Gender Based Violence AoR
Palestine

Child Protection
Area of Responsibility
Global Protection Cluster

State of Palestine
Child Protection AoR

STANDARD OPERATING PROCEDURES
PREVENTION AND CARE FOR CHILD SURVIVORS

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GLOSSARY

Accountability: The responsibility to answer for one's actions or decisions; in the context of these SoPs the principle serves to promote accountability to the affected population through enabling the feedback of the beneficiaries and promoting the use of complaint mechanisms without any fear.

AoR: Area of Responsibility in context of humanitarian response referring to technical area or expertise, such as child protection, GBV or other.

Best Interest of the Child: The principle that decisions about children should be made based on what is best for their well-being.

BID: Best Interest Determination is a process that legitimizes change in child's care and involves experts' recommendations toward child's best interests and lasting solutions. The process is activated when child's safety and well-being are in danger.

Case Management: The process of linking/coordinating access and monitoring the services provided to a child or family, with a purpose of providing support and comfort to a survivor until their recovery.

Case Worker (or Case Manager): A case worker, also known as a case manager, is a trained professional responsible for coordinating, monitoring, and ensuring the delivery of services to individuals or families in need, particularly in situations of vulnerability, abuse, or crisis. In the context of child protection (CP) and gender-based violence (GBV), a case worker's role involves conducting assessments, developing individualized care plans, and referring clients to appropriate services such as medical care, legal assistance, shelter, and psychosocial support. The case worker provides continuous support to survivors, ensuring that they receive the necessary services while maintaining confidentiality and protecting their rights. In both CP and GBV contexts, case workers act as the primary point of contact for survivors, helping to navigate complex systems and facilitating the delivery of comprehensive, survivor-centered care.

Case Closure: The process of ending a case or investigation.

CCS TF: Care for Child Survivors Task Force.

Child Survivor: A child who has experienced abuse or exploitation.

Child Caregiver: A person responsible for the care of a child, which can be their parent, guardian or other.

Child Protection (CP): A field of work focused on safeguarding children from harm, including abuse, exploitation, and neglect.

Child-Friendly Approaches: Methods or strategies that are designed to be appropriate and accessible for children in relation to their age and maturity

Confidentiality: The obligation to keep information private and in context of case management refers to the obligation of a service provider to ensure that the space of service provision can

secure confidentiality, protect the privacy of the survivor and minimize their exposure to anyone who is not involved directly in supporting the recovery and healing of the child-survivor.

Do No Harm: A core humanitarian principle that guides service providers, humanitarian professionals, to avoid causing harm to people they work with and serve. In the context of these SoPs, it is an obligation of the case workers and the service providers to ensure that the child-survivor is participating in the case planning process to the best of their ability and that the risks are assessed within each step. The approach is to mitigate the risks of short-term and long-term harm and facilitate the recovery and the reintegration of the child.

Gender-Based Violence (GBV): Violence or discrimination directed at individuals based on their gender.

Informed Consent: The process of obtaining a person's voluntary agreement to participate in an activity after they have been fully informed about the potential risks and benefits.

Inclusion: The principle promoting equal access to opportunities and resources, regardless of their physical or mental ability.

Legal Framework: The laws and regulations that govern a particular area or activity.

Non-Discrimination: The principle of treating everyone equally regardless of their economic status, social background, political opinion, identity, ability, age, gender or other diversity.

PSEA: Prevention of Sexual Exploitation and Abuse.

Perpetrator: A person who commits a crime or harmful act.

Referral: The process of referring a child or family to appropriate services providers or resources.

Safety: The state of being free from harm or danger, including the sense of safety and comfort..

Standard Operating Procedures (SOPs): Detailed instructions on how to perform specific tasks or activities.

Sexual Abuse of Children: Any sexual act with a child that they do not fully understand and cannot consent to.

Stakeholders: Individuals or organizations with an interest in or affected by a particular issue.

1. BACKGROUND

These SOPs are developed by an interagency group of child protection (CP) and gender-based violence specialists, and in an effort to enhance prevention of and the response to the incidence of sexual abuse of children. The SoPs provide the framework for operation of relevant organizations (non-governmental, international, national); promote use of all available resources and capacities on the ground, their further development and strengthening, in order to provide at least the basic environment for protection of Gazan children from sexual violence.

LEGAL FRAMEWORK

Nothing in these SoPs can or will be interpreted or applied against the laws and regulations relevant to the operational space in Gaza, including the national laws that were applicable before the aggression of 8 October 2024, the 1990 Convention on the Rights of the Child and the 1979 CEDAW . When in doubt, the international human rights law will be given prevalence, as well as the procedures designed within an emergency to secure the child from further violence. Here, the 2004 Palestinian Child Law is specially relevant as it defines the sexual or organized crime against a child and promotes *mandatory reporting*. These SoPs are to be interpreted as an adaptation of the process in the context of emergency, hence aligned with the international standards of GBV in emergencies, child protection in the context of emergencies and the SEA Inter-Agency SOPs.[1]

The conflict and the extremely complex and politically sensitive operating environment have resulted in the complete disruption of state's child protection and social services within the Gaza Strip. As a result the state authorities are limited in capacity to respond to the high numbers of children at serious risk of harm or death. As a result, the previously agreed upon Inter-Agency Standard Operating Procedures for child Protection Case Management and referral in Gaza are no longer operational.

Given the scale and magnitude, and unique protection issues stemming from the conflict and mass forced displacement, there is a need for simplified procedures and tools to provide guidance to humanitarian actors and ensure quality, consistency, coordination and adherence to national and international standards on child protection case management.

STAKEHOLDERS

The SoPs are developed by the members of the GBV AoR, members of the CP AoR that are national and international, non-governmental and governmental organizations. They are the members of the each AoR who have been involved in the care for child survivors of sexual

[1] The Palestinian Child Law Article 54 stipulates that any person who contravenes the mandatory reporting provisions will be punished with a fine. (4) The law does not however stipulate the timing of this reporting. The identity of the notifier may not be disclosed unless the notifier provides their consent (Article 55). The Palestinian Child Law does not specify any other confidentiality requirements, however, in keeping with the best interests of the child, their right to confidentiality and privacy should be maintained and information on the case should only be shared on a 'need-to-know' basis.

violence as a CP or GBV expert, understand the context and challenges. The group identified the following stakeholders who are relevant to the implementation of these SoPs:

- Ministry of Health (MoH) in their capacity to secure age-appropriate physical and mental health services, including the clinical management of rape services delate); promote confidentiality and survivor centered approach in accessing the health services.
- Ministry of Social Development (MOSD) in their capacity to support continued care for a child through best-interest determination; support development and outreach with the use of the SoPs, ability to ensure they align to the local culture and are only interpreted in the best interest of a child.
- SOS and Hayat with their capacity to provide safe shelter in circumstances of high risk of the repetition of sexual violence against a child, and of their dependants (children).
- PSEA network who will be actively engaged and involved in monitoring and reporting of the cases relevant to the sexual abuse and exploitation of children, in ways detailed further in the SoPs.
- GBV AoR and CP AoR - each ensuring that the members are given an opportunity to build capacity and meet the standards of CCS service provision; secure quality, comprehensive response to sexual abuse against children in an age- and maturity- appropriate level; and are directly and actively engaged in prevention of the sexual violence. GBV and CP AoRs will promote access to all specialized services as a lead or supporting agency: legal aid service ,case management, women empowerment and education, age-appropriate health services (including mental health) et cetera.

The Prevention and Care for Child Survivors of Sexual Violence Task Force (PCCS TF)

The implementation of these SoPs will be secured through the PCCS TF, who will monitor, update and adapt the SoPs in line with the context, ensuring that they provide practical guidance and facilitate the safe access and response to sexual violence against children.

The PCCS TF will operate based on the Terms of References that will be signed by the organizations that are members of the TF.

2. Purpose and Vision

The protection and response to any harm, sexual or gender-based harm including exploitation of children. These SoPs set the minimum standards and provide a basis for coordination and a response that is safe for children and is focused on their recovery, healthy development and wellbeing. Even though drafted in the war-time, the SoPs are to guide the response and prevention within conflict as well as in the post-conflict context. The SoPs provide practical guidance to the organizations and the case workers on their roles and responsibilities and lay the foundation for strong cooperation toward the quality, age-appropriate and comprehensive service provision.

3. Challenges

The care, protection and response to sexual abuse of children in Gaza faces several significant challenges, primarily stemming from the ongoing conflict, limited state capacity, and coordination issues between various stakeholders. These can be organized in challenges related to coordination, implementation, and the challenges related to awareness and social attitudes.

- Coordination Challenges
  - Role and responsibility confusion: Lack of clarity among stakeholders in the humanitarian context regarding their specific roles and responsibilities in addressing child sexual abuse.
  - Cross-cutting issues: Difficulties in handling cases involving adolescents, particularly girls, due to their unique needs and their increasing vulnerabilities.
  - Weak coordination: Lack of relevant, regular service mapping and inconsistent collaboration among stakeholders in responding to cases of child sexual abuse. At the same time, existing referral pathways and protocols have been weakened during the current context.
  - Questions related to mandatory reporting, response and protection efficiency upon the reporting in the context of inactive law enforcement institutions.
  - Sectoral coordination: Both CP and GBV stakeholders acknowledge the need for a wholistic approach and comprehensive response to the sexual violence against children; one that would enable specialized, age-appropriate and adequate health, mental health, legal and other services. This requires strong coordination with different humanitarian sectors, such as health, social development, and psychosocial support.
- Implementation Challenges
  - In the current context, partners recognize the slow response: delays in responding to cases of child survivors and high-risk cases, as well as the need for stronger capacity of Ministry of Social Development (MOSD) to legitimize the work of the NGOs in the context when the work of the governmental institutions is hampered by destruction of public services and related infrastructure.
  - Child protection, best interest determination committees require strong capacity of the national and international partners who apply the same standards that will facilitate absorption of the cases by the relevant national institutions and non-governmental organizations once their work resumes in the post-conflict context.
  - Limited availability of safe and accessible complaint mechanisms at the NGO and stakeholder levels, including for SEA cases. There is a great need to ensure the community feedback mechanisms that enable the receivers of the services to comment on the performance of the service providers. Such should be adapted to different age, and especially in relation to provision of care to children survivors of sexual violence.

- Awareness and Community Acceptance Challenges
  - **Lack of effective community engagement:** Repetitive and fund-driven campaigns, underutilization of community leaders, and reliance on traditional approaches hinder awareness-raising efforts.
  - **Cultural barriers to disclosure:** Family reluctance to report cases of child sexual abuse due to cultural traditions that protect perpetrators further complicates the issue.

These SoPs are designed by the field workers in an effort to ensure organized, systemic and quality response to the challenges listed above.

RESPONSE

a. GUIDING PRINCIPLES

The care for child survivors is sensitive work and increasingly important in the given setting in Gaza. With an objective to promote safe access and availability of appropriate, adapted and child-friendly services; and to promote the additional care for protection of child survivors of sexual violence, the working group on the CCS in Gaza agrees to adopt the following principles that will guide the response and prevention in the given context:

a) **Best interest of a child**. Interests of a child are to be given a priority throughout the support of a service provider. For example, a case worker/worker will consider if the child will be in danger due to intervention, if the child has a carer or not, if the perpetrator is with them and if safe to talk to them and any other circumstance that will enable healthy environment, recovery and development of a child will be promoted. Based on the maturity of the child, a child will be involved in the process and the case leader (manager, worker) will ensure that the child is adequately informed and understands the related procedures. If the child is 14 years and older, and the case leader assesses that the child is mature enough to make decisions, especially when it comes to their security and health, the case leader will seek the readiness of a child and their consent, along with the consent of a carer (if they have one).

b) Do no harm. The umbrella principle requires the case leader to ensure that their assessment considers short- and long-term risks and consequences of every action or step of the response. While the protection of the child survivor is a priority, the case leader will promote alignment with this principle also for the members of the child's family.

c) Non-discrimination. Every child, regardless of their age, sex or gender identity, their status, (dis)ability, social background or education - will be given full consideration and cared for without prejudice, with their wellbeing guiding the response and care, toward their full recovery.

d) Respect. The wishes and expressions of a child with respect to their age, maturity, their culture are to be accepted by the case leader, who will guide the carers and other involved service providers to show nothing but acceptance and accept their opinion and willing.

e) Safety. Safety of a child is a priority, their physical and mental wellbeing to be assessed constantly from initial stages of the case. Thus, safety is both physical and emotional and needs to be considered by the case leader in order to achieve a safe and supporting environment, in line with the Caring for Child Survivors Guidelines (p. 68).

f) Inclusion. To the extent possible, the service providers will ensure equal access for all persons regardless of their physical, emotional, or other mental ability. CCS Service providers will promote the inclusive approach and cooperate with the relevant technical working groups, partners and specialists when needed to ensure inclusive approach that will allow

(re)integration and recovery of every child. This may require the service providers to ensure that their space is physically accessible for children with disabilities, and the staff is able to provide service without prejudice.

g) Accountability and responsibility. Promote monitoring and complaint mechanisms that provide for safe engagement of children in provision of feedback, their participation and safe expression of their needs. The service provision will include regular consultations with the child in the manner that is adapted to their age and maturity, and give due consideration to the feedback a child-survivor shares (tools are to be developed by the CCS Taskforce, monitored and adapted).

h) Child-friendly approaches. A service will be provided in the environment that is adapted to responding to children, suitable to their age, safe and child-friendly. All the tools used should be adapted to the age of the children and their maturity, suitable to their age. The counsellor that is working with the children must be accepted by the survivors (an option to choose their gender should be secured) and they must be trained on CCS, use of the terminology and attitudes that are suitable to working with children.

i) Care for caregivers, family focused approach. The working group designing these SOPs acknowledges that the sexual violence against children affects the family/caregivers and invites the service providers to give due care for their participation and support in recovery (where the family members are not the perpetrators or source of the risk).

b. MINIMUM STANDARDS FOR AN NON-GOVERNMENTAL ORGANIZATION TO PROVIDE

A RESPONSE AND CARE FOR A CHILD SURVIVOR.

Below standards are the **minimum,** the setting **that must be secured** by any organization that would provide response and care for child survivors:

a) Organization is experienced in working with CP or GBV or both.
b) Organisation is reporting to the GBV and/or CP subclusters.
c) Case management staff trained on CCS and who meet the knowledge, attitude and skills requirements are present in service-provider agencies.
d) Supervision system for caseworkers providing care to child survivors.
e) Safe, locked filing space to keep child records confidential.
f) Referral system for children is documented and functioning.
g) A private room is available for meetings with children and caregivers.
h) Informed consent and confidentiality forms and procedures are adapted for child survivors.
i) Inclusion and non-discriminatory
j) Child friendly approaches and gender options of the workers
k) Protected referral pathways (confidential) to protect the organizations involved

Roles and Responsibilities

In the current context of Gaza, when families are forced to move and live without little-to-no privacy and the existential needs are limited, the capacity to respond to all the risks and incidents is challenged on a daily basis. Therefore, the SOPs acknowledge the need to use all the sources available on the ground and aim to equally equip the CP and GBV specialists with skills and tools to respond to sexual violence against children. The SOPs acknowledge the risks of disclosure, the fears one has to face before disclosing or reporting a case of sexual violence against children, and therefore promote approach of care within the same organization that received the disclosure; as well as the cooperation between the GBV and CP specialists as per specific contexts, needs and the survivor centered approach.

Service map

Prevention and Care for Child Survivors Task Force will monitor the capacity and services available for CCS cases on the ground. CCS Service maps are therefore monitored and shared on a monthly basis only with the GBV and CP AoRs.

The lead agency

The organization that will provide care to a child survivor, and meets the above criteria/minimum standards for provision of care for child survivors, is the one that is approached and available in the service area. In addition, the organization is in fact:

- Able to provide resources, commit and support the child survivor in line with the guiding principles defined in these SOPs.
- Able to provide supervision support to the case workers and,
- Can secure comprehensive care for child survivors of sexual violence regardless of their gender.

In case the case worker that received the disclosure is not ready to lead the case, the organization will, with the consent of the carers and the child, offer the alternative case worker if available, and if not, refer to the nearest organization ready to receive the child survivor cases (based on the service map).

When deciding if the case should be referred external for case management, the organization receiving the disclosure will consider the developmental stage of the child. For example, if the child is very young (12 and younger) and the organization that receives the disclosure/identifies the case as more in need of child protection specialty, it may be more appropriate that the case is led by the CP organizaiton. However, the organization will prioritize the needs, trust and relationship already built with the child and consider if, prior to referring the CP organization can provide specialized services other than case management (e.g. MH, education, legal).

When the case needs to be placed in the safe shelter, the case is handed over to the shelter case workers, who will secure involvement of the child protection specialists, including child psychologists, and promote access to child friendly services.

Complementary service provision

In cases when the organization/case worker that received the disclosure cannot obtain a consent to refer externally to what may be more appropriate lead agency/case worker, the case worker will ensure consultations with the relevant specialist and support in provision of specialized services.

For an example, if the case is disclosed to a GBV case worker, but the child is, due to age, requiring close intervention and monitoring by child specialists (and therefore CP organization/case worker might be a better fit for leading the case), for the interest of the child and ensuring that the child is receptive to the service provision, the GBV case worker will provide the case management and accompany the child in accessing the services under the CP AoR. The CP organization will assign a focal point to consult the GBV case worker in the case, within the case conference or on a per-need basis. The other way around is also to be applied - if the CP organization received a disclosure but there is no consent to refer externally to a GBV organization that may be more appropriate for the case, the GBV organization will assign a focal point to be available for the CP case worker and provide assistance/consultation within the GBV case conference or on a per-need basis.

In both cases, the case worker will continue to seek consent for each of the services available prior to the referral and if the consent to refer for case management by needed CP / GBV organization is obtained, the case will be handed over fully for a leadership by that organization.

Health Organisations

Healthcare workers are responsible for providing immediate medical care to child survivors, addressing both physical injuries and psychological trauma. This includes treating wounds, infections, and injuries resulting from violence, including sexual violence, and providing emergency contraception or treatment for sexually transmitted infections (STIs), including HIV prevention.Healthcare providers must ensure confidentiality and adopt a child-centered approach, respecting the survivor's dignity and autonomy. They should establish a safe space where the child feels secure and supported and refer/involve child protection workers or GBV workers who are trained in handling sensitive situations.

Cases of Sexual Exploitation and Abuse (SEA)

If the case can qualify as the SEA, as per the PSEA Toolkit for State of Palestine, the case worker will ensure reporting with the consent of carers and the consent/assent of the child if appropriate for the maturity/development of a child. If the consent is not given, the case worker will report the case without disclosing identifiable information of the case.

Cases of SEA as well as any concern related to a SEA incident pertaining to aid workers, suppliers, volunteers, consultants or any other worker operating under humanitarian or development aid must be reported to the PSEA Coordinator within 24hr of receiving the case. The PSEA Coordinator in collaboration with the focal point will assess the report, concern, or claim and decide the course of action according to the PSEA toolkit. Incidents with non-identified survivors, organization or alleged perpetrator must also be reported.

Focal points referring an incident or claim of SEA will submit the information through the following Kobo link https://ee-eu.kobotoolbox.org/x/WslktA5O and complement with an email informing that a case has been submitted to the address: optconfidential@un.org . If access to

the link is not possible you can contact the PSEA Coordinator directly or record the case via the helpline 164.

CASES OF GRAVE CHILD RIGHTS VIOLATIONS

If the case could be considered as a grave child rights violations committed against children in a situation of armed conflict (under the Monitoring and Reporting Mechanism and Security Council Resolution 1612), such as an act of conflict-related sexual violence attributed by a party to the conflict, the case worker can receive information on how this can be documented and reported by contacting UNICEF's Children and Armed Conflict team: OCT-SOP-MRM@unicef.org / +972-59-499-3307 (whatsapp/signal only).

Before sharing any information on the case, the caseworker will ensure consent of carers and the consent/assent of the child if appropriate for the maturity/development of a child.

UNICEF's Children and Armed Conflict team will also provide information or orientations on grave violations to child protection and GBV organisations providing case management, upon request of the PCCS TF.

Grave violations include:

- Killing or Maiming of Children: Direct targeting or harm to children in armed conflict, resulting in death or permanent injury.
- Recruitment or Use of Children in Armed Forces or Groups: The forcible enlistment or voluntary participation of children under the age of 18 in armed groups or national armies, which is prohibited under international law.
- Sexual Violence Against Children: This includes any form of sexual violence such as rape, sexual slavery, and exploitation of children during conflicts.
- Abduction of Children: The forcible removal or kidnapping of children, often with the intent to use them for military purposes, forced labor, or as sexual slaves.
- Attacks Against Schools or Hospitals: Direct attacks on educational institutions or medical facilities, often used by armed groups to recruit children or as military targets, putting children at extreme risk.
- Denial of Humanitarian Access for Children: Preventing or obstructing aid, including food, medicine, and protection services, from reaching children in conflict zones

COORDINATION WITH THE GOVERNMENT AGENCIES: MINISTRY OF SOCIAL DEVELOPMENT AND MINISTRY OF HEALTH

Coordination with the government agencies during the war is limited as the law-enforcement is non-existing. However, the MoSD and MoH are participating in their expert capacity and ensure that the standards, rules and procedures may be applied in the post-conflict context. The role will be expanded with the capacity the institutions and the GBV/CP AoR commit to ensuring the institutions are included in all the capacity strengthening efforts and design of policies, protocols

and procedures. The role of MoSD is especially significant for the successful protection of a minor from sexual violence in situations of a high risk of the repetition of the violence, or similar circumstances that may require separating the child from his immediate family. In such situations and, under the umbrella of CP AOR the Best Interest Determination (BID) procedure will be initiated and prioritized by the relevant committee, of which MOSD is a member.

c. Procedures: Steps of Case Management Specific to the Protection and Care for Child Survivors

The steps below should be considered by the GBV and CP case workers, requiring the adaptation of their usual procedures related to the CP and GBV case management (added or adapted case management to the care for child survivors).

1. Identification:

Children at risk can be identified through various sources, including local community members, child protection committees, government officials, child protection and / or GBV service providers, and self-identifications (direct disclosures). Community outreach and awareness campaigns are crucial to help people recognise signs of distress in children and understand how to report their needs. For that, the outreach teams of both GBV and CP AoR members will be trained on the safe identification and regularly provided with the service map or the referral focal point (by their own organization and supervisor).

2. Consent

Survivor-centered approach will be promoted to the extent possible and both the CP and GBV Case Management Task Forces will use a consent form prepared by the Protection and Care for Child Survivors of Sexual Violence Task Force. The capacity building team of the latter will ensure that each AoR is trained on the safe use of tools by case workers and the relevant procedures.

3. Best Interest of the Child

In situations where a **child survivor**'s safety and well-being are at risk, particularly when the perpetrator is a caregiver (parent or guardian or a family member), the best interest of the child must be assessed in accordance with Palestinian law and international Child Protection Minimum Standards. This process is required when the child may need to be removed from their family or household due to immediate threats.

The **Child Protection Case Management Task Force** and the **GBV Case Management Task Force** are integral to this process. To ensure the best interest of the child is paramount, the following adapted process will be used:

A. **Ad-Hoc Decision-Making Group**:

a. A group will be formed from the **Child Protection Case Management Task Force**, the **GBV Case Management Task Force**, and appointed member of Ministry of Social Development (MOSD) including:
    i. The **caseworker is** responsible for the child survivor.
    ii. A **social worker** or child protection specialist from the MOSD to ensure the implementation of the local law or from a local NGO if MOSD is unable to provide staff.
    iii. Experts from the **GBV Case Management Task Force**, especially in cases involving sexual or gender-based violence.
    iv. Experts from the **CP Case Management Task Force**, especially in cases involving sexual or gender-based violence.

B. **Information Gathering**:
    a. The case worker will collect and present vital details about the child survivor's situation, including personal information (age, gender, health), family conditions (living situation, relationships), and legal documents (court orders, social services reports). The child's preferences, as well as those of non-offending caregivers, will also be considered. The case worker will use the detailed assessment form to document the information from the assessment.

C. **Risk and Safety Assessment**:
    a. The group will assess the risks to the child and explore protective options using standardized tools developed by the Task Forces. The decisions will prioritize the child's best interests, while ensuring compliance with international standards and local laws.

D. **Consultation**:
    a. Where needed, consultations with child protection or legal experts will occur. The child's input, based on their age and maturity, will be gathered through the case worker, ensuring the child's voice is central to decision-making.

E. **Implementation and Monitoring**:
    a. The group will document its recommendations and ensure a protection plan is in place. Regular consultations will be conducted during case follow-up and any significant decision points, including case closure, with continued involvement from the Task Forces. The recommendations will be documented for each case using the case conference form.

F. **Case Plan**
    a. The caseworker will prepare the case plan outlining clear goals and actions to address the child's needs and support the caregiver's ability to provide safe, stable care in accordance with the recommendation of the committee. It will identify necessary services, assign responsibilities, and establish timelines for progress. The plan will prioritize the child's well-being and long-term stability, in alignment with best practices and legal requirements. This will be reviewed as frequently on a case-by-case basis and on a minimum every 3 months.

Throughout the process, efforts will be made to protect the child's identity and minimize further harm. All documentation will be securely stored, with access restricted to authorized personnel.

4. Referrals, Codes

Whether the CP or GBV case worker leads the case, they are obliged to consult and engage the other expert when there is a need for such expertise, especially in situation when accessing specialized services. A survivor-centered approach is promoted throughout the process. Further, the referrals will be carried out safely to appropriate health, mental health and education agencies. These agencies are to be sensitized to accommodate service provision with respect to confidentiality and do-no harm.

Each case will be assigned a code - to be used for the record keeping and referrals within the organization and externally. The Taskforce will develop a guideline that will become a part of this SoPs, and shared with the members of the Taskforce.

Other psychosocial interventions to offer
Aims at building the child's resilience through addressing the psychological, emotional, and social needs of the child. This is achieved through the care and support offered by family members, caregivers, friends, neighbors, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialized services and professionals by including four levels of MHPSS as part of case management and care plan.

5. Case closure

Cases are closed in agreement with the survivor, and such is seen as in the best interest of the survivor by the case worker. Case will also close with the child turning 18, in what case the survivor will be given an opportunity to continue receiving specialized GBV services, including the case management. If such is requested by the survivor, the case will be handed-over to the GBV organization if such is not already a case leader. The conditions for consideration of case closure are that the child's has a lasting safety and environment that can support their recovery and development, including solution for their care until adulthood (a relative or other solution that survivor presents as confident and agrees to).

In case the survivor was under consideration of the BID Committee, the proposal for closure will be submitted by the case worker in consultation with the child and caregiver when appropriate. The Committee will assess and confirm that the objectives of case plan have been achieved, and confirm the closure of the case.

d. Special considerations for the CP/GBV AORs

- Where GBV and Child Protection AoRs have overlapping responsibilities to shared populations, it is important that the AoRs cooperate to ensure that needs and gaps are identified, needs are met, and gaps filled, and coherence and complementarity promoted. In situations where there is a lack of services, GBV and Child Protection actors should jointly advocate for adequate resources to respond to the identified needs and address the gaps in services.

- The GBV and Child Protection coordinators will ensure that services for child and adolescent survivors integrated in GBV and Child Protection referral pathways identify and resolve duplication of services to child and adolescent survivors and other shared populations. -
- Child survivors TF will orient staff who support child and adolescent survivors on both GBV and Child Protection minimum standards and good practice guidelines to avoid causing harm.
- Facilitate joint capacity building activities and provide cross skilling opportunities during, for example, Caring for Child Survivors' training, GBV risk mitigation in Child Protection programming, Clinical Management of Rape training, and orientations on GBV and Child Protection Minimum Standards, Interagency GBV Case Management, etc. for identified cadres of staff that are involved in providing services and address the needs of shared populations

4. INFORMATION MANAGEMENT

Case management must prioritize the safe, confidential, and efficient handling of sensitive information. This includes establishing systems for collecting, storing, sharing, analyzing, and, if necessary, destroying information securely. All stakeholders involved in case management should follow a Data Protection and Information Sharing Protocol (ISP) in an emergency context developed by the Taskforce. The ISP is considered as a part of the SoPs and is Annexed to it.

BELOW ARE SOME OF THE MINIMUM REQUIREMENTS FOR SAFETY OF THE INFORMATION RELATED TO CCS.

Documentation and Record Keeping

Unique Case Codes: Each case should be assigned a unique code to anonymise and track the case. This code should be used in all documentation and communication to protect the child's identity.

Secure Storage: Case files must be kept in secure, locked cabinets or as password-protected digital files, with access limited to authorized personnel only. All agencies will put effort and include in their budget plans the training and use of the cloud for the data storage, minimizing any need for written, hardcopy and trace of the case. In emergencies, procedures should be in place to secure or destroy these files quickly.

Information Sharing between service providers

Informed Consent: Whenever possible, obtain consent from the child and/or caregiver before sharing any information. Children should have the option to restrict certain details from being shared with specific people or agencies.

Exceptional Circumstances: Confidentiality may only be breached without consent when the child's life is in immediate danger or when someone else is at risk of serious harm. In such cases, information should be shared with the agency best positioned to provide urgent protection, with the reasons clearly explained to the child. Similarly, and in line with the PSEA SoPs in Palestine,

the (limited, or full with a consent) information about the case will be shared in case the perpetrator is a humanitarian worker.

Need-to-Know Basis: Information sharing should always be limited to what is necessary and guided by the Data Protection and Information Sharing Protocol. All staff must understand and adhere to these protocols, with regular monitoring to ensure compliance.

This approach ensures that even in emergency situations, the child's safety and confidentiality are maintained, while also allowing for quick and effective response to urgent needs

Child Protection Information Management System Plus (CP IMS+)

To further strengthen information management practices outlined above, child protection organizations are strongly encouraged to adopt the **Child Protection Information Management System Plus (CPIMS+), also known as Primero.**

CPIMS+ is a secure, digital platform specifically designed to enhance effective, accountable, and high-quality child protection case management. It provides intuitive digital forms and structured workflows that support each phase of the case management process including identification, registration, assessment, case planning, referral, transfer, and case closure while upholding the confidentiality and security standards described earlier.

The **Child Protection Case Management Guidelines** serve as the foundational reference for the implementation of case management services. The Case Management forms referenced in the Guidance are closely aligned with the information fields in Primero. Caseworkers should use the forms as a tool to guide to collect necessary information throughout the case management process, ensuring a **smooth transition into the digital system** for safe storage and management.

It is recommended that once all of the information from the CPCM forms has been entered into Primero, caseworkers should shred/destroy the forms and paper files in a safe and confidential manner. A copy of some forms such as Consent and Assent form, Case Plan, and Referral Form, which require physical signatures, should be uploaded into Primero before being shredded/destroyed. It is also strongly recommended that social workers/caseworkers keep all the paper files until all necessary information has been transferred into Primero.

Annex 1

DEFINITIONS

B.1. Child sexual abuse

Child sexual abuse is the involvement of a child in sexual activity that they do not fully comprehend, cannot consent to, or that violates the laws or social taboos of the society in which they live. It can include a wide range of acts from fondling and exposing genitals to penetration and sexual exploitation through prostitution or pornography.

As defined by the (IRC, 2023), child sexual abuse is any sexual activity with a child that they do not fully understand or cannot consent to. It encompasses a spectrum of harmful experiences, causing significant and lasting physical, emotional, and psychological harm.

Primary Forms of Child Abuse:

- Physical Abuse: Intentional injury to a child, including hitting, kicking, burning, or shaking.
- Emotional Abuse: Causing psychological harm through verbal abuse, rejection, terrorizing, or isolation.
- Neglect: Failure to provide for a child's basic needs, such as food, clothing, shelter, medical care, or supervision.
- Sexual Abuse: Any sexual activity with a child that they do not fully understand or cannot consent to.

Forms of Child Exploitation:

- Child Labor: The employment of children in work that deprives them of their childhood, potential and dignity, and is harmful to their physical and mental development.
- Child Sexual Exploitation: The use of children in sexual activities for the sexual gratification, financial gain, or advantage of the perpetrator or others.
- Online Child Exploitation: The use of the internet to sexually exploit children, including grooming, child sexual abuse material, and live streaming of child sexual abuse.
- Child Trafficking: The recruitment, transportation, transfer, harboring or receipt of a child for the purpose of exploitation.

In the context of Gaza, during the current crisis post October 7, 2023, the most common forms of child abuse are child labour, unaccompanied and separated children, injured children, detained children that have faced physical and sexual abuse, and physical violence against children within households.

It's important to note that these categories often overlap, and children can experience multiple forms of abuse and exploitation simultaneously.

For these SoPs, the focus is understanding and addressing the sexual exploitation and abuse of children, including online child exploitation, child trafficking and the child marriage.

B.2. PERPETRATOR.

A perpetrator is an individual who commits an act of child abuse or exploitation. This person is responsible for the harm inflicted on the child. Perpetrators often use their power, authority, or manipulation to exploit and harm children.

It's important to note that perpetrators can be anyone, including:

- Family members: parents, siblings, grandparents, or other relatives
- Caregivers: babysitters, teachers, coaches, or other adults in a position of trust
- Humanitarian workers or volunteers
- Strangers

B.3. Child Survivor

A **Child Survivor** refers to a person under the age of 18 who has experienced sexual, physical, or emotional violence, exploitation, neglect, or abuse, including harmful practices such as child marriage. **For the purpose of this SOP a child is younger than 18 years of age.**

B.4. Child caregiver

A **Child Caregiver** is a person who is responsible for the care, protection, and well-being of a child. This can include biological parents, extended family members, foster parents, or non-relative legal guardians such as state or NGO actors.

B.5. Stakeholders

In the context of Child Protection and GBV, **Stakeholders** refer to groups, organizations, or institutions that work or support child protection and GBV issues. Stakeholders can include a wide range of actors, such as government agencies, non-governmental organizations (NGOs), community-based organizations (CBOs), healthcare providers, law enforcement agencies, legal professionals, educators, and community leaders.

B.5. Spouse of child survivor

A *Spouse of a Child* refers to an individual who is legally married to a person recognized as an individual under 18 years of age. This is applicable when the "child" is granted permission by the Chief Justice or relevant religious authorities under specific conditions.

B.6. Informed Consent

Informed consent means making an informed choice freely and voluntarily, understanding the full scope , Whenever possible, obtain consent from the child and/or caregiver before sharing any information. Children should have the option to restrict certain details from being shared with specific people or agencies.

Exceptional Circumstances: Confidentiality may only be breached without consent when the child's life is in immediate danger or when someone else is at risk of serious harm. In such cases, information should be shared with the agency best positioned to provide urgent protection, with the reasons clearly explained to the child.

Need-to-Know Basis: Information sharing should always be limited to what is necessary and guided by the Data Protection and Information Sharing Protocol. All staff must understand and adhere to these protocols, with regular monitoring to ensure compliance.