, orphans land rights, inheritance rights, child sensitive legal procedures)

1.3 Specific concerns for Child Protection

- Best Interest Assessments and Best Interest Determination
- Interim Care
- Identification, Documentation, Tracing and Reunification (IDTR) for separated and unaccompanied children
- Mine Risk Education
- (Life) Skills and education training
- Child Abuse (which is a cross cutting concern for health, psycho-social, protection/security and legal aid)

1.4 Companion Guides and Key Resources

These SOPs were developed within the framework of the following international guidelines and National Standards:

Establishing Gender based violence Standard Operating Procedures (SOPs) for multi-sectoral and inter-organizational prevention and response to Gender based violence in humanitarian settings IASC Sub-Working Group on Gender and Humanitarian Action. www.humanitarianinfo.org/iasc/gender

Guidelines for Gender based violence interventions in humanitarian settings: focusing on prevention of and response to sexual violence in emergencies. Geneva, Inter-Agency Standing Committee, 2005/ 2014. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp (available in several languages)

Sexual and Gender based violence against refugees, returnees, and internally displaced persons: guidelines for prevention and response. Geneva, United Nations High Commissioner for Refugees, 2003. http://www.unhcr.org/protect/PROTECTION/3f696bcc4.pdf

WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva, World Health Organization, 2007 http://www.who.int/gender/documents/EthicsSafety_web.pdf (available in several languages).

Clinical management of survivors of rape: developing protocols for use with refugees and internally displaced persons, revised ed. Geneva, World Health Organization/United Nations High Commissioner for Refugees, 2004. http://www.who.int/reproductivehealth/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf (also available in Arabic and French)

Inter-Agency Guiding Principles on Unaccompanied and Separated Children. Geneva International Committee of the Red Cross, 2004. http://www.icrc.org/eng/assets/files/other/icrc_002_1011.pdf

The Paris Principles: The Principles and Guidelines on Children Associated with Armed Forces or Armed Groups 2007. http://www.un.org/children/conflict/_documents/parisprinciples/ParisPrinciples_EN.pdf.

Convention on the Rights of the Child (Signed by Somalia but not Ratified) & Optional Protocols

Convention on Elimination of All Forms of Discrimination against Women

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Setting
http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/

Special Series – Draft UN Guidelines for the Appropriate Use and Conditions of Alternative Care for Children: An introductory briefing on its background, core principles and scope ISS/IRC Monthly Review N° 3/2008 http://www.crin.org/docs/Special%20Series%20ISS.pdf

CHAPTER 2. DEFINITIONS AND TERMS

2.1 Definitions to be used by actors[1]:

Actor(s) refers to individuals, groups, organizations, and institutions involved in responding to gender based violence or child protection

Best Interest Assessments (or child protection assessments) should be seen as an essential element of individual case management with children at risk, and must be the basis before any action affecting an individual child of concern and support actors in any decision or action taken on behalf of a child in line with Article 3 of the CRC.

Best Interest Determination describes the formal process with strict procedural safeguards designed to determine the child's best interests for particularly important decision that affect her/him. It should facilitate adequate child participation without discrimination, involve decision-makers with relevant areas of expertise and balance all relevant factors in order to identify and recommend the best option.

Caretaker and caregiver: Terms used interchangeably to describe the person exercising day-today care of a child, whether parent, relative, family friend or another person; does not necessarily imply legal responsibility. The term might include foster parents who take in a child either spontaneously or more formally through some kind of fostering arrangement.

Child is a person under the age of 18 years.

Child Abuse encompasses all forms of physical, emotional, and verbal ill-treatment, sexual violence, neglect or negligent treatment resulting in actual or potential harm to the child's physical, emotional, psychosocial well- being, survival, development, and dignity.

Physical abuse: Physical abuse of a child is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent, care provider, or a person in a position of responsibility, power or trust. These may be single or repeated incidents.

Emotional abuse: Emotional abuse is failure to provide a developmentally appropriate, supportive environment, or other non-physical forms of hostile, or rejecting treatment. Emotional abuse is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance.

Sexual Abuse: includes activities or conduct of a parent or caregiver or other adults such as fondling a child's genitals, penetration, incest, rape, molestation, indecent exposure. Sexual abuse also includes exploitation through prostitution or the production of pornographic materials through the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct.

Neglect: Neglect is the failure of a parent, guardian, or other caregivers to provide for a child's basic needs. Needs can be physical (food, shelter, protection, and care), medical, educational, or emotional.

Exploitation: Commercial or other exploitation of a child refers to the use of the child in work or other activities for the benefit of others. These activities are detrimental to the child's physical or mental health, education, spiritual, moral, social, and emotional development or dignity in the context of a relationship or responsibility, trust or power.

[1] All definitions are adapted from CRC, Optional Protocols, CEDAW, National legislation, Policy, and other child protection and GBV standards.

Child in contact with the law is any child who comes into contact with the justice system as a result of being suspected or accused of having committed an offense, or is need of legal support including victim and witnesses of crime.

Children associated with armed conflict or armed groups is any person below the age of 18 years of age who is or has been recruited or used by an armed force or armed group in any capacity, including but not limited to children, boys and girls, used as fighters, cooks, porters, cleaners, messengers, spies or for sexual purposes. It does not only refer to a child who is taking part or has taken a direct part in hostilities (Paris Principles 2007).

Children living on the street are those children who do not have homes or caregivers and live and work on the streets. This differs from those children who work on the street but return to a home at night.

Gender refers to a socially constructed roles and responsibilities that a particular society, community assigns to women/girls and men/boy

Gender based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments and conventions. Many — but not all — forms of GBV are illegal and criminal acts in national laws and policies.

Around the world, GBV has a greater impact on women and girls than on men and boys. Women remain vulnerable in economic status, excluded from decision making and the majority of domestic work is imposed on women and girls, rather than men.

The term "Gender based violence" is used interchangeably with the term "violence against women" and "sexual and gender based violence". These terms highlight the gender dimension of these types of acts; in other words, the relationship between females' subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender based violence, especially sexual violence.

Incident refers to the specific act of gender based violence or child protection violation or rights violation

Interim care refers to alternative forms of care of children that cannot live with their families, interim and temporary care arrangements can include; family-based care; foster care; child-headed households; group care; supported independent living; residential care; centre-based care.

Separated children are those who have been separated from both parents and legal primary caregivers (previous or current), but not necessarily from other relatives.

Unaccompanied Children (also called ***unaccompanied minors***) are those children who have been separated from both parents, primary care givers, and other relatives, and who are not being cared for by an adult who, by law or custom, is responsible for doing so.

Survivor refers to the person against whom the act of violence was committed

Perpetrator is the alleged attacker **or abuser**

2.2 GBV Classification Types

The six core GBV types were created for data collection and statistical analysis of GBV. They should be used only in reference to GBV even though some may be applicable to other forms of violence which are not gender-based. The GBV classifications relate directly to the GBV Information Management System, and the standard intake form follows the same classifications.

Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.

Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. *This incident type does not include rape, i.e., where penetration has occurred.* Female Genital Mutilation is an act of sexual violence that impacts sexual organs, and as such will be classified as a sexualized act. This harmful traditional practice should be categorized under sexual assault.

Physical Assault: an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

Forced Marriage: marriage of an individual against her or his will.

Denial of Resources, Opportunities or Services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

Psychological / Emotional Abuse: infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

CHAPTER 3: GUIDING PRINCIPLES

Guiding principles are a set of norms which are considered best practice. The guiding principles were developed through a group work exercise which involved input from all organizations mentioned above. All actors agree to adhere to the following principles as guides for their behaviour, intervention, and assistance:

The below items were the points that were unanimously agreed upon by all of the present representatives as fundamental and core principles which must be taken into account by all actors of the Child Protection and GBV Working Groups. The guiding principles are in line with the four guiding principles of the Convention on the Rights of Children: Non-Discrimination; Best Interest of the Child; Survival and Development; and Participation.

3.1 Guiding Principles and Rights for Working with Individual Survivors and Children

3.1.1 Empower Children and Families to Build upon their Strengths

All children, and their families, possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems. Social workers must work to engage children and families to play an active role in the case management process.

3.1.2 Adhere to Ethical Standard

For agencies and staff working with children, professional ethical standards and practices should be developed and applied; these may be professional codes of conduct and child protection policies. Child act, international norms and standards to protect children that are relevant must be respected. Adhering to ethical standards.

3.1.3 Best Interest of the Child

In all cases concerning a child, the best interest of the child should be the primary consideration. Apply all the listed guiding principles to children, including their right to participate in decisions that will affect them. A child should be listened to and believed in, and their concerns should be taken seriously. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding guide and the appropriate procedures should be followed. It is important to note that these kinds of issues involving children are complex and there are no simple answers. The WHO Ethical and Safety Recommendations document provides some guidance on these issues and offers additional resources that can be consulted. Best interest determination guidelines can also be consulted.

3.1.4 Safety and Security

Ensure the safety of the survivor, child and family at all times. Remember that s/he may be frightened, and need assurance that s/he is safe. In all types of cases, ensure that s/he is not placed at risk of further harm by the assailant. If necessary, ask for assistance from security, police, elders, community leaders or others who can provide security. Maintain awareness of safety and security of people who are helping the survivor, such as family, friends, counsellors, health care workers, etc.

3.1.5 Do No Harm

If documenting, reporting, monitoring or providing a service to a survivor will have greater risks than benefits, it must be avoided.

3.1.6 Confidentiality

Respect the confidentiality of the survivor, child and their family at all times. If the survivor gives his/her informed consent, share only relevant information with others for the purpose of helping the survivor, such as referring for services. All written information about survivors must be maintained in secure, locked files. If any reports or statistics are to be made public, only the actors who report data each month will have the authority to release such information. All identifying personal information (name, address, etc.) will be withheld in the reporting, compilation and sharing of data. Encourage other community members and humanitarian actors to respect the confidentiality of the survivor and not gossip about a case which may increase the stigma of the survivor and discourage other survivors from seeking help in future. When relating to children make sure they understand that you have to share the information with their caretakers other appointed legal guardian to ensure the safety and security of the child.

3.1.7. Information

Everyone has the right to information, what services are available, how to reach the services, the potential risks and consequences of accepting additional services and not accepting additional services. Make sure information is given to children in a manner they understand and is child friendly. Information should be honest and complete.

3.1.8. Informed Consent

All actors must receive informed consent from the survivor, or legal guardian if working with a minor, prior to any response service or sharing of information. If the survivor cannot read and write an informed consent statement will be read up to the survivor and a verbal consent will be obtained. The survivor should have the option to provide limited consent where they can choose which information is released and which is kept confidential. The objective of informed consent is that the survivor understands what s/he is consenting and agreeing to.

Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely.

3.1.9. Self-Determination and Child Participation

Offer information about available support services and respect the choice of the survivor concerning which services s/he wishes to access. Maintain a non-judgmental manner; do not judge the person or her/his behaviour or decision. Be patient; do not press for more information if s/he is not ready to speak about it. Ensure that children are participating in the decision making process of services they can access, make sure that children are involved in all decision making processes regarding referral and access to services.

3.1.10. Non-Discrimination and Impartiality

Ensure non-discrimination and impartiality in all interactions with survivors and in all services provision. All actors will provide services without discrimination based on age, sex, religion, clan, ethnicity, wealth, language, nationality, status, political opinion, culture, etc. All actors must be impartial.

3.1.11. Privacy and Survivor's Comfort

Ensure privacy before starting interviews of survivors, this includes child survivors also. Avoid requiring him/her to repeat the story in multiple interviews. Only ask survivors relevant questions. Be empathetic. Do not show any disrespect for the individual or her/his culture or family or situation. Where possible conduct interviews and examinations by staff of the same sex as survivor unless there is no other staff available. Survivor's comfort must always be taken into consideration, and interview settings must reflect that.

3.1.12. Survival and Development

Children should be provided with the environment that enables them to grow and develop to their full potential. This includes the provision of skills, resources and protection from neglect, exploitation and abuse. Where organizations are not able to provide the necessary resources they will refer the child to services to ensure the child's health and development, including medical and psychosocial activities.

3.1.13. Family and community based approach:

As far as possible, the children's need of care and protection should be provided in family and community based environment. Provision of family/ or parental care should be given priority unless that is not in the best interest of the child. Interim care and protection for child survivors without parental care should be provided through the foster and extended family with adequate assessment of the best interest of the child. Institution based care should be considered as measure of last resort and for a minimum period of time.

3.2. Guiding Principles for All Actions of Stakeholders

3.2.1. Ethics and Safety

All agencies and organizations that are documenting and reporting any form of GBV or child violations must first be able to provide BASIC support for the survivors of violence. Referral must be provided to individuals disclosing violence. An Information Sharing Protocol must be developed and abided by all members of the GBV and Child Protection working groups (See Annex … for Child Protection Information Sharing Protocol). If documenting, reporting, monitoring or providing a service to a survivor will have greater risks than benefits, it must be avoided. Understand and adhere to the ethical and safety recommendations in the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (WHO, 2007).

3.2.2. Islamic Law, National Laws and Policies, and Human Rights, Treaties and Declarations

Islamic laws, national laws and policies and all Human Rights treaties and Declarations will be respected. Practitioners must be professionally developed and be aware of the International Human Rights Laws, Convention of the Rights of the Child (CRC), Women's Rights, Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and Conventions and Treaties already in place to govern response to survivors.

3.2.3. Multi-sectoral Coordination and Communication

Extend the fullest cooperation and assistance to each other in preventing and responding to GBV to improve services, avoid duplication and maximize a shared understanding of the situation. Establish and maintain carefully coordinated multi-sectoral and inter-organizational interventions for GBV and CP prevention and response. All actors agreed to use the same referral system. An Information Sharing Protocol must be developed and abided by all members of the GBV and Child Protection working groups (See Annex … CP Information Sharing Protocol). Coordination meetings are compulsory for all members of the GBV and Child Protection working groups.

3.2.4. Data collection, Incident Collection and GBVIMS

The GBVIMS, its intake forms, classification system and incident recorder must be adopted by all service providers within the GBV and Child Protection Working Groups. An Information Sharing Protocol must be developed and abided by all members of the GBV and Child Protection working groups. Data and information collected will be distributed through one channel, all service providers will submit reports to the national consolidating agency for further consolidation and distribution. Members whom submitted information to the focal point must receive a copy of the consolidated report for transparent distribution of all submitted information.

3.2.5. Accountability, Credibility and Transparency

Ensure accountability and credibility of all stakeholders at all levels. All actors signing this document of SOPs assume a responsibility to ensure that guiding principles reflected in the SOPs are respected when handling GBV and CP cases, and that procedures are followed as much as possible. Professional and skilled personnel are to provide services. All actors must be transparent on their motivation behind their actions. All actors must operate on a voluntary basis and not be motivated by incentives.

3.2.6. Information Sharing

Each survivor and child/guardian has the right to decide which information to be shared with who, s/he has the right to place limitations on the type(s) of information to be shared, and to specify which organisations can and cannot be given the information. S/he must also understand and consent to the sharing of non-identifying data about the case for data collection and security monitoring purposes. An Information Sharing Protocol must be developed and abided by all members of the GBV and Child Protection working groups. When reporting on GBV and Child Protection cases, information must conceal identity of survivor i.e. no real names, no pictures or descriptions of address or any other information that might identify the survivor or location of survivor.

3.2.7. Sexual Exploitation and Abuse and Code of Conduct

All actors involved in prevention of and response to GBV should understand and sign a Code of Conduct or a similar document setting out professional standards of conduct. Humanitarian agencies have a duty of care to beneficiaries and a responsibility to ensure that beneficiaries are treated with dignity and respect and that certain minimum standards of behaviour are observed.

In order to prevent sexual exploitation and abuse, the following core principles must be incorporated into humanitarian agency codes of conduct:

- Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.

- Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief in the age of a child is not a defence.
- Exchange of money, employment, goods, or services for sex, including sexual favours or other forms of humiliating, degrading, or exploitative behaviour is prohibited. This includes exchange of assistance that is due to beneficiaries.
- Sexual relationships between humanitarian workers and beneficiaries are strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, s/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create and maintain an environment which prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all levels have particular responsibilities to support and develop systems which maintain this environment.

To ensure the maximum effectiveness of the Code of Conduct, it should be posted in clear view in the public areas of each actor's office/centre, introduced and explained, signed by all staff and kept in employee files. The sample Code of Conduct attached may be modified to make it more effective or understandable in a particular culture or country. The Code must not, however, be modified in such a way as to weaken its effectiveness or diminish any of the core principles. All posted and distributed copies of the Code of Conduct should be translated into the appropriate language of use for the field area.

CHAPTER 4: REPORTING AND REFERRAL MECHANISM

The person/organisation who receives the initial disclosure (report) of a GBV or CP incident from a survivor or child will act in accordance with the referral mechanism illustrated in annex 1, which includes opportunities at each stage to move forward or stop. The survivor or child has the freedom to choose whether to seek assistance, what type(s) of assistance, and from which organisations. Health assistance is the priority for cases involving sexual violence and/or possible bodily injuries. In the case of rape, assistance must be in accordance with the WHO/UNHCR *Clinical Management of Rape* guidelines and may include emergency contraception and post-exposure prophylaxis for HIV. Service providers will inform the survivor or child of what assistance they can offer and clearly relate what cannot be provided or any limitations to services, to avoid creating false expectations. All service providers in the referral network must be knowledgeable about the services provided by any actor to whom they refer a survivor or child. Children must be accompanied to all services within the referral pathway.

4.1. Disclosure and Reporting

A survivor or child has the freedom and the right to disclose an incident to anyone. S/he may disclose her/his experience to a trusted family member or friend. S/he may seek help from a trusted individual or organization in the community. S/he might choose to seek some form of legal protection and/or redress by making an official "report" to a UN agency, police, or other local authorities.

Anyone the survivor or child tells about her/his experience has a responsibility to give honest and complete information about services available, to encourage her/him to seek help, and to accompany her/him and support her/him through the process whenever possible.

The suggested entry points to the helping system for survivors and children seeking help are the health and/or psychosocial service providers (national, international, and/or community-based actors). Entry points will be accessible, safe, private, confidential, and trustworthy.

4.2. Sexual Exploitation and Abuse

Incidents of sexual exploitation involving humanitarian workers must be reported according to the *UN Secretary General's Bulletin on Sexual Exploitation and Abuse*, 2003. Please contact the GBV and CP WG coordinators and/or Directors/Representatives of the organisation that the humanitarian worker works for, alternatively contact the following Prevention of Sexual Exploitation and Abuse (PSEA) Focal Points in this location. Note that the PSEA Focal Points are not responsible for investigating cases, but can assist in referring and contacting the right bodies.

4.3. Mandatory Reporting

Currently there are no mandatory reporting requirements in Somaliland, however all actors are highly encouraged to report any and all incidents related to abuse children.

4.4. Survivor and Child Centred Approach

Child centred approach is focusing on the short-term and long-term best interest of the child. The child/survivor should be at the centre of any reporting and referral mechanism, reflecting the principle of respect for survivor's choice and having the child participate in the decision making. A clear referral system ensures that the service providers know how to provide timely assistance and should take into consideration of the urgent, life threating, and serious physical and mental status of the survivors in response. It should be noted that all survivors are eligible and have right to access available services and assistance.

The child/survivor should be clearly informed of what assistance can be offered by each service provider (see Chapter 5 for an overview of the roles of service providers in Somaliland) including any limitations to services or risks involved. Following the guiding principles, it is the survivor's choice whether s/he seek medical, legal, psycho-social or other support. If the child/survivor requests a referral service s/he must give his/her informed consent before any information is shared with others. The survivor must also understand and consent to the sharing of non-identifying data about his/her case.

4.5. Special Procedures for Children

Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely (see guiding principles).

All actors providing services to survivors should have staff adequately trained to handle the specific needs of child survivors. Upon receiving the initial report from or on behalf of a child survivor, an assessment should be made of the child's medical, psychosocial, legal and security needs. A well-trained and skilful social worker, community counsellor or Child Protection Advocates are recommended to make this assessment.

The parents or guardian of the child should be informed about the on-going interview and supported to provide the best care possible for the child. However, as the parent or guardian is a potential perpetrator, the child should be given the chance to talk privately to the social worker or counsellor.

4.6. Identification, Documentation, Tracing and Reunification (IDTR) for separated and unaccompanied children

Urgent action for interim care for separated and unaccompanied children means that you cannot leave the child behind. However, all efforts must first be made to locate family or guardians on the spot before removing any child in order to prevent any unnecessary separation occurs.

CHAPTER 5: RESPONSIBILITIES FOR SURVIVOR ASSISTANCE (RESPONSE)

Child protection violation requires multi-sectoral assistance and services. The availability and quality of the required range of services vary from district to district depending on the context (Urban, Semi-Urban or Ruler). Therefore, a service mapping exercise should be conducted periodically to identify/update both available services and critical gaps in service provision using the agreed Service mapping Tools.

CPWG members and all actors should play an active role to inform families, children, and communities on available services and how to access them. No survivor should be denied of services and should be facilitated, advocated for, referred to appropriate services.

MOLSA as the lead body for coordination should collaborate, mobilize existing services and advocate with national and international communities to fill the gap in services.

***5.1. Minimum services*: at the minimum Child** Protection and GBV Service providers **should provide following services to survivors as per the needs and informed consent:**

- Medical and Health Services
- Psychosocial and emotional support services
- Counselling
- Legal Aid
- Care and protection
- Referral and follow up services

- Safety and Security
- Child Friendly Space

CAVEAT: Prior to provide prevention and response services to child and GBV survivors, service providers should:

- Accurately inform survivor of other available services that meet her stated health, legal, safety, and psychosocial. Inform the survivor of benefits and consequences of each service and refer the survivor as needed according to her wishes and consent;
- Complete Medical Report and Consent for Release of Information Forms and ensure the confidentiality of these forms and file them in a safe cabinet;
- Medical Report Forms can only be released when evidence is required and request for this information is forwarded by the competent authorities.

In collaboration with other governmental agencies and non- government actors, building on the understanding of government accountability for protecting children under national and international child protection standards and policy framework all actors mentioned in the outline of roles and responsibilities below have given their permission to be mentioned as service providers in the four main response sectors: health, psychosocial, legal/justice and security.

Specific services for HIV positive children and/or children living with HIV positive caregivers.

5.2. Response to Sexual Violence

The WHO Clinical Management of Rape guidelines provide a clear protocol on the health response to survivors and highlights the specific needs of children. Medical providers must ensure they provide confidential, accessible, compassionate, and appropriate medical care for survivors of GBV. Timely provision of medical health care for sexual violence include:

Post-Exposure Prophylaxis (PEP) – within **72 hours** of exposure, HIV test NOT necessary, PEP is safe for pregnant women and children – check dose.

Emergency Contraceptives – within **120 hours/5 days** after assault (reduce chance by 80-90%), pregnancy test not necessary – emergency contraceptives do not affect already existing pregnancy

Sexually Transmitted Infections (STIs) – preferably within **72 hours** (some antibiotics may be effective up to 2 weeks after)

Hepatitis B – within 14 days of exposure

For sexual violence, health care includes, at least:

- Examination and history taking
- Treatment of injuries
- Prevention of disease, including STIs/HIV
- Prevention of unwanted pregnancy
- Collection of minimum forensic evidence
- Psychological/emotional support
- Medical documentation
- Follow up care

Specify that the first doses of PEP should not be delayed by baseline HIV Testing that Emergency Contraception should be offered to women at risk of pregnancy, the documentation of clinical evidence of assault (appropriate swabs and forensic specimens), STI prophylaxis and hepatitis B vaccination, trauma counselling and referral.

MOLSA in coordination with MOH and Inter- Ministerial Task Force for Child Rights will ensure that hospitals and clinics each have medical personnel trained in the provision of clinical management of rape. Each health centre has post-rape treatment kits 3 which include PEP, STI antibiotics and emergency contraception.

MOLSA in coordination with MOH and Inter- Ministerial Task Force for Child Rights will ensure that hospital and clinics, are committed to providing all people including survivors of GBV with medical care as a first priority. A survivor will not be turned away from accessing health care because s/he has not first reported to the police. The provision of adequate health care to a survivor is the first priority. The attached medical form will be filled in by the clinical officer attending the survivor and kept confidentially.

MOLSA in coordination with Inter- Ministerial Task Force for Child Rights and in partnership with Civil Society will support/ facilitate/ encourage capacity building of service providers to respond to survivors of child protection violation and GBV.

5.2.3. Psycho-Social Services: Psycho-social services for children and survivors of GBV include:

- Basic psychosocial first aid and counselling;
- Emotional support and counselling to assist with psychological and healing from trauma;
- Case management, follow-up and assistance with social re-integration
- Advocacy to assist survivors' access to livelihood and education/skills building
- Specific support and follow up for children born of rape, both to children and their mothers.
- Child specific counsellors and recreational activities in line with Child Friendly standards

In Somaliland the following groups are agreed referral partners who provide counselling services to children and survivors of GBV. The following information about their services and location can be provided to children and survivors.

.

5.3. Reintegration Services

Reintegration activities include specific activities related to skills building, education and livelihoods through a community based approach. Reintegration activities focus on children formerly associated with armed conflict/groups.

5.3.2. Skills Building, Livelihoods and Education

Education is one of the basic human rights and provides a safe space for children to learn and develop in addition to that education functions as an integral part of prevention of violations against children as they mature.

Skills building targets both children and survivors of GBV to provide a supportive environment and independence. Skills building can as such reduce and eliminate needs for survival sex and other forms of rights' violations.

Livelihood projects are an important and integrated part as prevention through livelihoods projects which includes resilience against future shocks. For children and survivors of GBV access to livelihoods activities are part of social reintegration and survival.

CAVEAT: Service providers for psychosocial support should respect the following minimum requirement:

- Psychosocial and counselling support should be done by qualified professional staff
- Listen to the concerns of the CP and GBV survivors and receive survivors with compassion and accept the survivor's story without being judgemental;
- Inform survivor about other available services with benefits and consequences of taking and not taking the services;
- Refer the survivor as needed according to her /his wishes and consent;
- Follow-up to ensure needs are met and advocate on behalf of survivor for services;
- Accompany survivor when requested for other services;
- Document CP and GBV cases reported and take necessary measures to insure her/his information is kept completely confidential;
- Facilitate outreach activities for difficult to reach population and inform the communities about CP and GBV services and the importance of seeking immediate care

5.4. Protection and Security

5.4.1. Child Specific Services

Child specific response services in regards of protection and security is related to caring for children while durable solutions are sought. Such services should represent the best interest for children as described in the guiding principles. For protection and security children must be identified, documented, families/caretakers traced and then children and families/caretakers reunified, children must be offered interim care while tracing is on-going.

5.4.3. Safe Shelters, Interim Care and Networks

Survivors may choose to inform police, local leaders or neighbours who are able to improve their security and help them feel safe in their own homes. Training for police, local leaders and community members is therefore a priority to ensure they respond positively to the needs of survivors. Safety for survivors can be offered through safety networks and foster families that accept a survivor (adult and/or minor) to stay with them for a period of

time. Interim care is for unaccompanied or separated children, children formerly associated with armed conflict/groups or other children with specific needs. Interim and temporary care arrangements can include: family-based care; foster care; child-headed households; group care; supported independent living; and residential care.

5.5. Police procedures

Referrals should be made to police ONLY if the child/guardian or survivor has given her/his informed consent. A limited number of police in Somaliland have been specially trained to handle GBV cases and cases involving children.

Legal actors will assess the national justice system for child-friendly procedures. In the absence of established procedures, legal actors will introduce and support innovative practices, such as including social workers/case workers in sessions in which children are expected to deliver official statements to the police/courts, or advocate that hearings for children should take place in the judge's chambers, in the presence of social workers/case workers.

If a survivor chooses to report her/his case to the police, the procedures are:

- The police officer at the desk will show the survivor/child and guardian to a private interview room
- A specially trained police officer will take the survivor's statement and obtain information relevant to investigation of the alleged crime
- If there are female police officers available, they will conduct the interview
- Child/survivor does not need to present a medical form before investigation starts
- Police begin to conduct investigation immediately
- When warranted, police arrest alleged assailant, and file charges with the court

5.6.1. Prison and Juvenile Justice

Juvenile offenders must be protected from suffering abuse while they are in prison. This can be achieved by:

- promoting laws and procedures that ensure proper safeguards for juvenile offenders;
- fast-track hearings and monitoring the process;
- assisting with their psycho-social rehabilitation;
- in the absence of national structures, exploring alternative solutions with the camp committee or judiciary body or elders committee while ensuring that the rights of the child are not further violated;
- informing children accused of GBV-related offences of the legal proceedings and enabling them to express themselves. A child's testimony should be presumed credible until proven otherwise, and as long as his/her age and maturity allow him/her to provide intelligible testimony, with or without communication aids and other assistance.
- Ensure that children are not mixed with adults in prison/detention facilities.

5.7. Mine Awareness and Removal Services

Children are extremely vulnerable to unexploded ordinances (UXOs), Improvised Explosive Device (IEDs) and land mines, as such it is of outmost importance to keep children informed and aware of the dangers UXOs in their areas. When areas where UXOs and land mines are present, it is urgent that child friendly information is disseminated that reaches and is understood by children.

If anybody finds a suspicious object they must immediately contact the nearest police, solider or government official to advise them where the suspicious objects are located. The Somali police have specific staff trained for Explosive Ordinance Disposals (EODs). **DO NOT TOUCH OR REMOVE ANY DEVICE.**

Steps to follow if you suspect UXOs, land mines or IEDs:

1. Do not touch it
2. Mark the area
3. Advise people around
4. Call for the nearest police, soldiers, Mine Action Authority, or organisation that works for Mine Action

5.8. Legal Aid

Legal aid includes legal response to GBV and children in contact with the law, child abuse survivors. Legal actors will clearly and honestly inform the child and caretaker or survivor of the procedures, limitations, pros, and cons of all existing legal options. This includes:

- Child friendly and child sensitive legal support;
- Ensuring child sensitive procedures;
- Legal representation, legal advice to those survivors who cannot afford to pay legal fees, transport to attend the court proceedings (including all CP and GBV cases referred to the Clinic) on survivor's request/choice;
- Accompany, advocate for and support the survivor during meetings with the court officials;

- Provide the survivor with support for court filing fees and transport to and from the court house;
- Giving information about existing security measures that can prevent further harm by the alleged perpetrator;
- Ensuring orphans access land rights, inheritance rights and benefits;
- Giving information about procedures, timelines, and any inadequacies or problems in national or traditional justice solutions (i.e., justice mechanisms that do not meet international legal standards); and
- Informing about available support if formal legal proceedings or remedies through alternative justice systems are initiated.

5.9. Rehabilitation and Reintegration Services to children living/working on the street:

Children living/ working on the streets are among the most vulnerable children and are at risk of violence, abuse and exploitation. Child protection actors and service providers should take special consideration of such children's need and assist in their rehabilitation and reintegration to family/ community avoiding the institutionalization. Residential services should be used as last resort and in best interest of the child. The service providers should provide below as Full document information of Childs information

- Prepare individual case management plan
- Provide accommodation and basic services: education, recreational activities, life/ skill trainings, and regular health care
- Provide counselling and spiritual healing assistance;
- Facilitate family tracing and reunification
- Children's regular communication with their parents/families
- Organize parents/Families regular visits

5.10. Child Protection Case Management and Referral Pathway

Child protection case management details the different steps of the case management process, and key factors to consider at each step of the process. It is aimed primarily at social workers, case workers and their supervisors those who actually have the day-to-day contact with children and families. These SOPs should also be used/adhered by the managers, advisors and coordinators who are designing case management procedures and responsible for their implementation. Based on the needs of each individual child following steps should be followed in case management.

- Identification/Registration
- Assessment (initial & comprehensive levels of assessment)
- Case Planning
- Implementation of the Case Plan
- Follow Up and Review
- Case Closure

See ANNEX … for summary diagram of case management steps.

5.10.1. Referral Pathway

Community in General needs to be familiar with the referral pathway and know how to access services. This should be done through identified "entry points" and simple information about reporting and referrals in the local language of each setting. Messages using pictures will also be disseminated so all persons are aware of where to go for help and what to expect

All service providers must work together to ensure the referral pathway is strong and function. If the referral pathway fails, survivors and the community at large lose faith in GCP services and stop reporting.

Survivors are more likely to come forward to seek help and report a CP incident in a place that is safe, private, confidential and accessible. If there are quality services that survivors trust in the IDP/Refugee Settlement and host community; more survivors will come forward to report. **SEE ANNEX … for CASE MANAGEMENT REFERAL PATHWAYS SHEET.**

CHAPTER 6: INFORMING SERVICE PROVIDERS ABOUT THESE SOPs

Dissemination of SOP to Service Providers

The entire standard operating procedure is useful only if the community can access services and benefit from the agreed upon procedures and practices. This SOPs will only be disseminated in paper copy to those relevant organizations that provide services to survivors of gender based violence or child protection violations including

members of the Somaliland GBV Working Group, Child Protection Working Group, medical service providers, or other humanitarian services. In order to regulate the dissemination of the SOPs, the CPWG and GBVWG will hold the contact information of all those involved in the SOPs.

Additionally, it was agreed that all organizations involved in the referral pathway will provide all of their staff training on the implementation of the SOP to familiarize all field staff with the guiding principles and referral services available. Additionally, where possible, field staff will be a good source to use for disseminating information regarding these SOPs such as the Child Protection Advocates and Child Protection Committees. Finally, they should be involved in contextualizing the SOPs to the different areas.

CHAPTER 7: Roles and Responsibilities of Key Child Protection

As listed under the above service provider mapping each agency will take the responsibility to delivery all the CP services under their mandate and MOLSA should play critical role as leady agency for coordinating and certification of the service providers to ensure each agency to provide children in need CP services as planned.

7.1. Role of leading Agency (MOLSA)

On behalf of the National Taskforce ministry of labor and social affairs will take the lead the child protection case management system implementation in Somaliland collaboration with other government mandated institution.

- Disseminate child protection standard operating procedure through district and community based mechanisms and facilitate child protection service provider to apply to their day to day activities
- Ensure service providers time quality service delivery with consideration of the CP issues into high, medium and low risk cases based on the CP issues and agree on timing for response to each level of risk (referral and provision of service)High risk – within 24 hours to 48 hours Medium risk – 48 hours to 72 hours Low risk – within a week
- Identify and map out services available in each location that can respond to each of the levels of risks/issues identified and ranked (formal and informal)
- Clarify who benefits from such services, how they benefit and access the service, when and where they can access the service and who (at least two people per service provider agency) to contact in order to access the service
- Agree at each location how cases can be referred between agencies or institutions including feedback and follow up processes (coordination)
- Agree on standard forms for referral, follow up and record keeping or documentation of cases and the processes and update on cases.

7.2. Role of child protection Service providers

- Provide timely (it depends level of risk) quality CP services for the children with protection concerns.
- Refer to the other Service providers in case child need further assistance or specialized service
- Prepare proper case plan for each case for better service delivery and follow up
- Report to the trained social workers with consideration of the confidentiality principle
- Recruit adequate number of staff and train them
- Institutional commitment and allocation of resources to effectively respond to the CP cases
- Document progress and share with the social workers
- Keep records in a confidential manner and in adherence with Data Protection Protocol

7.3. Role of the child protection community committees

- Provide community awareness/education on exist child protection services
- Identify protection concerns and report to CP services that are closest to child's location for appropriate service
- Facilitates and supports child in accessing to the available CP services
- Refer children with protection concerns for specialized services
- Facilitate child protection social workers accessibility to the survivor and their family or guardian
- Conduct follow-up for progress of the of the survivor(s) and report to the service provider or social workers in case of need further assistance
- Activate and Strengthen the key role of the CPC in the referral and follow up of cases

7.4. Role of the child protection social workers, monitors, advocates

Referral will be done based on the referral pathway developed for each region followed by the following procedure:

- Visit child within one day to assess the child's situation and take action
- Ensure the child is supported to provide informed consent for assessment, developing a case plan if needed, and accessing the services
- Ensure the child is referred to service providers using the referral form
- One SW will act as the focal person in each district to facilitate coordination meetings between SW and service providers in case management on a weekly basis
- Assure confidentiality in response mechanism
- Agree on a monitoring and follow up plan with child and family as part of the case plan
- Assess with child and family any other protection issues as a result of the response action that may occur and develop a plan to deal with it (e.g., stigma, abandonment, threats from perpetrator etc.)
- Inform service providers for required services prior to the child is referred
- Fill the referral form for support based on agreed procedure and timing in the referral protocol
- Follow up on the service provided and family to assess child's progress
- Close the case if the child and family feel confident with the progress and if the child's situation is changed. Use the case closure form.

CHAPTER 8: DOCUMENTATION, DATA, AND MONITORING

Child protection monitoring reporting tools, case intake forms, IDTR forms and formats should be applied for effective monitoring, data management, reporting and information sharing on child protection cases. Child Protection Information Sharing Protocol (Annex..), CP and GBV Data Protection Protocol (Annex …) and Case Management/ Referral Pathways Sheet (Annex..) are integral part of this SOPs, hence all child protection and GBV service providers and actors should follow and adhere to those documents for recording, managing data, and information sharing.

***8.1. DATA BASE**:* CPIMS and GBVIMS are the primary Data management systems supported by specific intake, registration, and case management forms. All actors should use and adhere to those forms.

For monthly reporting CPWG can develop a separate monthly reporting tool which will feed information to CPIMS and GBVIMS.

For sharing information all actors must follow the Information Sharing Protocol signed by all agencies involved. Ministry of Labour and Social Affairs as Chair of CPWG/ Somaliland will ensure that all actors adhere with the Data Protection Protocol and Information Sharing Protocol (Annexed with this SOPs).

8.2. INFORMATION MANAGEMENT (documentation, record keeping, data protection and sharing):
A safe and confidential system for data collecting, storing and sharing information is imperative. Ministry of Labour and Social Affairs and all organizations working for child protection and GBV shall ensure that all the staff of concern area trained, understand and comply with Information Sharing Protocols and Data Protection Protocols including processes for appropriate documentation, record keeping, database access and use, and sharing of information with others.
All actors shall use the agreed standard tools for data collection, documentation, record keeping, reporting, and referral and follow up services.

CAVEAT: Case notes should be based on fact and professional judgment rather than on personal bias. Language that is dismissive, judgmental, or offensive should be avoided. The information collected about the children belongs to the children themselves and should not be shared/ published without informed consent of the child.

8.1. Children
8.1.1 IDTR Forms
The attached documents include the Rapid Registration and Assessment Form for registration along with the Tracing and Reunification Form for separated and unaccompanied children. Both of these registration forms should be used to document S/UAM (annexed). UNICEF is available to train actors on the IDTR system and database. For Somaliland, INTERSOS and UNICEF are keeping the IDTR database.

8.1.2 MRM

UNICEF is responsible for monitoring of grave child rights violations, and compiles quarterly reports to the UN Security Council. Contact UNICEF for MRM information.

8.2. GBV

8.2.1 Standard Intake Form

The attached intake form is a template for use by all actors, particularly those participating in the GBV Information Management System (GBVIMS). This form can be adapted for use by each organization as long as the items marked with a * remain to ensure each organization is collecting the same information which can then be compiled and compared.

Actors should ensure members of their organization who collect information from the survivor are appropriately trained on how to fill out the form and how to act in accordance with the guiding principles. They should carry out their responsibilities with compassion, in confidentiality, and with respect for the survivor. UNICEF, UNFPA, and some members of CPWG and GBVWG are available to train actors on use of the standard intake form, incident definitions, plus basic case management and counselling skills.

Molsa Compiles monthly incident reports for [Somaliland] and quarterly narrative trend analysis. Monthly incident reports are only available for data gathering organisations as per specific Information Sharing Protocols, while the quarterly narrative trend analysis is available externally.

CHAPTER 9: CO-ORDINATION

Ministry of Labor and Social affairs with collaboration of the other mandated governmental institutions and key civil society organization (CSO's) established child protection coordination with the objective to strengthen and harmonize child protection intervention activities by the child protection actors in Somaliland at all levels.

9.1. National child protection coordination mechanism

A national child protection coordination working group (CPWG) is established under the leadership of MOLSA. The CPWG is operational since 2011 in Somaliland. MOLSA in close cooperation and collaboration with the Inter-Ministerial Child Protection Task Force will coordinate, administer and monitor the implementation of the this SOPs, child protection priority response and service deliver at national, regional, district and community level. The CPWG coordinated effort will also link with and contribute to child protection systems building approach at all levels.

The National Inter-Ministerial Child Rights Task Force consists of representatives from: Ministry of Labour and Social Affairs (MOLSA), Ministry of Justice (MOJ), Ministry of Religion (MOR), Ministry of MRR&R, Interior (MoI), Ministry of Planning and Development (MoPD), Ministry of Religion (MoR), Ministry of Health (MoH), Ministry of Education (MoE), Public Attorney's Office, National Human Rights Commission, UNICEF, Save the children International (SCI) and Somaliland Child Right Forum (SOCRIF). The Task Force is Chaired by the Director General of the Ministry of Labour and Social Affairs (MoLSA) and co-chaired by the Director General of the Ministry of Justice (MoJ).

9.2. Regional child protection coordination:

Regional Child protection will be coordinated by Regional CPWG led by MOLSA regional representative and a network of child protection actors representative of other government agencies. Regional CPWG will facilitate cooperation/collaboration among the child protection actors to address the diverse needs of the children in their respective regions.

9.3. District child protection networks:

The District Child Protection Networks will facilitate coordination and cooperation among the child protection actors and strengthen district child protection systems and structures to prevent and respond to violations, abuses and neglect and exploitations against children in their districts.

9.4. Child protection community committees (CPC):

Community-based child protection committee will play a key role in monitoring, identifying, mitigating risks, providing response, referral for specialized services to child protection violations and building a protective environment at the community levels.

9.5. Somaliland Coordination structure:

The Somaliland Protection Cluster will meet to coordinate activities of actors and to discuss and analyse information about Child Protection and GBV incidents being reported, general outcomes, security issues, referral and coordination issues, and other factors. This information will guide the continuous development of response interventions.

9.5.1 SOMALILAND Protection Cluster

UN Lead: UNHCR
NGO Lead: DRC

9.5.2 SOMALILAND GBV WG

Government Lead: MOLSA Representative
UN Lead: UNFPA

9.5.3 SOMALILAND CP WG

Government Lead: MOLSA
UN Lead: UNICEF

Regional CPWG
Government Lead: MOLSA Representative
Community Based Network:
MOLSA CP officer or Social Worker
CPC Network

9.5.4 Nairobi based Coordination Mechanisms

GBV WG

UN Lead: UNFPA
NGO Lead: SWDC

Child Protection WG:

UN Lead: UNICEF
NGO Lead: CISP

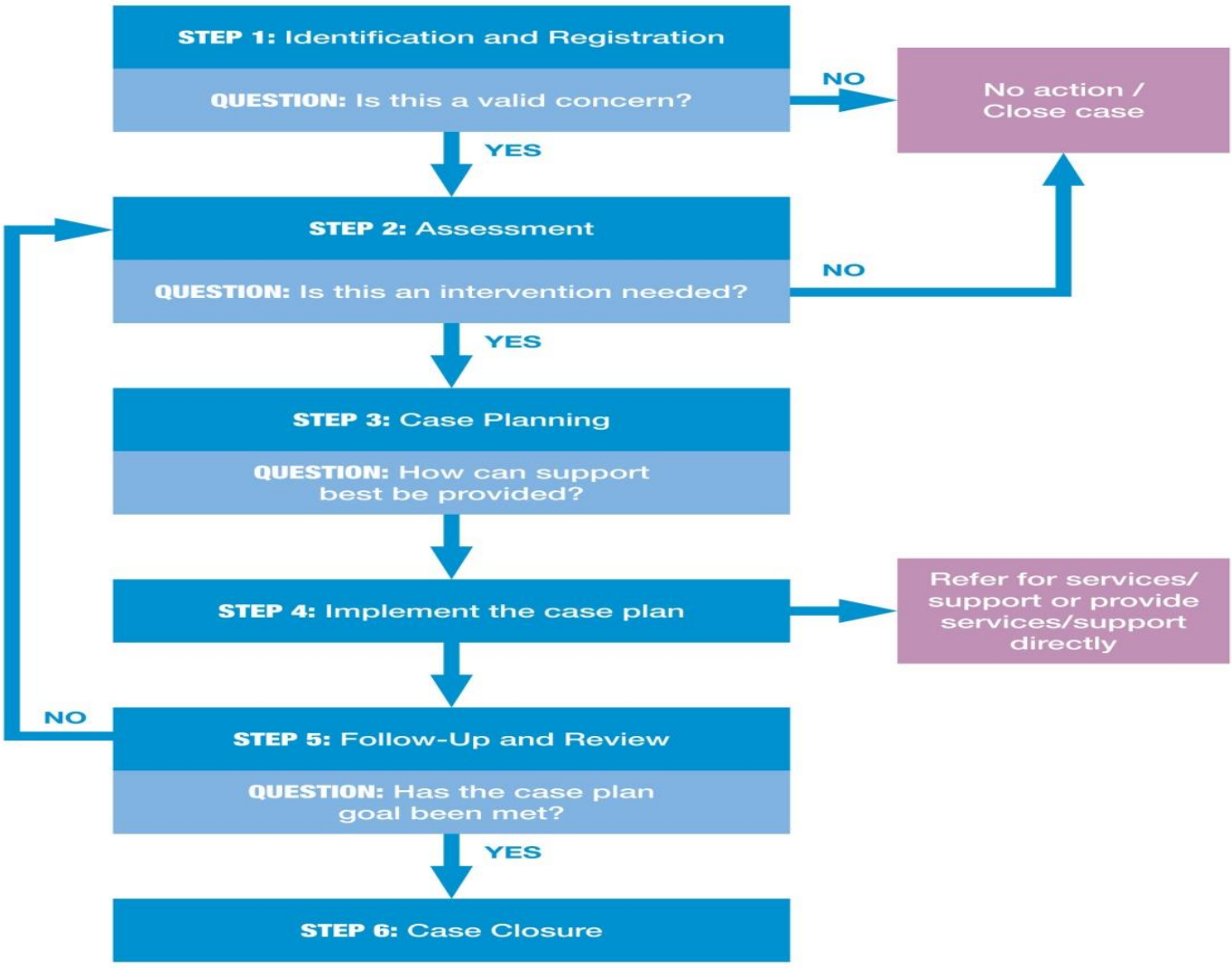
ANNEX: 1

SIGNATORY PAGE FOR PARTICIPATING ACTORS

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

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

ANNEX II: STEPS of CASE MANAGEMENT



ANNEX 3: REFERAL PATHWAYS SHEET

GENDER-BASED VIOLENCE& CHILD PROTECTION
STANDARD OPERATING PROCEDURES – Somaliland
Service Mapping SHEET

GUIDING PRINCIPLES AND RIGHTS OF CHILDREN AND SURVIVORS OF VIOLENCE

Everyone has the right to competent, compassionate and confidential treatment. Best interest of the child is overarching. Children and survivors of violence have the right to health care, right to information, right to self-determination (adults) and participation in decision making (children), right to non-discrimination, right to privacy and right to confidentiality. Always consider safety and security risks. Do no harm. Children/caregivers and survivors have to provide informed consent. Children's survival and development should always be considered.

HEALTH, NUTRITION and CLINICAL MANAGEMENT OF RAPE

PEP – within **72 hours** of exposure, HIV test NOT necessary, PEP is safe for pregnant women and children – check dose
Emergency Contraceptives – within **120 hours/5 days** after assault (reduce chance by 80-90%), pregnancy test not necessary – emergency contraceptives do not affect already existing pregnancy
STIs – preferably within **72 hours** (some antibiotics may be effective up to 2 weeks after)
Hepatitis B – within 14 days of exposure
Nutrition – provision of nutritional support and supplementary feeding for children
Basic Support Services for Child Protection and GBV Survivors – provision of nutritional support to accompany drug regimen
General health for children – vaccinations, HIV
Children with disabilities – born with disabilities, conflict-related disabilities, child-mine survivors

HEALTH CARE SERVICE PROVIDERS

PSYCHO-SOCIAL SUPPORT AND COUNSELLING

Psycho-social services for children and survivors of GBV include the following inter-related types of activities:

- Child friendly spaces;
- Emotional support;
- Trauma Counseling services for children associated with armed conflict;
- Reintegration services;
- Education, formal and non-formal; and
- Livelihood and/or skills building activities;

PROTECTION, SECURITY and LEGAL AID

Referrals to the police should ONLY be done if the child or survivor has given her/his informed consent. A number of police in Somaliland have been specially trained to handle GBV cases and cases involving children (see contact details below).

Protection, Security and Legal Aid services include:

- Identification, Documentation, Tracing and Reunification (IDTR);
- Safe shelters/safe houses;
- Interim Care;
- Shelter assistance for children and child-headed households;
- Security actors (police);
- Prison, detention and juvenile justice actors;
- Mine removal services and mine risk education; and
- Legal Aid

For further information contact:

Contact details for GBV Working Group:	**Contact details for Child Protection Working Group:**
Government: Abdishakuur Ahmed Adan <shako102@yahoo.com> UN: UNFPA Ahmed Jama , ajama@unfpa.org	Government : Ashahamda Mohamed Ali , hamdahoney@gmail.com UN: Unicef , Esse Ahmed ,ianur@unicef.org

ANNEX: 4 REFERRAL FORM

Referral Form

1 ORGANISATION FILE NUMBER

2 LOCATION (OFFICE & CENTRE)

3 DATE OF REFERRAL

4 SUMMARY OF CASE

5 REFFERAL TO WHICH PERSON, INSITUTION OR ORGANISATION?

***6* PLANNED FOLLOW-UP**

7 STAFF INTERVIEWER

CONTACT NUMBER OF INTERVIEWER

SIGN: _____

Consent given by survivor before making a referral? ☐ YES ☐ NO

ANNEX 5: Rapid Registration & Assessment Form for Separated & Unaccompanied Children

A: Child's Personal Details

Child's Full Name:			
Nickname:		Country of Origin:	
Age:		Region of Origin:	
Date of Birth:		District of Origin:	
Gender:		Settlement/Town:	
Reg. Number/ID		Date of Arrival:	

Father's Name _____Tel_____

Mother's Name _____ Tel_____

Address of Parents(if different from from the address of origin)

Country	Region/Province	District	Town/Settlement

Category of the Child

□ Separated □ Unaccompanied □ Other Vulnerable

Is the child in school? □ Yes □ No

If yes, specify Type of Education.

Primary □ Secondary □ Tertiary □ Vocational Training □

Other(Specify)_____

Level of Training. _____

B: Circumstances of Child's Separation from Parents(only for separated & unaccompanied)

Date of Separation(mm/dd/yyyy(approximate if full date is not available

Reasons of separation from parents

Armed Conflict □ To access services elsewhere □

Drought □ Poverty □

Death of Parents □ Other(Specify)_____

Place of Separation (Last Address)

Country	Region/Province	District	Town/Settlement

Is the child in contact with the parents/relatives?

Yes □ No □

Was the separation voluntary

Yes □ No □

If separation was involuntary, would the child like their relatives to be traced?

Yes □ No □

Child's next destination? _____ _____

C: Current Care Arrangements

Type of Care Arrangement

Headed Household	□	Living alone	□
Interim Care Center	□	Foster Family	□
Other Relatives/Adults	□	Other(Specify)_____	
Living on the Street	□		

Name of Care Giver _____ Tel. No. _____

Relationship with Caregiver _____

Address of Caregiver/Institution

Country	Region/Province	District	Town/Settlement

D:Protection Concerns

Does the child have specific Protection concerns? If yes select from the list below

Medical Problems	□	Psychosocial Distress	□
Wounded	□	Orphan	□
Pregnancy	□	Other(Specify)_____	
Action taken?	Yes □	No □	

Describe action taken _____

Is further follow-up required? Yes □ No □

If yes, describe _____

Has the child been referred to any service? Yes □ Yes □

If yes then, then select type of service GBV Support □ PSS □

Medical Support □

E: Place of Registration:

Country	Region/Province	District	Town/Settlement

Name of interviewer _____

Date of Interview _____

Agency _____

Any comments_____

_____

_____

ANNEX 6: TRACING ACTION AND REUNIFICATION FORM

SECTION 1 - CHILD'S PERSONAL DETAILS

Registration I/D Number	

	First Name	Middle Name	Last Name
Child's Name			

Type of Tracing Action

Mass Tracing List	☐	**Individual Tracing**	☐
Referral to ICRC	☐	**Referral to another NGO**	☐
Photo Tracing	☐	**Radio Tracing**	☐
Red Cross Messages	☐	**Other(Specify)**_____	

Date of Tracing _____

Location of Tracing	Country	Region/Province	District
	Settlement/Town (if not known enter landmarks e.g. hills, trees, names of schools or hospital etc.)		

Outcome of Tracing Action	**Successful**	☐
	Unsuccessful	☐
	Pending	☐

SECTION 2 - IDENTITY OF THE ADULT WITH WHOM THE CHILD WAS REUNIFIED

Date of Reunification _____

Adult's Name	First Name	Middle Name	Last Name
Address of adult with whom the child was reunified	Country	Region/Province	District
	Settlement/Town (if not known enter landmarks e.g. hills, trees, names of schools or hospital etc.)		

Telephone number

Relationship of adult to child

(Father, Mother, Sister, Brother, Uncle, Aunt, Grandmother, Grandfather, other)

SECTION 3 - FORM COMPLETED BY

Name/Sign.		**Position**	
Agency		**Place**	**Date**

Location of Reunification	Country	Region/Province	District
	Settlement/Town(if not known enter landmarks e.g. hills, trees, names of schools or hospital etc.)		

ANNEX 7: SAMPLE CODE OF CONDUCT[2]

To: All staff

From: President or Director of Humanitarian NGO

Re: Code of Conduct for all Staff

In accordance with the mission and practice of [YOUR ORGANIZATION] and principles of international law and codes of conduct, all [YOUR ORGANIZATION] humanitarian staff, including both international and national, regular full- and part-time staff, interns, contractors, and volunteers, are responsible for promoting respect for fundamental human rights, social justice, human dignity, and respect for the equal rights of men, women, and children. While respecting the dignity and worth of every individual, the [YOUR ORGANIZATION] humanitarian worker will treat all persons equally without distinction whatsoever of race, gender, religion, colour, national or ethnic origin, language, marital status, sexual orientation, age, socio-economic status, disability, political conviction, or any other distinguishing feature.

[YOUR ORGANIZATION] humanitarian workers recognize that certain international standards of behaviour must be upheld and that they take precedence over local and national cultural practices. While respecting and adhering to these broader frameworks of behaviour, [YOUR ORGANIZATION] specifically requires that [YOUR ORGANIZATION] humanitarian workers adhere to the following Code of Conduct.

Commitment to [YOUR ORGANIZATION] Code of Conduct

A [YOUR ORGANIZATION] humanitarian worker will always treat all persons with respect and courtesy in accordance with applicable international and national conventions and standards of behaviour.

A [YOUR ORGANIZATION] humanitarian worker will never commit any act that could result in physical, sexual, or psychological harm to the beneficiaries we serve.

A [YOUR ORGANIZATION] humanitarian worker will not condone or participate in corrupt activities or illegal activities.

[YOUR ORGANIZATION] and [YOUR ORGANIZATION] humanitarian workers recognize the inherent unequal power dynamic and the resulting potential for exploitation inherent in humanitarian aid work, and that such exploitation undermines the credibility of humanitarian work and severely damages victims of these exploitative acts and their families and communities. For this reason, [YOUR ORGANIZATION] humanitarian workers are prohibited from engaging in sexual relationships with beneficiaries.[*] Sexual activity with children (persons under the age of 18) is strictly prohibited.

A [YOUR ORGANIZATION] humanitarian worker must never abuse his or her power or position in the delivery of humanitarian assistance, neither through withholding assistance nor by giving preferential treatment including requests/demands for sexual favours or acts.

It is expected of all [YOUR ORGANIZATION] humanitarian workers to uphold the highest ethical standard of integrity, accountability and transparency in the delivery of goods and services while executing the responsibilities of their position.

A [YOUR ORGANIZATION] humanitarian worker has the responsibility to report any known or suspected cases of alleged misconduct against beneficiaries to senior management (as outlined in the reporting pathway) immediately. Strict confidentiality must be maintained to protect all individuals involved.

[•] NOTE: Different considerations will arise regarding the enforcement of some of these principals for humanitarian workers hired from the beneficiary community. While sexual exploitation and abuse and the misuse of humanitarian assistance will always be prohibited, discretion may be used in the application of the principles regarding sexual relationship for this category of humanitarian worker.

I, the undersigned, hereby declare that I have read and understand this Code of Conduct. I commit myself to exercise my duties as an employee of the Gender-based Violence Program in accordance with the Code of Conduct. I understand that if I do not conform to the Code of Conduct, I may face disciplinary sanctions.

Name: _____
Function: _____
Signature: _____

[2] Gender-based Violence Tools Manual: For Assessment & Program Design, Monitoring & Evaluation in conflict-affected settings (RHRC Consortium 2003) pgs 137 & 138

Date: ____

Manager's Name: ____
Signature: ____
Date: ____

ANNEX 8: **CHILD PROTECTION INFORMATION SHARING PROTOCOL**

Child Protection Information Sharing Protocols

Date of first Draft: 6th May 2015
Date of Finalization: 22 June 2015

Date of First Review:
Date of second Review:

1. Introduction:

The Child Protection Information Sharing Protocols (**here in after "The Protocols**") are developed to facilitate sharing information related to child protection issues, needs, trends, safety, and for mobilising child protection response and services for boys and girls at risk or affected by violation, including sexual violence, abuse and exploitation in Somalia. Child protection violation is a life threatening protection, health, and human rights issue that can have devastating impact on children (both and girls) as well as families/ care providers and communities.

The Protocols have been developed to facilitate action by all child protection actors to respond to Child Protection concerns in Somalia. The Protocols are developed by the CPWG represented by member organisations and describes clear guidance, procedures, roles, and responsibilities for all actors, furthermore all organisations signatory to the Protocols agree to the same procedures, guiding principles and working together for the best interest of boys and girls with regards to sharing information.

It is important to remember that information on children belongs to the children. Those who keep the information do so on their behalf and should use it only in their best interest, and with their informed consent.

The Protocols are based on the principle of confidentiality which is a central component of the principles of best interest and participation for children[3], follows the child protection minimum standards, and the **Joint Standard Operating Procedure for Child Protection and Gender based Violence, Somalia**.

2. This information sharing protocol has been developed to ensure:

- The highest possible standards for safety of the children and parents/ caregivers (**here referred to as 'clients'**) are followed by all actors/organisations working on prevention and response to child protection issues in Somalia.
- Best practices for sharing of information with other actors who work with children either on a regular or an ad hoc basis in child protection situations of concern are followed in Somalia.
- The Child protection Minimum Standards for information sharing is followed: up-to-date information necessary for effective child protection programming is collected, used, stored and shared with full respect for confidentiality, and in accordance with the "do no harm" principle and the best interest of children.

3. General principles:

3.1. Confidentiality:

The Protocols are based on the principle of confidentiality. Confidentiality means ensuring that information disclosed in confidence to child protection actor (staff, organization, social worker, case worker, law enforcement and justice for children actors) by a child is not used without his or her consent or against his or her wishes and is not shared with others without his or her permission, except in exceptional circumstances.

Keeping data confidential is in the best interest of the child and promotes children's safety and security because it prevents the misuse of information about them for purposes beyond their control, including their exploitation,

[3] These principles are outlined in the United Nations Convention on the Rights of the Child, and the Organization of African Unity African Charter on the Rights and Welfare of the Child.

stigmatisation and abuse, either intentionally or unintentionally. It also helps to ensure that their views and opinions are heard and respected at all times.

Information can be stored or transmitted verbally, on paper or electronically. Every effort should be made to ensure that confidentiality is maintained for all concerned in a case. In terms of child protection this means that the identifying and sensitive information and data are protected under the principle of confidentiality. The identifying information includes: name and other identifying details of a child survivor; his or her family/close contacts; key actors handling the case; and if relevant the complainant; witnesses; accused and/or perpetrator; and any other information that can compromise the safety of the child and his or her family and care givers. It ensures that information is accessible only to those authorised to have access to it for example the Project manager, Information manager, case manager or whoever is a designated person to manage such information in the organization).

3.2. Informed Consent

3.2.1. The **client** can choose the level of detail in which they are willing for their personal information to be shared with other service providers in case of referral. They can also specify the particular agencies they are willing for this to be shared with.

3.2.2. Informed consent should be sought with clients whenever possible. Social workers/child protection actors are obliged to explain the options of disclosing personal information to the **client** at the point of interview and documentation what they consent to in the Intake Form.

3.2.3. All information sharing between agencies on individual clients can only occur when the **client** has given informed consent.

3.3. Best Interests

3.3.1. When a child's safety or well-being is in severe danger, social workers/child protection actors have a responsibility to refer or pass information on to others. If the child does not give permission to share information;
CP actors will have to consider the child's ability to understand the consequences of that decision.

3.3.2. In exceptional circumstances, if the CP actors determine that sharing the information is in the best interests of the child, after a careful evaluation, then the information can be shared against the wishes of the child and/or the parent/caregiver. This **exception of overriding the confidentiality principle** with the child's best interests should be explained to the **clients** explicitly before actions are taken. For example, if the child insist on not sharing the information, but the evaluation indicates that holding the information is not in the best interest of the child, then it should be well explained to the child before the decision is taken to share such information.

3.3.3. Information should be shared when the child or another person is at risk of being harmed, each case should be considered individually, and decisions to disclose information should be taken at the highest level of the agency or agencies involved.

4. Protocol for General data protection (*refer to CP and GBV SOPs****)***

4.1. It is important to have a clear understanding of the context CP actors are working in. Before starting to use the database, an assessment should be carried out that reviews all applicable domestic data protection laws and the possible implications they might have for staff and the organizations involved. This process should also take into consideration the level of sensitivity of the data that will be collected related to security risks specific to the context. In cases where data will need to be shared or transferred across borders, agencies should consider potential constraints to protecting data and managing the consequences (e.g. security officials at borders who may request to access data).

4.2. All staff involved in the work should be aware of the data protection protocols and the security implications of sensitive data.

4.3. All agencies holding information on children should have a written data protection policy, based on the principle of confidentiality, which should ideally be framed within the agencies' broader child protection policy. An obligation to uphold this policy should be written in to staff contracts.

4.4. All children on whom information is gathered should be allocated a code based upon an agreed upon standard coding format. This format may indicate areas of identification or areas of origin but should

guarantee anonymity of the child. The code should be used to refer to the child's case either verbally, on paper or electronically in place of any identifiable information such as name or date of birth. All files should be stored according to the allocated code.

4.5. Children have the right to access and review information held about them. Agencies holding information should therefore make provisions for them to be able to access their information as and when they need to do so.

4.6. Staff working directly with children must receive regular debriefs for their own well-being. During debriefs, information disclosed by staff about children should be discussed anonymously. If there is a need to break such anonymity, this should be done with the person designated to receive the information and in conformity with the best interest of those concerned.

4.7. It is important for managers to make sure that the data protection protocols are being followed and that they are updated when needed (e.g. if changes in the context occur).

5. Ground Rules for Information Sharing:

5.1. Identifying information of a child should only be shared with relevant service providers and/or government ministries if:

- The client has agreed to information being shared with the particular service providers and;
- The identifying information is shared with the responsible persons within their agency on "who needs to know" basis and in order to provide the services;
- Electronic documents with identifying information must be password protected before sending to partners or other agencies;
- Paper files with identifying information must be transferred by hand between people responsible for the information and the files should be stored in a sealed envelope;
- Information shared verbally should be transmitted in a confidential place.
- Sharing of information should be strictly on a need to know basis and done only if it is in the best interests of the child, or aggregated data depending on its intended use.

5.2. Identifying information for a child should NOT be shared in the following situations:

- Case conferences allow other social workers to get support on how a case should be handled or how an intervention can be improved but identifying information does not need to be shared for this purpose;
- During Child Protection Working Group Meetings, or needed updates to be provided to the GBVWG on issues of GBV against children, information disclosed by staff about children should be discussed anonymously;
- When discussing cases in public places or vehicles where you can be overheard by others who are not part of the project team;
- During initial contacts made with other agencies for referral, identifying information should not be shared with the agencies before they confirm services or assistance can be provided to the individual child.

5.3. Sharing of non-identifying information:

- Non- identifying information about children, child protection violations, issues, trends, etc., can be shared with the government and other agencies. It is acceptable to share non-identifying information with other actors which does not pose security and safety risks to individual clients and for the purpose of statistical analysis and mapping out of child protection trends, needs, and services also.

- Parents and care providers should be encouraged to share information on **a need to know basis** with other agencies and individuals who may be able to support them and help them to meet their children's needs and protection.
- If an organisation is sharing information about a family with other agencies, this should only be done with the knowledge and consent of the child, family and care providers unless that is against the best interest of the child.
- If an organisation becomes concerned that a child may be at risk of significant harm, then the organisation has a duty to refer their concerns to the appropriate authorities or to the organization that

is in the position to ensure safety of the child with parents/ care givers' knowledge and consent unless that is not against the best interest of the child.

5.4. Sharing of information should be strictly on a need to-know basis and done only if it is in the best interests of the child and add value to the support he or she needs.

5.5. After gathering information, it should be passed only to a person designated to receive it, for clearly defined purposes, such as a line manager or partner agency.

5.6. Information sharing lines must be clearly mapped out and understood by all staff of the organization. Passing information between different agencies also requires that all agencies concerned comply with the Standard Data Protection Protocols under the **CP and GBV SOPS, Somalia**.

6. Access to information

6.1. Access to information on children should be limited only to those **who need to know it and who the children agree to know**. Those gathering information should explain to the child exactly why they are gathering it, how it will be used and by whom. Their informed consent is central to gathering and sharing information, and should be given, where possible, in written form.

6.2. Children should be given the opportunity to highlight any information that they do not want any particular person to know. For example, they may not want their family to be told personal details about them that they would rather communicate face-to-face.

6.3. After gathering, information should be passed only to a person designated to receive it for clearly defined reasons, such as a line manager or partner agency Child Protection staff who will be taking action. Information sharing lines must be clearly mapped out and understood by all staff. Passing information between different agencies requires that all agencies concerned comply with the standard data protection protocols. ***(For details on Data Protection Protocol see CP & GBV SOP for Somalia***)

6.4. Children have the right to access and review information held about them. Agencies holding information should therefore make provisions for them to be able to access their information as and when they need to do so.

6.5. Staff working directly with children must receive regular debriefs for their own well- being. During debriefs, information disclosed by staff about children should be discussed anonymously. If there is a need to break such anonymity, this should be done with the person designated to receive the information and in conformity with the best interest of those concerned.

6.6. In exceptional circumstances, information disclosed by children can be shared against their wishes if it is considered – after careful evaluation - in their best interest to do so, but the reasons for doing so must be clearly explained to them. If information disclosed by a child indicates a crime, or withholding it risks harm to themselves or others, then there is a legal obligation to disclose this information, with or without their informed consent.

6.7. Names of children should only be shared to designated officials when it is ***absolutely*** necessary. Instead statistics (graphs, tables and pie charts) can be shared between agencies, partners and government.

7. Adaptation, Review and *Breaches*

7.1. After finalization this Information Sharing Protocol shall be used by all child protection actors in Somalia. **Regional CPWGs can use this Protocol as it is if deemed suitable or can customize and adapt it as per the regional needs. Customization and adaptation must be in compliance with this Protocol, any contradicting provision will be considered as breach of this protocol.**

7.2. In cases of breach by any of those participating in this Information Sharing Protocol, information sharing will cease until resolved, responsible parties will be held accountable.

7.3. The review of the Information Sharing Protocol will be done every year or in the request of one quarter of CPWG members based on the needs and change in the situation.

8. Signing

The undersigned is the representative of the organisations working for child protection in Somalia bounded and committed to this Information Sharing Protocol. By signing this, the organisation agrees to uphold the guidelines and protocols detailed in this document.

I ……..(name printed in capital letters) the undersigned, do agree to adhere to the above protocol and procedures in order to ensure that data and information is kept confidential and shared accordingly that children and their families are kept safe.

Signature……

Name and Designation……

Name of the Organisation ……..

Date (day/month/year) ……

Signature……

Name and Designation……

Name of the Organisation ……..

Date (day/month/year) ……

ANNEX 9: CP AND GVB DATA PROTECTION PROTOCOL

ANNEX 10: CASE MANAGEMETN REFERRAL PATHWAYS VISUAL

GUIDELINES

- Always observe the guiding principles of **CONFIDENTIALITY**, **SAFETY**, **RESPECT**, **DIGNITY AND BEST INTEREST OF THE CHILD**
- No decision is made without the **INFORMED CONSENT** of the survivor, and **PARTICIPATION** by children
- Conduct discussions in **private** settings with same-sex staff
- Be a good listener, and non-judgmental
- Be patient; do not press for information the survivor does not want to share
- Ask only relevant questions; avoid the survivor having to repeat her story multiple times
- Do not laugh, show disrespect or disbelief; **NEVER** blame the survivor
- At all times, prioritize the **safety and security** of the survivor as well as involved staff, volunteers and service providers

IMPORTANT – CASE MANAGEMENT!

- Case identification: identify through either direct disclosure or through community members
- Client and Family Assessment: determining a child and family's needs, current and potential strengths and weaknesses
- Case Planning: develop a specific, comprehensive, individualized and/or family-based treatment and service plan
- Implementation of the Plan: provide direct services to meet the client's needs or refer to services
- Monitor and follow up the Case: conduct ongoing evaluations of the client's progress and ongoing needs
- Client Advocacy: promote the best interest to ensure fair treatment and services

Case Management Referral Pathway Guide

Developed by the CP and GBV WG

ATTENTION!

Interviewing children under the age of 18, and/or documentation of cases involving children under the age of 18, should be done in the presence of a trusted adult or caretaker, as chosen by the child.

Possible Results of Seeking Support (SURVIVOR INFORMATION)

BENEFITS

- Treatment of injuries
- Access to medical care within three days (72 hours) for post-exposure prophylaxis, and within five days for emergency contraception and STI prevention
- Access to emotional and psychosocial support
- May be able to conduct forensic report and file case with police/court if survivor chooses

CONSEQUENCES

- Compromised confidentiality and safety
- Possible inappropriate treatment by service providers
- Incident reported to others (community leaders, etc.)

IF THE SURVIVOR HAS GIVEN CONSENT, THE IMMEDIATE RESPONSE SHOULD BE:

SEXUAL VIOLENCE

Ensure immediate (within 3 days, or 72 hours) access to medical care

PHYSICAL VIOLENCE

It is advisable to seek medical care

PRIORITIZE HEALTH CARE!

1

FREE HEALTH CARE

(within 3 days for HIV prevention; within 5 days for emergency contraceptives and treatment of injuries)

2

FREE PSYCHOSOCIAL CARE

(follow the case management model above, and follow up the client)

PRIORITIZE SAFETY & SECURITY OF THE SURVIVOR!

IF THERE IS AN IMMEDIATE RISK OF SAFETY OF THE SURVIVOR:

- Safe spaces (formal or informal) for women and girls
- Alternate place to live or temporary shelter
- Relocation to other district
- Interim care of children

ANNEX 11: MEDICAL CHECKLIST FOR INCIDENTS OF SEXUAL VIOLENCE

MEDICAL CHECKLIST FOR INCIDENTS OF SEXUAL VIOLENCE

Interviewing children **under the age of 18**, and/or documentation of cases involving children **under age of 18** should be done in the presence of an adult or guardian, as chosen by the child

Always keep the best interest of the child in mind, and provide everyone with quality services!

KEY GUIDELINES

BENEFITS

- Prevention of HIV infection
- Prevention of pregnancy as a result of rape
- Treatment of sexually transmitted infections
- Treatment of injuries
- Access to emotional and psychosocial support
- Able to conduct forensic report and file case with police/court
- Self-esteem

CONSEQUENCES

- Compromised confidentiality and safety
- Possible inappropriate treatment by service providers
- Incident reported to others: the police, community leaders, etc.
- Discrimination, social stigma,
- Community may isolate the survivor,

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PRIORITIES FOR HEALTH CARE:

 # 1

POST-EXPOSURE PROPHYLAXIS:

- Give to patient **within 72 hours/3 days after exposure to blood or semen**
- **Prevents HIV infection**
- 28 days course of zidovudine and lamivudine, **give 1st dose immediately**
- Do NOT insist on HIV test before giving drug
- Does NOT treat HIV if a patient already infected

 # 2

EMERGENCY CONTRACEPTIVES:

- Give to women and girls **within 5 days after vaginal intercourse**
- **Prevents pregnancy**
- Is NOT an abortion method
- Does NOT affect an already existing pregnancy if the women/girl was pregnant before the rape

 # 3

SEXUALLY TRANSMITTED INFECTIONS:

- Give antibiotics to patients after intercourse to **treat all sexually transmitted infections**
- Give to patient within 2 weeks after intercourse
- Treats chlamydia, gonorrhea, syphilis
- No treatment available for warts

ANNEX 12

HELP-SEEKING AND REFERRAL PATHWAY FOR Somaliland

Use the full SOP and fill in specific details for the setting, one pathway for each IDP settlement, each district of the cities. Copy up enough copies and hand out to each MCH, organisation working in area, centres, feeding centres, etc.

TELLING SOMEONE AND SEEKING HELP (REPORTING)	
Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial entry point:	Survivor self-reports to any service provider

IMMEDIATE RESPONSE The service provider must provide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals; accompany the survivor to assist her in accessing services	
Medical/health care entry point [Enter name of the health centre(s) in this role]	**Psychosocial support entry point** [Enter name of the psychosocial provider(s) in this role]

IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - *OR* - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS *TO THE SURVIVOR OR TO OTHERS* Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police	
Police/Security [Enter specific information about the security actor(s) to contact - including where to go and/or how to contact them]	**Legal Assistance Counsellors or Protection Officers** [Enter names of organisations]

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's choices **can** include any of the following (details in Section 6):			
Health care	Psychosocial services	Protection, security, and justice actors	Basic needs, such as shelter, ration card, children's services, safe shelter, or other