

INTERAGENCY STANDARD OPERATING PROCEDURES FOR CHILD PROTECTION CASE MANAGEMENT IN THE KURDISTAN REGION OF IRAQ

Location	Kurdistan Region of Iraq
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1.0 BACKGROUND & INTRODUCTIONS

1.1 Context/Setting

The Child Protection Standard Operating Procedures (SOPs) concern all children in the Kurdistan Region of Iraq (KRI), including children displaced as a result of ongoing events in Iraq, and refugee and asylum-seeking children from Syria and other countries. The humanitarian situation in Iraq is one of the most severe and rapidly deteriorating crises in the world. Escalations in conflict across northern and central Iraq has led to unprecedented displacement of more than three million people since the beginning of 2014 that has eclipsed the existing refugee crisis. Over 249,000 refugees fled to Iraq to seek shelter and protection following the outbreak of conflict in 2011 according to UNHCR statistics. There are an estimated 1.5 million Internally Displaced Persons (IDP) children (47% of the total IDP population) and 101,000 refugee children (41% of the total refugee population) who are in need of protection and assistance. Despite the geographical distribution, most child protection interventions have been focused in camps and in the KRI.

Children continue to bear a heavy brunt in the violent conflict in Iraq. Since the situation significantly deteriorated in 2014, children have been killed, maimed, abducted, exposed to rape and sexual violence, as well as recruited and used for different purposes by armed forces and groups. The ongoing conflict in Iraq and Syria has exposed children to new levels of violence. Children have intense psychological distress from witnessing or directly being exposed to violence, interrupted schooling, and stress linked to disintegrated families, multiple displacements, as well as the breakdown of community structures and social fabric. They suffer from social isolation and marginalisation, and often lack safe spaces where they can de-stress, make new friends, and seek help¹. Girls are at increased risks of Gender Based Violence (GBV), in particular sexual violence and early and forced marriage. Boys are increasingly exposed to child labour.

Refugee children face specific protection risks, including limited options for durable solutions. The risk of *refoulement* for children and families not in possession of valid residency permits creates heightened psychosocial distress, and eventual exposure to violence, including recruitment by armed forces and groups, in the event of return. Requirements for documentation are a greater obstacle to birth registration for refugee children, when documents have been left behind or can only be obtained from Syria, leaving many children at risk of statelessness. Limited options for employment in Iraq are even more so for refugee families, increasing vulnerability to exploitation and negative coping mechanisms such as child labour and child marriage. Furthermore, safeguards for children under the Social Care Act of 1980 do not apply to refugee children, leaving them without legal protection.

1.2 International and Regional Legal and Humanitarian Framework

- United Nations Convention on the Rights of the Child (CRC) (1989)
- The 1951 Convention Relating to the Status of Refugees, and its 1967 Protocol
- United Nations Convention on the Elimination of Discrimination against Women (CEDAW) (1982)
- ILO Convention No 138 on the minimum age for admission to employment and work
- ILO Convention No 182 on the Elimination of the Worst Forms of Child Labour
- Universal Declaration of Human Rights (UDHR) (1948)
- United Nations Convention on Rights of Persons with Disabilities (CRPD) (2006)
- The 1954 Convention Relating to the Status of Stateless Persons
- The 1961 Convention on the Reduction of Statelessness
- The UN Security Council Resolution, No. 1325 (on women, peace and security) (2000)
- International Convention on the Protection of the Rights of Migrant Workers and Members of their Families – 1990 (resolution 45/158).
- Principles And Guidelines On Children Associated With Armed Forces Or Armed Groups (Paris Principles) (2007)
- UN Security Council, Resolution 1612 (on Children in Armed Conflict) (2005)

¹ Iraq Child Protection Sub-Cluster Strategy 2016

1.3 National Laws/Legal Framework

- The Constitution of Iraq
- The Iraqi Civil Code No. 40 (1951) ²
- Labour Code of Iraq, and amendments
- Domestic Violence Law of KRI, no 8 of 2011
- Law on the Care of Persons with Disabilities and Special Needs (No 38/2013)
- Personal Status Law (No 188/1959, No 15/2008)
- Penal Code No. 111 of 1969
- Criminal Procedure Code 23 of 1971 [as amended 14 March 2010]
- The Juvenile Care Law (Act No. 76 of 1983)
- The System of Juvenile Rehabilitation (Act No. 32 of 1971). Rules and Regulations
- System of Pre-trial (Act No. 6 of 1987. Rules and Regulations)
- Law of Social Care (Act No. 126 of 1980)
- The Child Welfare Authority Act (No. 272 of 1982)
- The Welfare of Minors Act (No. 78 of 1980)
- The Labour Act (No. 71 of 1987), laid down conditions for the employment of young persons
- The Penal Code Act (No. 111 of 1969)
- The Code of Criminal Procedure (Act No. 23 of 1971)
- The Act of Combating Domestic Violence in Kurdistan 2011
- Child Protection Law 2013

1.4 Guidelines and Policies

- IASC Guidelines for Case Management Child Protection (January 2014)
- Guidelines on the Determination of the Best Interests of the Child (2008)
- Field Handbook for the Implementation of the BID Guidelines (2011)
- IASC Guiding Principles on Unaccompanied and Separated Children (2004)
- Guidelines on Mental Health and Psychosocial Support in Emergencies (IASC, 2007)
- Minimum Standards for Child Protection in Humanitarian Action (CPWG, 2012)
- Alternative Care In Emergency Toolkit (IAWG on UASC, 2013)
- IRC/UNICEF Caring for Child Survivors of Sexual Abuse (2012)
- GBV Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action (2015)

1.5 Existing Standard Operating Procedures in KRI

- Interagency Emergency SOP For Prevention of and Response to Sexual and Gender-based Violence in KRI (2014)
- Interagency Guidance Note on the Prevention of and Response to Child Marriage in KRI (2015)
- Interagency Protection Referral Form SOP (2015)
- Interagency SOP for BID of UASC and Vulnerable Children (2014)

1.6 Dissemination

The responsibility for disseminating these SOPs amongst the staff of participating and referral agencies rests with the Child Protection Focal Points of each participating agencies. The focal points will, with the support of managers and supervisors within their own agency, ensure the implementation of these SOPs.

² The Iraqi Civil Code defines as a child every human being below the age of 18 years. The Juvenile Welfare Act No. 76 (1983) places children in the following categories, by age group: (a) A youngster is a person under 9 years of age; (b) A juvenile is a person over 9 but under 18 years of age; (c) A juvenile is designated as a preadolescent if he is over 9 but under 15 years of age; (d) A juvenile is designated as an adolescent if he is over 15 but under 18 years of age. The Civil Code No. 40 (1951) does not provide a definition of "child". However, article 106 thereof states that the age of majority is 18 full years and article 97, paragraph 2, states that the age of discretion is 7 full years. Article 3 of the Child Welfare Act No. 76 (1983) applies the act to youngsters and juveniles and clarifies the meanings of youngster, juvenile, preadolescent and adolescent for the purpose of determining criminal responsibility (a youngster under the age of nine cannot be held criminally responsible).

Focal Points of each participating agency will also be responsible for disseminating the contents of the SOPs amongst the community structures with which they work.

1.7 Review and Revision

The SOPs will be reviewed annually in April.

However, any of the focal points can request a review meeting if any of the following circumstances ensue:

- If the SOPs are not reaching stated objectives.
- If there have been any changes to the operational environment since the SOPs were last reviewed, which significantly impact child protection.
- If there have been any changes (increase or decrease) in the number of service providers in the area of operation.
- If any of the service providers have adopted a different strategy/approach that impacts service provision.
- If any of the procedures have proven unworkable in the current context.

1.8 Objectives of the SOPs

These SOP's define best practices, guiding principles, roles and responsibilities, case management processes, and coordination procedures to prevent and respond to protection concerns affecting all children in the KRI. Protection concerns covered by this SOP include child protection issues such as children without adequate care including orphans, unaccompanied and separated children, children in need of protection such as neglected children, children living on the street, children in conflict/contact with the law, those experiencing psychosocial distress and trauma, children associated with armed groups and armed forces, child labour, child survivors of GBV including sexual abuse, child marriage, prostitution and trafficking, child abuse including physical and emotional abuse, and other forms of violence including corporal punishment. The SOP is aligned with minimum standards and international guidelines related to child protection case management, as well as addressing more comprehensive and context specific guidelines for responding to challenging child protection cases.

This SOP was developed in consultation with KRI government partners, UN agencies and national and international NGOs. This document is designed to be used in coordination with existing national and international resources, policies and standards.

2.0 DEFINITIONS AND GUIDING PRINCIPLES OF CHILD PROTECTION CASE MANAGEMENT

2.1 Definitions

Alternative Care:	The care provided for children by those who are not their usual caregivers. This may take the form of informal or formal care. Alternative care may be kinship care; foster care; other forms of family-based or family-like care placements; residential care; supervised independent living arrangements for children. ³
Caregiver:	A person with whom the child lives and who provides daily care to the child, without necessarily implying legal responsibility. Where possible, the child should have continuity in who provides their day-to-day care. Frequent changes of placement and caregiver should always be avoided. The caregiver should not be the child's child protection worker. This person has a parental role, but may or may not be related to the child and may not be the child's legal guardian. In residential care there should be an adequate ratio of caregivers to children in order to ensure that a child receives sufficient care, supervision, and stimulation.
Case Management:	The process of helping individual children and families through direct social-work type support and information management. It is a way of organising and carrying out work to address an individual child's (and their family's) need in

³Alternative Care in Emergency toolkit. Extended care guidance. Inter-Agency Working Group on Unaccompanied and Separated Children

	an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or programme's objectives.
Caseworker:	The key worker in a case who maintains responsibility for the child's care from identification to case closure
Child/Children:	Any person under the age of 18, unless the laws of a particular country set the legal age for adulthood younger ⁴ .
Children Associated with an Armed Force or Armed Group:	Any person below 18 years of age who is or who 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, messengers, spies or for sexual purposes. It does not only refer to a child who is taking or has taken a direct part in hostilities ⁵ .
Children with Disabilities:	Children who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. ⁶
Children in Street Situations :	Any girl or boy who has not reached adulthood for whom the street (in the broadest sense of the word, including unoccupied dwellings, wasteland, etc.) has become her or his habitual abode and/or sources of livelihood, and who is inadequately protected, supervised, or directed by responsible adults. ⁷
Child Labour:	Child labour generally includes all children below 12 years of age directly involved in any economic activity, and children below the minimum age for work (between 14 and 16) engaged in more than light work. Child labour includes work that is mentally, physically, socially or morally dangerous and harmful to children; and work that interferes with their schooling. The concept of child labour is based on the ILO Minimum Age Convention (No.138).
Child Marriage:	A formal marriage or informal union before age 18. Child marriage is a reality for both boys and girls, although girls are disproportionately the most affected. It is widespread and can lead to a lifetime of disadvantage and deprivation.
Child Prostitution/ Forced Prostitution:	Prostitution involving a child. It is a form of commercial sexual exploitation of children. The term normally refers to prostitution of a minor, or person under the legal age of maturity. The act of obtaining, procuring, or offering the services of a child or inducing a child to perform sexual acts for any form of compensation or reward. ⁸
Child Protection:	The prevention of and response to abuse, neglect, exploitation, and violence affecting children.
Child Protection System:	The set of laws, policies, regulations, and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and protective responses inclusive of family strengthening ⁹ .
Child Trafficking:	The recruitment, transportation, transfer, harbouring or receipt of children for the purpose of exploitation. ¹⁰
Children in Conflict with the Law:	Refers to anyone under 18 who comes into conflict with the justice system as a result of being suspected or accused of committing an offence.
Children in Contact with the law:	Is the general term for all children in contact with the justice system. This includes child offenders, victims, and witnesses.

⁴ Article 1: Convention on the Rights of the Child, 1989

⁵ Paris Principles: Principles and Guidelines on Children Associated with Armed Forces or Armed Groups, 2007

⁶ Convention on the Rights of Persons with Disabilities, or CRPD, Article 1

⁷ Inter-NGOs in Switzerland in 1983

⁸ Convention on the Rights of the Child's Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography

⁹ UNICEF Global Strategy, 2008.

¹⁰ Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000)

Child Survivor:	Any person under the age of 18 who has experienced any form of GBV. The terms “victim” and “survivor” can be used interchangeably, although “victim” is generally preferred in the legal and medical sectors, and “survivor” in the psychological and social support sectors. Throughout this SOP, we use “child survivor.”
Confidentiality:	Confidentiality is an ethical principle that is associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client’s case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files.
Corporal Punishment:	The use of physical force causing pain, but not wounds, as a means of discipline. ¹¹
Foster Care:	A care arrangement administered by a competent authority or agency, whether on an emergency, short-term or long-term basis, whereby a child is placed in the domestic environment of a family who have been selected, prepared, and authorized to provide such care, and are supervised and may be financially and/or non-financially supported in doing so. ¹²
Gender Based Violence (GBV):	An umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females”. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices, including forced, early marriage. ¹³
Informed Consent:	Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. In all circumstances, consent should be sought from children and their families or caregivers prior to providing services. ¹⁴
Informed Assent:	Informed assent is the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child’s “informed assent” is sought. ¹⁵
Kinship Care:	Kinship care is family-based care within the child’s extended family or with close friends of the family known to the child, whether formal or informal in nature.
Mandatory Reporting:	State laws which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g. physical, sexual, neglect, emotional and psychological abuse, and unlawful sexual intercourse).
Neglect:	Neglect occurs when parents, guardians, or caregivers deliberately or intentionally fail to meet the child’s physical, emotional, and development needs. For example, by not providing adequate food, housing, clothing, education, hygiene, supervision, and access to medical care. Neglect can cause serious damage to a child’s health or physical, spiritual, mental, moral, and social development.
Orphans:	Children, both of whose parents are known to be dead. In some countries, however, a child who has lost one parent is called an orphan. ¹⁶

¹¹ Educate, don’t punish!, Save the Children

¹² Alternative Care in Emergencies Toolkit, 2013, Save the Children

¹³ Inter-Agency Standing Committee (IASC) (2015) Guidelines for GBV interventions in humanitarian settings:

¹⁴ IRC/UNICEF Caring for Child Survivors of Sexual Abuse 2012

¹⁵ Ibid

¹⁶ Inter-Agency Guiding Principles on unaccompanied and separated children

Protective Factors:	Conditions or attributes in individuals, families, communities, or the larger society that, when present, mitigate or eliminate risk in families and communities that, when present, increase the health and well-being of children and families. ¹⁷
Psychosocial Support:	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, neighbours, teachers, health workers, and community members on a daily basis but also extends to care and support offered by specialized services and professionals.
Physical Abuse:	Physical abuse occurs when there is physical use of force against a child, resulting in harm and injury to the child. It includes, but is not limited to, hitting, beating, kicking, shaking, strangling, scalding, burning, poisoning, suffocating, and severe corporal punishment. ¹⁸
Psychological/ Emotional Abuse:	Psychological and emotional abuse occurs when caregivers consistently fail to care and love their children, by failing to provide a nurturing, loving and supportive environment appropriate for their development. Abuse of this type includes humiliation, withholding of love, blaming, frightening, threatening, terrorising, discrimination, ridiculing, and other non-physical forms of rejection or hostile treatment. Emotional abuse can damage a child's physical or mental health as well as impair the child's physical, mental, spiritual, moral, or social development. ¹⁹
Referral:	The process of formally requesting services for a child or their family from another agency (e.g. cash assistance, health care, etc.) through an established procedure and/or form. Caseworkers maintain overall responsibility for the case regardless of referrals.
Resilience:	The ability of children and their families to deal with, and recover from, adversity and crisis, influenced by individual characteristics and external factors such as diversity of livelihoods; coping mechanisms; and life skills such as problem-solving, the ability to seek support, motivation, optimism, faith, perseverance and resourcefulness.
Risk:	The likelihood that a hazard will happen, its magnitude, and its consequences; the probability of external and internal threats (e.g. armed attacks, natural disasters, gender-based violence) occurring in combination with individual vulnerabilities (e.g. poverty, disability, membership of a marginalized group). ²⁰
Risk Assessment:	Methodology to determine the nature and extent of risk by taking into account potential hazards and existing conditions of vulnerability that together could harm children and their families. Risk assessments should take into account community capacity to resist or recover from the hazard's impact. ²¹
Separated Children:	Children separated from both parents, or from their previous legal or customary primary care-giver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members. ²²
Sexual Abuse:	The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is defined as any form of sexual activity with a child by an adult or by another child who has power over the child. ²³
Unaccompanied Children /	

¹⁷Preventing Child Maltreatment and Promoting Well-Being: A Network for Action, Resource Guide. 2013

¹⁸ UNICEF Physical abuse factsheet, Malaysia 2011

¹⁹ UNICEF Emotional abuse factsheet, Malaysia 2011

²⁰Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

²¹Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

²² Inter-Agency Guiding Principles on unaccompanied and separated children

²³ World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

Unaccompanied Minors	Children who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so. ²⁴
Vulnerability:	Physical, social, economic, family, and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering, and death.
Worst Forms of Child Labour:	Defined by ILO Convention No. 182, the worst forms of child labour include: all forms of slavery or practices similar to slavery (sale and trafficking of children, debt bondage, forced or labour, including forced or compulsory recruitment of children for use in armed conflict); using children for prostitution and/or pornography; using children for illicit activities (e.g. drugs) and work likely to harm children's health, safety, or morals. The worst forms of child labour are prohibited for all children under the age of 18, even those who have reached the legal working age of 16.

2.2 Guiding Principles of Child Protection Case Management

Agencies and staff engaged in child protection case management should comply with a core set of principles to guide their behaviour and interaction with children and their families. This also provides a foundation of care and responsibility for decisions and actions taken. These core principles are similar to those which underpin all good practice with children. They also reflect the Protection Principles in the Sphere Handbook²⁵ and the key principles and approaches developed in the CPMS²⁶.

Do No Harm: This means ensuring that actions and interventions designed to support the child (and their family) do not expose them to further harm. At each step of the case management process, care must be taken to ensure that no harm comes to the children or their families as a result of caseworker conduct, decisions made, or actions taken on behalf of the child or family. Caution should also be taken to ensure that no harm comes to children or families as a result of collecting, storing, or sharing their information. For example, care should be taken to avoid creating conflict between individuals, families or communities, and collecting unnecessary information that, if in the wrong hands, could put the child or family at risk of violence. Unless care is taken, this may expose a child and his/her family to further harm such as revenge acts of violence.²⁷

Best Interests of the Child: The *“best interests of the child”* encompass a child's physical and emotional safety (their well-being) as well as their right to positive development. In line with Article 3 of the United Nations Convention on the Rights of the Child (UNCRC), the best interests of the child should provide the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. Caseworkers and their supervisors must constantly evaluate the positive and negative consequences of actions and discuss these with the child and their caregivers when taking decisions. The least harmful course of action is always preferred. All actions should ensure that the child's rights to safety and on-going development are never compromised.

Confidentiality: Confidentiality requires service providers to protect information gathered about clients and to ensure it is accessible only with a client's explicit permission. For agencies and caseworkers involved in case management, it means collecting, keeping and sharing information on individual cases in a safe way and according to agreed upon data protection policies. Workers should not reveal children's names or any identifying information to anyone not directly involved in the care of the child. When information is shared, it should be shared on a need-to-know basis and limited to only the information necessary to enable better protection of the child.

Non-discrimination: Based on Article 2 of the CRC, caseworkers, supervisors, and managers must ensure that all children receive appropriate care and support in their best interests, regardless of their individual characteristics or a group they belong to (e.g. gender, age, socio-economic background, race,

²⁴ Inter-Agency Guiding Principles on unaccompanied and separated children

²⁵ Sphere Minimum Standards

²⁶ Minimum Standards for Child Protection in Humanitarian Action, Child Protection Working Group, 2012

²⁷ Interagency Guidelines for Case Management and Child Protection

religion, ethnicity, disability, sexual orientation, or gender identity). Agencies and caseworkers must be trained and skilled to form respectful, non-discriminatory relationships with children and their families, treating them with compassion, empathy, and care. Case management staff must actively work to be non-judgmental and avoid negative/ judgmental language in their work.

Child Participation: Refers to the full and equal involvement of boys and girls to participate and express their views in all matters affecting them in accordance with their gender, age, maturity, and capacity. As stated in Article 12 of the CRC, children have a right to express their opinions about their experiences and to participate in decisions that affect their lives. Agencies and caseworkers are responsible for communicating with children their right to participate, including the right not to answer questions that make them uncomfortable, and supporting them to claim this right throughout the case management process.

Adhere to Ethical Standards: 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. In addition to international norms and standards, existing national laws and policies to protect children that are relevant should be to be respected. Adhering to ethical standards includes following the guidelines presented in this document. These guidelines are fundamental to the delivery of professional and quality care and protection for children. Agencies and staff should be trained and be knowledgeable about child-sensitive interviewing and reporting techniques, which should preferably be done by staff of the same sex as the child.

Seek Informed Consent and/or Informed Assent: Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. In all circumstances, consent should be sought from children and their families or caregivers prior to providing services. To ensure informed consent, caseworkers must ensure that children and their families fully understand: the services and options available (i.e. the case management process), potential risks and benefits to receiving services, information that will be collected and how it will be used, and confidentiality and its limits. Caseworkers are responsible for communicating in the language spoken by the child and family and in a child-friendly manner and should encourage the child and their family to ask questions that will help them to make a decision regarding their own situation.²⁸

Informed assent is the expressed willingness to participate in services. It requires the same child-friendly communication of information outlined above. However, for younger children who are by nature or law too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Even for very young children (those under 5 years old) efforts should be made to explain in language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.

Ensure Accountability: Accountability refers to being held responsible for one's actions and for the results of those actions. Agencies and staff involved in case management are accountable to the child, the family, and the community. Agencies and individuals providing case management must comply with the national legal and policy framework.²⁹ They will also have to comply with professional codes of conduct where these exist. In the absence of a legal framework, the guiding principles and the good practice standards outlined in the CPMS provide a foundation for practice. Agencies introducing or supporting case management services must take responsibility for the initial training, on-going capacity building and regular supervision of staff to ensure appropriate quality of care. This must also provide children and their families with routine opportunities to give feedback on the support and services they have received.

Empower Child 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. Caseworkers and supervisors must work to engage children and families to play an active role in the case management process. Throughout the case management process (including during assessment, case planning, and reviews) caseworkers should focus on empowering children and their families to recognize, prevent and respond to child protection concerns themselves. In practice, this means that, in addition to identifying problems and providing services, caseworkers must consider and foster the child and family's strengths and resources on how to build their resilience and capacity to care for themselves.

²⁹ There are times when the national legal and policy framework may go against the best interests of the child. In this case, the best interests of the child should prevail and caseworkers should discuss with their supervisors about how best to deal with the situation.

Provide Culturally Appropriate Processes and Services: Caseworkers and agencies should recognize and respect diversity in the communities where they work and be aware of individual, family, group, and community differences as well as social and cultural norms and prevailing attitudes. This is important to be able to make an informed and holistic assessment of a child's situation. Cultural sensitivity also improves caseworkers' capacity to work effectively with children, families, and communities and to identify solutions that leverage local methods of care and protection and are in line with the children and families' values and beliefs. Without consideration of the cultural context, the quality of case management services can be hindered, leading to the development of case plans that do not fit the realities of people's lives and beliefs and that may not be acceptable and therefore difficult to implement. When what is in the best interest of the child conflicts with cultural values or practices, managers and caseworkers must continue to prioritize the child's best interests and take decisions that do not place them in additional risk (do no harm). It may be difficult to identify solutions that are seen as acceptable to the family or community, but managers and caseworkers must make every effort to work with children and families to identify culturally acceptable solutions that at the same time uphold the rights of children. With difficult issues like female genital mutilation, non-education of girls, or child labourers, caseworkers should develop harm reduction strategies and seek to address the underlying causes of social conditions. For example, families who send girls to school might be given priority access to cash transfer programs or livelihood projects.

In some contexts, confronting these protection issues and cultural practices can lead to conflict and may create additional risks for children, families and communities as well as for caseworkers. Decisions made around these issues must include a careful assessment of risk and always respect the principles of do no harm and the best interests of the child.

Maintain Professional Boundaries and Address Conflicts of Interest: Caseworkers and agencies should act with integrity by not abusing the power or the trust of the child or their family. Caseworkers must not ask for or accept favours, payments or gifts in exchange for services or support as well as be diligent not to raise expectations. Personal and professional limitations and boundaries must be recognized and respected. Steps should be taken to build and maintain a trusting relationship and address conflicts of interest where these arise. An example of a conflict of interest might be where the caseworker and child are in some way related or from the same social network, or where the caseworker working with the child is also the caseworker for the perpetrator of the abuse. Caseworkers and agencies should take action to resolve these issues in a way that is positive for the child so that children are neither negatively affected nor given an unfair benefit as a result.

3.0 ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

Each agency participating in the responses has different roles and responsibilities within the case management process. At the local level, Child Protection Working Groups should maintain referral pathways with details of active case management agencies and service providers.

3.1 Child Protection Case Management Agencies:

Each organization involved in child protection should adopt an internal child protection policy/code of conduct that staff should be trained on and acknowledge through signature. Disciplinary measures should be in place to address breaches of the policy.

Child protection agencies must conduct an assessment of the staff's attitudes, skills, and knowledge to appropriately target capacity building initiatives. Staff should receive initial training on foundation knowledge areas, such as child protection and development, communication skills, and risk assessments. Staff should also have ongoing / refresher training and mentoring. Practice and mentoring by supervisors or colleagues with technical knowledge can also be used to skills and competencies.

Caseworkers

Caseworkers always maintain overall responsibility for a child's case³⁰ once assigned and must follow up on services provided internally and externally.

- a) Follow case management steps from identification through to closure or transfer.
- b) Follow information management protocol, including documentation in case files and confidentiality of data.
- c) Work with supervisors and managers to arrange case conferences for complex cases and ensure children receive multi-disciplinary support.
- d) Raise challenges including training needs to supervisors.
- e) Manage cases in line with SOPs, adhere to standard documentation processes and follow best practice guidance.
- f) Complete the 40 hours of caseworker specific learning/training modules recommended by Global Child Protection Working Group (GCPWG)³¹.

Managers and Supervisors

Managers and supervisors are responsible for assigning cases, providing technical and psychosocial support for caseworkers, and ensuring adherence to best practices. Supervisors should ideally supervise a maximum of 6 staff at a time.

- a) Assign cases in accordance with their experience, skills and capacity, and considering issues of age, gender, culture and identity.
- b) Support individual cases where required and provide regular monitoring of all aspects of case management services.
- c) Review staff caseloads to ensure they are manageable. Caseworkers should ideally not be responsible for more than 25 cases at a time, however this may be adjusted based on capacity and complexity of cases.³²
- d) Schedule and supervise regular case supervision³³ meetings to provide technical and psychosocial support to caseworkers.
- e) Monitor case management and progress of cases including Child Protection Information Management Systems (where CPIMS is used.) for all staff under supervision.
- f) Facilitate case conferences and peer to peer support groups for caseworkers.

³⁰ Best practice is for one caseworker to manage a child (and their family's) case from initial assessment through to case closure. This allows for the development of a positive, helping relationship and ensures confidentiality and consistent follow up. Caseworkers will follow the steps outlined below and in the next section for all cases.

³¹ <http://cpwg.net/resources/case-management-training-package-2014-zip-23mb/>

³² Minimum Standards for Child Protection in Humanitarian Action – Standard 15 – Case Management [Minimum standards require that caseworkers be responsible for no more than 25 cases at any one time, but this may need to be reduced based on caseworkers capacities and the complexity of cases.]

³³ All caseworkers should be provided with supervision and mentoring – both informal and more structured. Supervision and mentoring support technical competence and practice, encourage reflection, promote wellbeing and enable effective and supportive monitoring of casework. Recommended ratio of caseworker to supervisor is 1 supervisor for 5-6 caseworkers. The functions and purpose of supervision within case management are: Supervision of individual cases and professional practice; Support for personal wellbeing; Support for wider processes.

- g) Ensure access to material and logistical support.
- h) Set and monitor standards for case management processes (e.g. timescales for response and follow up, eligibility for material support) and adherence to this SOP.
- i) Review and analyse caseload trends to inform programming.
- j) Identify and address training and capacity building needs.

3.2 Kurdistan Regional Government (KRG)

Both humanitarian and development actors are mandated to support the **Ministry of Labour and Social Affairs (MoLSA)** in fulfilling their obligations, not to replace them. Agencies should respect the government's lead responsibility in child protection and explore ways to strengthen existing systems. In large-scale emergencies, this may involve ensuring government representation in coordination functions even if a major part of the implementation of case management services has been outsourced to external actors. Where possible and appropriate, the government should be supported to deliver direct case management services for vulnerable children and to link children with additional services. Indeed, in contexts where there are qualified social workers within national agencies, external actors should not be carrying out case management but should be supporting existing social workers and the existing case management processes, or filling gaps where capacity and resources are low.

The role of the government becomes most critical in decisions with a statutory/legal component, such as removal of children from care-giving arrangements where they are at risk of harm, placement of children in alternative care arrangements, or in complex family reunification situations. In some settings the government provides such services directly, while in other contexts the government may mandate a partner agency to engage in service provision. In situations where government capacity and presence is extremely limited the case management service provider will still need to seek local authorization and participation in decisions regarding the change of care situations for children. In Iraq, in cases where it is determined that a child requires removal from their family or legal guardian, the child's case will be presented to the Juvenile Court to recommend a protection order for the child for temporary guardianship. At present, this only applies to Iraqi and Palestinian children. For Syrian and other refugee children, there are no clear procedures or legal mandate for responding to cases requiring the removal from family or legal guardians. MoLSA is in the process of amending the Social Care Law Act No. 126 of 1980 to make provisions for refugee children.³⁴ In the absence of clear procedure, DoLSA should be consulted in cases involving non-Iraqi children.

MOLSA consists of four General Directorates

1. **General Directorate of Social Care and Development (Known as DoLSA)**
2. **General Directorate of Social Reform**
3. **General Directorate of Labour and Social Insurance**
4. **General Directorate of Follow up and Inspection**

General Directorate of Social Care and Development (Known as DoLSA): A General Directorate in each governorate represents the General Directorate of Social Care and Development. Each General Directorate is responsible for child protection and is tasked with offering social services such as women's shelters, financial assistance for those in need, family safety net, orphanages, homes for the elderly, disability assistance, and children's institutions. A new Department of Foster Care has been created and is under development. The Directorate operates above mentioned services in addition to operating the #116 child help line, available for children to call for assistance. The mandate of the **General Directorate of Social Care and Development** is the same throughout the KRI.

General Directorate of Social Reform: The General Directorate of Social Reform is responsible for reformatory services for children in conflict with law.

Juvenile Justice System: A specialized juvenile justice system exists and is moderately regulated by law and policy. The legal framework for the juvenile justice system is represented by a series of laws with special provisions relating to juveniles. As a whole this legal framework provides for a system of juvenile courts, for special penalties for juveniles, for reformatories for the rehabilitation of juveniles and for special measures of

³⁴ This amendment will require support from the Child Protection Sub Cluster to ensure that the needs of refugee children are well responded to in legislation.

protection for juveniles. In addition, a separate component of police – the juvenile police – is tasked with safeguarding juveniles (although the regular police are also involved) and juvenile police centres have been established as places of detention of juveniles.

The Juvenile Care Council in KRI established a task force to revise Juvenile Care Law, the Code of Criminal Procedure and the Penal Code, to introduce provisions of alternative custody measures and restorative justice measures to divert juveniles from juvenile liberty deprivation.

General Directorates of Labour and Social Insurance: General Directorate of Labour and Social Insurance is responsible for Child Labour issues in KRG. The main activities of this Directorate are:

- a) Pension and Social Instance of Labours
- b) Job and Employment
- c) Vocational training

The General Directorate to Combat Violence Against Woman (DCVAW) under the Ministry of the Interior specializes in pursuing cases of domestic violence, with three **Directorates to Combat Violence Against Women in Erbil, Sulaymaniyah and Dohuk.**

[**Hotlines:** Erbil: 066-256-7272 / 0750-759-8172 (DCVAW); Sulaymaniyah: 199 *Asiacell only* (DCVAW); Duhok: 062-165 (DCVAW)]

3.3 The Role of Community and Traditional Leadership

A community may not always be a homogenous group and understanding of what constitutes a community can vary from place to place. In these guidelines, “community” is defined, geographically as a group of people living in or near a particular location, such as a village or an urban neighbourhood.³⁵ Communities can play a significant role in preventing and responding to child protection risks.

Community mechanisms like Child Protection Committees (CPCs) are an essential component of wider child protection systems. The purpose of the CPCs is to have an organized community group which serves as agents of change with regards to, for example, negative behaviours and practices that engender abuse, violence and exploitation of children while promoting those positive values, attitudes and behaviours in the local community. Strategically, community level mechanisms, such as CPCs, are useful in part because they interconnect different levels of national child protection systems. CPCs can play a key role in identifying vulnerable children and referring them to child protection actors. However, setting up a community based child protection mechanism, does not guarantee that all children are protected.

Such mechanisms need regular capacity building and monitoring to ensure that they continue to protect children. The strengthening of community-level mechanisms of child protection can be an important step in developing effective national child protection systems. At the same time, community-level mechanisms of child protection draw considerable support from societal structures and mechanisms, and from family and kinship structures and mechanisms. In fact, the impact of community mechanisms depends on how well they link with, support, and derive support from mechanisms at other levels, such as those of the family and the national government.³⁶

3.4 The Role of Children and their Families

Case Management services should be child centred, which entails organizing and delivering services, and making decisions in a way that centres on children’s needs and best interests. Caregivers and family members can also play a key role in addressing child protection concerns. The caseworker needs to carefully consider the family environment dynamics through observation and conversation with the child and other family members. Due consideration has to be taken when dealing with sensitive cases or when the caregivers are the perpetrators in order to avoid putting the child to further harm.

Children and their families play a central role in the case management process – both in terms of their involvement in the development, implementation and review of their own case plan and in terms of helping to

³⁵ Minimum Standards for Child protection in Humanitarian Action – Standard 16 Community-based Mechanisms

³⁶What Are We Learning About Protecting Children in the Community? An inter-agency review of the evidence on community-based child protection mechanisms in humanitarian and development settings

design, review and improve case management procedures. Children and families who have participated in case management services are best able to give feedback on their experiences of the process. This valuable information can be used as part of the monitoring function, and in reviewing and refining procedures as they develop.

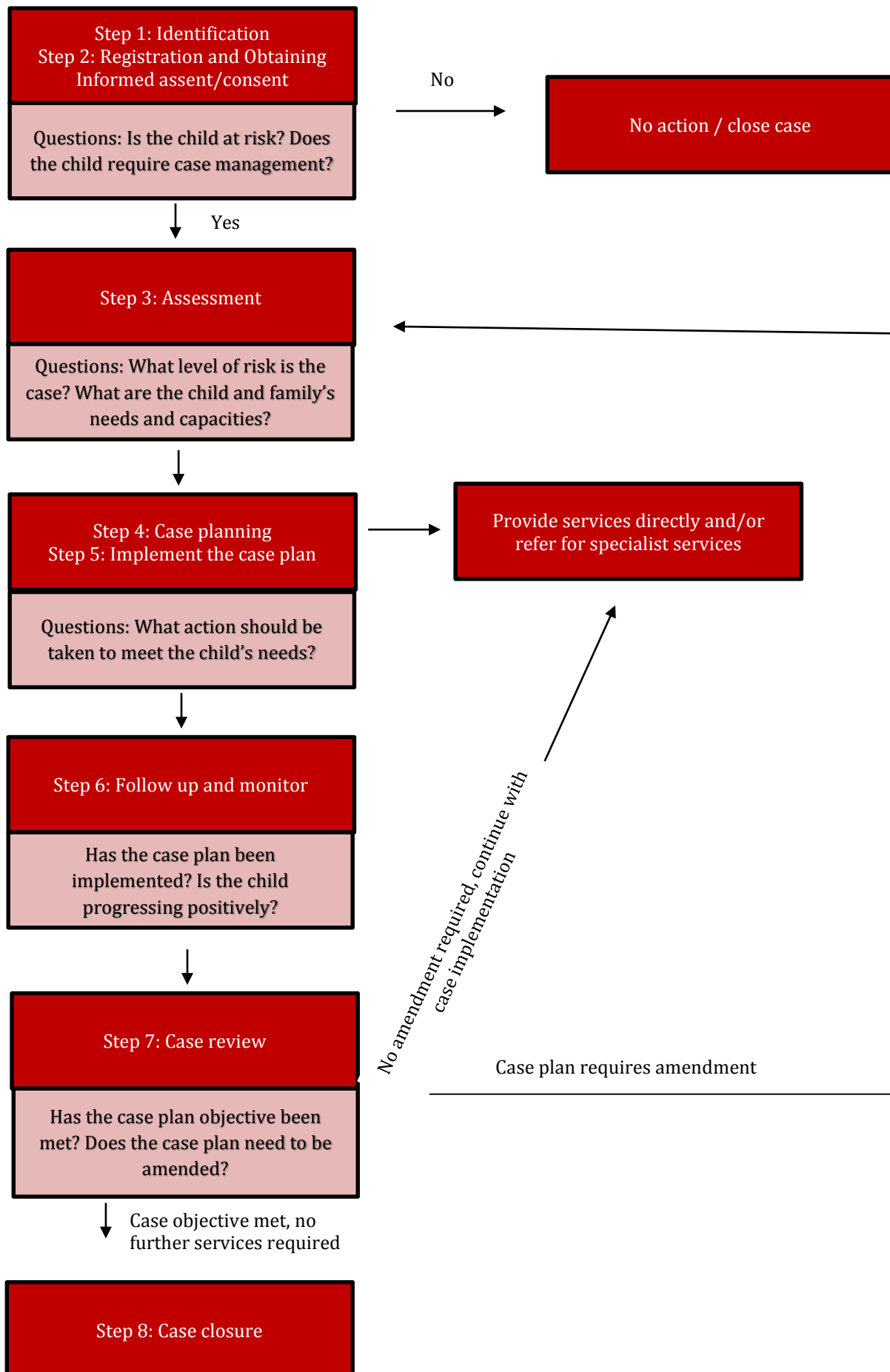
4.0 CASE MANAGEMENT STEPS

4.1 Case Management

The primary goal of child protection case management is to promote the well-being of child clients (and their families) by reducing protection risks and ensuring children have access to prevention and response services including formal services (e.g. case management, alternative care) that are linked with the child protection system. This SOP will enhance the quality of formal case management services, in addition to coordinated and standard case management services. Case management should focus on the needs of an individual child and their family, ensuring that concerns are addressed systematically in consideration of the best interests of the child and building upon the child and family's natural resilience.³⁷

Case Management is a way of organizing and carrying out work to address an individual child's (and their family's) needs in an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or program's objectives. Case management can be provided in emergency and development settings to address a range of issues, including child protection concerns. Case management services can be provided as part of programmes that address the needs of children with particular vulnerabilities or risks, or may be provided as part of program or services that address a broader range of child welfare and social protection concerns. Having case management procedures in place ensures quality, consistency, and coordination of services.

³⁷ Interagency Guidelines for Child Protection and Case Management, 2014



4.2 Informed Consent

Taking Informed Consent³⁸

Why? Proceeding with provision of case management services and other related actions including referrals and sharing of information requires permission that should be obtained from the child, as well as the caregiver or another suitable adult. In case management, there are typically three areas where client permission—referred to as “informed consent” and/or “informed assent” is needed. They are:

- At the start of case management services: that is, before conducting the initial intake and assessment interview.
- As part of case management: children and caregivers need to provide their permission for the caseworker to collect and store information about their case throughout the case management process.
- During case referrals: when caseworkers share information with other service providers who can help the child and family meet their specific needs. Often, caseworkers need to seek permission multiple times during case management as new referrals are needed.

Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. To provide “informed consent”, the person giving it must be able to understand what they are consenting to. To ensure informed consent, caseworkers must ensure that children and their families fully understand:

- the services and options available
- potential risks and benefits to receiving services
- Information that will be collected and how it will be used, and confidentiality and its limits, including situations when information would be shared without consent.

Information should be shared in languages and formats appropriate to the child’s age and capacity to understand. Caseworkers are responsible for communicating in a child-friendly manner and should encourage the child and their family to ask questions that will help them to make a decision regarding their own situation. For children under the age of 15, informed consent must be obtained from their parent / caregiver throughout the case management process. Children over 15 are able to provide informed consent, however their parent or caregiver should be included with the child’s permission. In the KRI, the parent/caregiver’s (or other responsible adult’s) legal consent to proceed with case management (and other case actions) should be obtained for children under 18 years of age. However if a child has reached the age of 15 years old, the child’s informed consent may be obtained instead of the caregivers if the parent/caregiver is not able or willing to provide consent.³⁹

Although it may not be possible to obtain informed consent or assent from younger children, efforts should still be made to explain in language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.

Consent can be obtained in **verbal or written** form, however written consent should always be sought where possible. **(Annex 2: Consent form)**

Informed Assent is expressed willingness to participate in services, and is sought from children who are by law or nature too young to give informed consent, but who are old enough to understand and agree to participate in services. Children between 6 and 15 years can provide informed assent, however permission is also required from the parent or caregiver. Even with very young children (under 5 years old), efforts should be made to share and explain information in an age appropriate language.

Unavailability of parent / caregiver consent: There may be cases in which it is not possible or appropriate to obtain parent/caregiver consent, including where the caregiver may be the perpetrator or complicit in the abuse, or where unaccompanied children are involved. Wherever possible the consent of another trusted adult should always be sought for children under 15 (for the purposes of these SOPs, a “trusted adult” is a related adult, or adult caregiver nominated by the child). For children above 6, they should participate in identifying this person. Where such person is not available, the case manager may have to provide consent

³⁸Includes information from the Case Management Guidelines.

³⁹ The Civil Law for the year 1951, Articles 93-103; Minor’s Care Law No. 78/1980, Articles 27-33; The Juvenile Welfare Law; Articles 3,4 & 5.

for children under 15 to proceed with case management processes. Any decision to take consent from anyone other than the parent, caregiver, legal guardian or nominated trusted adult should be reviewed by a qualified person/supervisor within the case management agency. The process should also be documented on the consent form.

Confidentiality: As a general rule, caseworkers must maintain confidentiality, and thus not act or share information without the informed consent/assent of a child or parent / giver.

However, there are limited **exceptional circumstances** when caseworkers may break confidentiality:

- a) When the child’s own life is at risk (from themselves or others)
- b) When someone else is at risk of serious harm (from the child or others)

In these exceptional circumstances, information can be shared with an organization that is best placed to provide timely protective services to the client or other people. There should be careful evaluation that it is in their best interests to do so, and the reasons for doing so must be clearly explained to the child. As the circumstances may be subjective, each case should be considered individually, and decisions to disclose information should be taken at the highest level of the agency or agencies involved.

Table 1: Snapshot on Informed Consent and Assent Guideline⁴⁰

Age Group	Child	Caregiver	If no caregiver or not in child best interest	Means
0-5	-	Informed Consent	Other trusted adult or caseworker informed consent	Written consent
6-11	Informed Assent	Informed Consent	Other trusted adults or caseworker informed consent	Oral assent Written consent
12-15	Informed Assent	Informed Consent	Other trusted adult or child’s informed assent and sufficient level of maturity can take due weight	Oral assent Written consent
16-18	Informed Consent	With child’s permission obtain informed consent	Child’s informed consent and sufficient level of maturity takes due weight	Written consent

4.3 Case Management Steps

Case management should be provided in accordance with the case management process established in this SOP through a series of steps (explained below). The guiding principles defined above should underlie all stages of the case management process. It is important to remember that every individual case is different and many cases do not follow a straight or smooth path – rather, it can be a ‘circular’ process with movements back and forth throughout the various stages of action and decision-making.

Step 1: Identification

Children harmed or at risk of being harmed can be identified by a variety of sources including community members, child protection committees, government authorities, asylum-seeker and refugee registration processes, self-referral (by the child or family) and other agencies providing services, or staff within child protection programs. To ensure that vulnerable children are appropriately identified, awareness-raising needs to be done among the affected communities so that they are aware of child protection issues, they know how to identify children and what services are available within government and agencies.

⁴⁰Adopted from Inter-agency guideline for case management, 2014

Identification is the initial contact with the child who may have protection needs, and the point at which an agency determines whether or not a child requires case management services. The caseworker should refer specific vulnerability criteria (**Annex 01: Vulnerability and Risk Assessment Criteria**) to determine whether a child's case is appropriate or should be referred on to another agency. Caseworkers should be careful not to make promises during this stage of case management and treat the child (and their family) with respect, care and empathy.

The vulnerability criteria are just a guideline. Caseworkers, with the support from the manager, may decide to respond to the case immediately despite which risk level they have fallen into. The caseworker may decide to take a case for formal case management services even if they have not fallen into to any of those criteria, given the best interest of the child.

Step 2: Registration

Once a child has been identified, registration occurs when the child meets the vulnerability or risk criteria and both the child and their family give informed consent/assent to accept services. Registration includes the initial collection of data on the child, and **obtaining the informed consent/assent of the child and family**. Key basic information should be obtained during the registration process, using the standard Registration Form applicable to the child (for example, for children who are under 5, refer to the 'Children under 5 Registration Form'.

Annex 02: Consent Form

Annex 03: Generic Registration form

Depending on the type of case identified, the following form can also be used:

Annex 05: Rapid Registration Form for UASC

Annex 06: Full Registration Form for UASC

Annex 07: Registration Form for Children Associated with Armed Group

Annex 08: Profile Form for Married Girls

Annex 09: Children under 5 Registration Form

Information collected should include:

- child's name, age, and sex
- who the child is living/ staying with (if anyone)
- where the child is currently staying and contact details
- date and location where they are registered
- initial protection concerns/ needs

At this time, the child should be assigned an individual case number to avoid confusion between children, facilitate easy retrieval of records and to ensure confidentiality.

Introducing Yourself

Why? All caseworkers must identify the organization they represent and explain their role and the purpose of the meeting. It helps the child/family feel comfortable and safe and builds the relationship and trust.

What to Do

If you have never met the child before, explain simply your name, your agency, and what services you provide. If you know the child already it can help to confirm that you know each other and put the child at ease.

For example: *"My name is Sara and my job is to help girls and boys when they feel sad or have any problems. The name of my organization is Safe Places and we have six other women here who also help children and other people. My job is to understand with you how we can keep you safe, listen to you, and give you information about how to get help if you need it."*

Introducing the Interview and obtaining informed consent/assent

Why? It helps to secure the well-being of the child and family throughout the process. It avoids raising the expectations of receiving additional benefits.

What to Do: Every time you communicate with a child and family, but especially during registration, you should take the time to explain the purpose of the meeting and the possible case management process that will follow.

Ask for permission to speak:

- Ask children over 6 for permission to speak with them (informed consent/assent).⁴¹
- This demonstrates your respect of their rights.

Explain to the child (in child-friendly language) and family:

- Why you want to speak with them and what you intend to ask.
- What you think is likely to happen.
- What their rights are in the process.
- There are no right or wrong answers.

Ending the Interview⁴²

Why? End with some **healing statements**. This is nearly always possible and makes the child feel valued and encouraged. E.g. "You have shown a lot of strength in the way you have helped your family/made friends here." "It was very brave of you to come all this way on your own."

What to Do:

1. Explain **next steps**,
2. Tell the child if and **when you are going to meet again**,
3. Ask the child **if they have any questions**.

Do not say anything that is untrue and end in a friendly way, making sure the child / family is not in any distress before ending.

Next Steps: "We're going to start looking for your family, although this may take a long time and we can't be sure of finding them." "I'm going to talk to your aunt to see if we can sort the problem out together."

Meeting Again: "I'll come and see you again next week and we can have another chat." "We won't be meeting again but I hope our talk has helped."

Do not make any promises of actions or outcomes, or create expectations that you cannot meet.

Last Minute Confidences: It is common for people to say at the very end of a conversation something that is very important to them, but is difficult to talk about. They want you to know, but at the same time want to suggest it is not really important. Give time at the end of your conversation with the child and family members for additional possible information sharing.

What to Do

- After discussing next steps, wait to see if the child has something else to say.
- Then say, "Perhaps there is something else you want to say".
- Wait and finally you could ask, "Is there anything else you would like to ask me?", or "Is there anything else that is worrying you?"

Step 3: Assessment

An assessment gathers and analyses information about a child (and their family's) situation, considering the protection risks/concerns involved as well as strengths, resources and protective factors of the child, their family and community.

⁴¹General practices in the clinical researches

⁴²Source: Communicating with Children: Helping Children in Distress

Initial Assessment

Caseworkers should use the initial assessment to identify immediate needs and risks. An initial assessment should be conducted within 24 – 48 hours of identification should prioritize the child's immediate physical protection and safety and basic needs such as food, shelter, and medical care.⁴³ In practice, initial assessments are often carried out as part of the registration process. The initial assessment is found in **Annex 04: Full Registration and Initial Assessment form**.

Depending on the type of case identified, the following form can also be used.

Annex 05: Rapid Registration Form for UASC

Annex 06: Full Registration Form for UASC

Annex 07: Registration Form for Children Associated with Armed Group

Annex 08: Profile Form for Married Girls

Annex 09: Children under 5 Registration Form

A **priority/ risk level** must be assigned based on these considerations:

- **Level 1: Urgent Priority/ IMMEDIATE RISK:** Recommended response within 24-48 hours and twice weekly follow up.
- **Level 2: High Priority/ HIGH RISK:** Recommended response within 24-48 hours and twice weekly follow up.
- **Level 3: Low Priority/ MEDIUM & LOW RISK:** Recommended response within 10 days and fortnightly to monthly follow up.
- **Level 4: Very Low Risk/Referral:** No action required, case closure recommend.

Case File Opening

Caseworker should open a case file within one week from the assessment. File should not contain child's name on the front, instead should have a reference code and should be kept in a locked cupboard.

Annex 10: Sample Case File Cover Sheet

Comprehensive Assessment

A comprehensive assessment follows the initial assessment and provides a more in-depth and holistic view of the child's situation. A comprehensive assessment looks beyond just a child's basic, immediate needs. Factors considered during a comprehensive assessment may depend on the scope of services provided by an organization. Comprehensive assessments typically assess: child's developmental needs, parenting/caregiver capacity, social and cultural context, economic factors, and community/wider family influences. A comprehensive assessment should not only consider risks and harm factors, but also identify positive, protective influences and strengths. The comprehensive assessment is the basis on which all other casework is done.⁴⁴

How long a comprehensive assessment takes will vary according the context as well as the needs of the individual child. The wishes and opinions of the child **MUST** be sought and taken into consideration when making decisions. Children should understand why they are being asked questions and for what purpose the information is used.

The recommended tool for the comprehensive assessment is the **Best Interest Assessment** (BIA) form

Annex 11: BIA Form

Case Conferences

Case Conferences are more formal multi-sector / inter-agency case planning or review meetings for very complex cases. The purpose of a case conference is to explore multi-sector / inter-agency service options, and to make formal decisions in the best interest of the child. Case conferences should be documented with a report / minutes (**Annex 16: Case Conference Report Form**). The child and family participate in some (but not all) case conferences. Any participation would require careful planning and facilitation. The opinions and input of the child and family should always be sought in order to feed into decisions made. Whenever possible and appropriate, case conferences should include government officials. In KRI, this will be mapped

43 Interagency Guidelines for Case Management and Child Protection.

44 Interagency Guidelines for Case Management and Child Protection.

out at the governorate level by the Child Protection sub cluster and details of relevant government entities included in referral pathways.

BID Process for Refugee Children

In refugee operations, a specific best interest procedure has been established for situations where equivalent national procedures are not available or accessible to refugee children. Best Interests Determination processes can be undertaken as a more formal process of determining the child's best interests, where the comprehensive assessment is insufficient. It can be used to identify solutions in more complex cases, including: temporary or longer term care arrangements; durable solutions for refugees (voluntary repatriation, local integration or resettlement); and family reunification.

- The Child Protection case manager, under supervision, should prepare an assessment and recommendation(s) using the **Annex 12: Best Interest Determination (BID) Form**.
- The assessment and recommendation should be analysed by a multi-disciplinary panel, comprising 3 – 5 people with child protection expertise, which should reach a decision based on the best interests of the child.
- The BID process should be in line with and complement existing national procedures. Whenever possible, BID panel membership should include government officials with decision-making capacity.

The implementation of the best interests' procedures will be guided by the UNHCR Guidelines on Determining the Best Interests of the Child (2008) and the Field Handbook for the Implementation of the UNHCR BID Guidelines (2011).

The wishes and opinions of the child and their family must be taken into consideration during the assessment and Best Interests Determination processes.

IMPORTANT: *BID Panel decisions in the above cases are limited to a best interest determination for the child. The BID is not a legal determination of custody.*

Step 4: Case planning

After an initial assessment has been made, the caseworker should discuss the case with their supervisor (and in some cases, a wider team) and develop a case plan within two weeks. The child and family should be fully involved in the development of the case plan. In some cases, a caseworker may convene a formal case-planning meeting that involves the other significant people in a child's life as well as other service providers and relevant authorities where possible and appropriate. If you convene a case-planning meeting, you will need to think about how to ensure that the child and family can fully participate in a meaningful way.

The case plan must be based on the needs and priorities identified in the assessment, and include specific, time-bound objectives and a list of services/ action points necessary to meeting the child's needs. Caseworkers should leverage both the services provided by their agency and the services and resources available from other agencies and the community. Supervisors are responsible for reviewing the plan, ensuring it is in the best interest of the child, and verifying that it is realistic and achievable within the timeframe given.

Once developed, a written copy of the case plan should be provided to or reviewed with the child (and their family, where appropriate).

Importantly, case-planning forms should document the case objectives, services to be provided and time frame and be signed by the caseworker, child, and caregiver.

Annex 13: Case planning template

Step 5: Implementing the case plan

Once the case plan has been developed and agreed upon with supervisors, the caseworker can then begin working with the child and their family to implement the plan. This will involve providing services directly and, with the permission of the child and family, linking them with specialized service providers through inter-agency referrals. In particular, protection actors should rely on the use of the Interagency Protection Referral

Form that was developed and reviewed by protection agencies and endorsed by the Protection Working Group in Kurdistan Region of Iraq (KRI) in 2015. The referral form is standardizing the referral of cases amongst protection actors working with IDPs, refugee and host community members in camp and urban locations.

Interagency Protection Referral Form were developed in October 2015 and should be used with existing GBV and Child Protection case management Standard Operating Procedures (SOPs). See **Annex 14: Interagency Referral Form**

A continuous and regular mapping of services available in the different operational areas should be carried out in order to regularly update the services directories and related Referral Pathways, thus contributing towards ensuring congruency of the services provided with the needs of the target population and fulfilling the gaps in assistance.

Importantly, while another agency may be responsible for providing a specific service, the caseworker is always responsible for ensuring that all agreed upon services are provided and that the needs of the child are being met on an on-going basis.

Step 6. Follow Up and Monitoring

Key Definitions

Follow up: *checking that specific actions have been implemented in the child's case plan*

Monitoring: *regular activities (e.g. home visits, weekly meetings with the child, etc.) to verify that the situation of the child is stable and progressing positively*

Throughout case management, caseworkers and their supervisors are responsible for follow up, monitoring, and review of the child's case. These processes can be just as important as the services provided as they ensure an on-going relationship with the child and family. Caseworkers have primary responsibility for follow up and monitoring (regardless of whether services are provided directly or through referrals) and will agree with their supervisors on appropriate timing and frequency. During follow up and monitoring, caseworkers should seek information on how the services impacted the child and how the child is progressing and if needed adjust the plan according to the new developments.

Supervisors should meet with caseworkers at least once a week (recommended) for either individual or group supervision to ensure the progression of cases and appropriate psychosocial support for caseworkers. Peer-to-peer groups may be scheduled to facilitate self-care and mutual support for caseworkers handling particularly challenging issues.

Case management meetings are routine, internal agency meetings among caseworkers, supervisors, and managers to review caseloads and discuss cases anonymously. These meetings allow the team to review progress, share common experiences, and receive technical advice and support from senior managers.

Annex 15: Case Follow Up Form

Annex 17: Service Provider Form

Step 7: Case Review

Review is a process done at specific intervals between the caseworker and supervisor (and in some cases the child and their family) to see if progress is being made towards case plan objectives, if the case plan remains appropriate, and whether the child requires additional/ different services.

Reviews should be conducted every three months, or once a month during emergencies.

Following the case review, adjust the case plan if appropriate, and implement accordingly.

Case conferences are planned opportunities to review a complex case's status at an inter-agency level with a structured agenda and identified chairperson. These forums are opportunities to review a child's case plan, to explore inter-agency service options, and to reach decisions in the best interest of the child.

Annex 16: Case Conference Report Form

Step 8: Case Closure / Reopen

Case closure is the final step in the case management process and is usually reached when the goals of the child's case plan have been met. The specific criteria for when a case can be closed should be identified by the agency or agencies involved. A case can be closed when the goals of the child's case plan have been met, and following a period of monitoring to ensure a child's status remains stable. The decision to close a case should only be taken by a manager after review of the case with the case manager and supervisor.

Closed cases should be stored in a safe place for a specific period of time in accordance with your agency's data protection protocol or national legislation.

Annex 18: Case Closure Form

Final follow up should be done after 3 months from the case closure (Except if child died) to ensure that child is safe. Depends on the outcome, case can be reopened, then process should start from the assessment. Moreover, the final follow up should be documented in the case file. If the result is negative, case should be re-opened.

Annex 20- Case Re-open Form

4. 4 Case Transfer

The transfer of a case indicates that the full responsibility for coordination of the case plan, follow up, and monitoring of the child is being handed over to another agency or department. This is often appropriate when a child moves but still requires support to ensure their protection. When transferring a case, caseworkers, supervisors and managers will need to put in place a clear plan for hand-over to the receiving agency, and clearly communicate this to the child and the family.

- Transfer of a child's case should be avoided unless it is absolutely necessary. If considering the transfer of a child's case, there must be good cause and a clear indication that the child will receive a better degree of service than they are currently receiving.
- A clear case transfer plan should be developed and agreed by handing over and receiving agencies.
- When transferring whole caseloads to another agency and/or the government, the process should include a review of all case files to confirm consent on sharing information where this is needed.

Annex 19: Case Transfer Form

5.0 INFORMATION MANAGEMENT

Case management requires a safe and confidential system for collecting, storing, and sharing information. Caseworkers are responsible for completing documentation throughout all stages of case management.

The recommended information management system in KRI is the Inter Agency Child Protection Information Management System (CPIMS).

5.1 Documentation and Record Keeping

- a) A separate case file should be maintained for every child, with key information presented in a standard, structured way.
- b) Case files should include the following documents:
 - Consent Form: written permission to provide services and release information to other agencies, signed by the child and/or the parent/ caregiver.
 - Full Registration and Initial Assessment, BIA and/or BID forms all assessments made during the course of case management should be documented.
 - Case Plan documenting the case plan as described in step 4 of the case management process above.
 - Case Notes: an on-going document that details all services provided, referrals made, and actions taken on behalf of the client including dates, names and contact information of those present, and observations of the child/ their family. There should be records of all activities which takes place, whether this is through direct contact or another service provider.
 - Case Closure/ Transfer Forms: documenting the reason for a case closure or transfer, signed by the child (and in some cases their caregiver), and receiving agency, if appropriate
 - A section marked "strictly confidential" to store particularly sensitive information
- c) A code that does not identify the child should be allocated to and marked on the front of each case file and marked on the front of the case file for confidentiality. The code should be used for documentation of the case, referrals, and when sharing information relating to the case. A list which links the case file codes with the children's names should be stored in a different location from where the files are stored.
- d) Caseworkers and their supervisors are responsible for ensuring that all case documents are complete and factual. Caseworkers should be careful to distinguish between facts and professional judgement, ensuring that all professional judgements are substantiated.
- e) Case files should be held in a locked case file cabinet or password protected computer and managed according to the agency's data protection policy. Caseworkers and their supervisors should be aware of procedures for securing or destroying case files in the case of an emergency evacuation or relocation.
- f) Agencies may use case management databases to track and document the status of individual cases being managed. These document and manage case flow, and are different from registration databases, which records information taken during registration only. Databases should be password protected and sharing of databases should follow the data protection protocol. Databases should be supported by appropriately skilled data entry and data management staff. Staff responsible for data entry and management should be fully integrated into the child protection team and included to capacity building activities to ensure they understand child protection concerns and response processes, and especially data protection / confidentiality issues.

5.2 Information Sharing / Data Protection

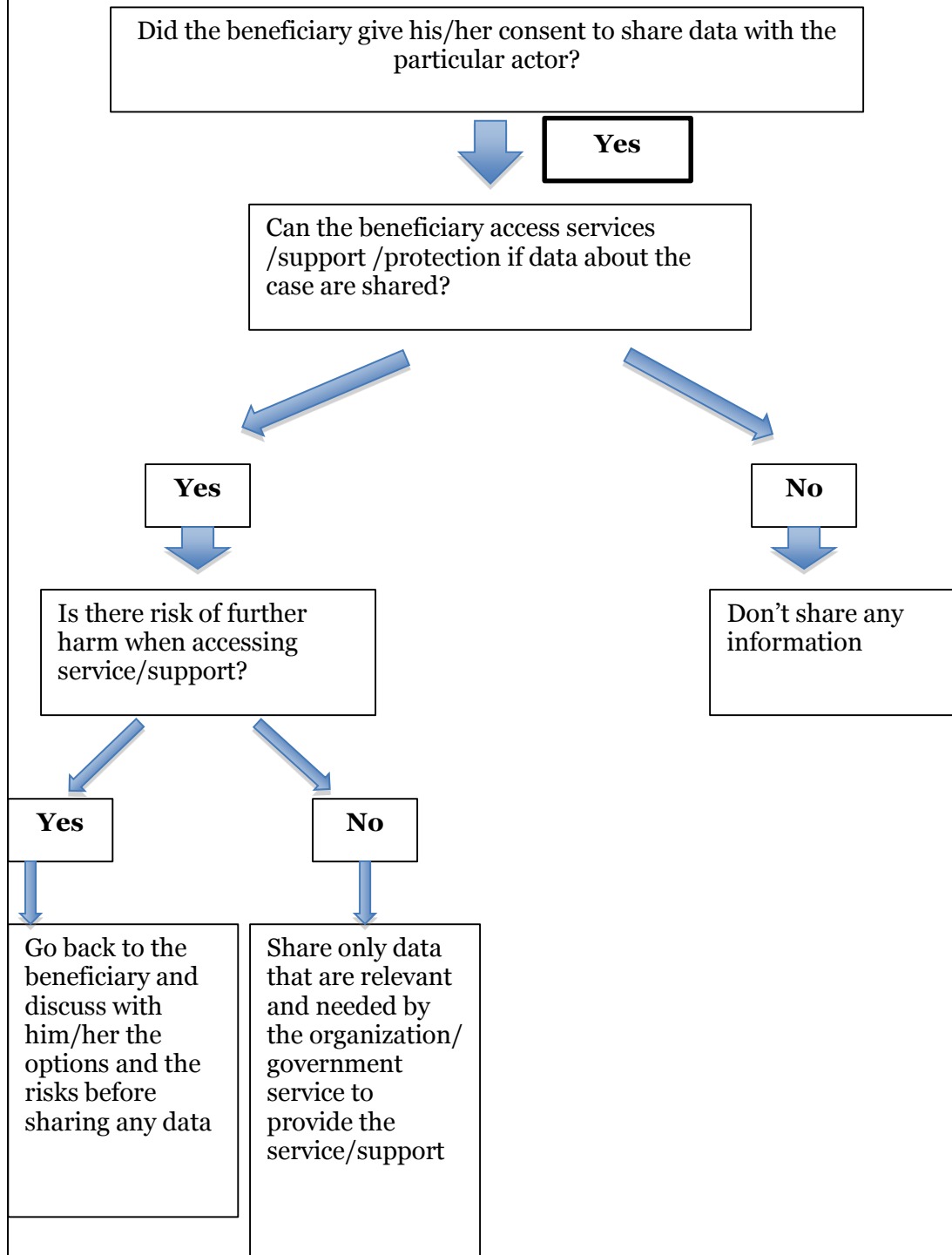
This section should be read in conjunction with the section on informed consent and the flowcharts below.

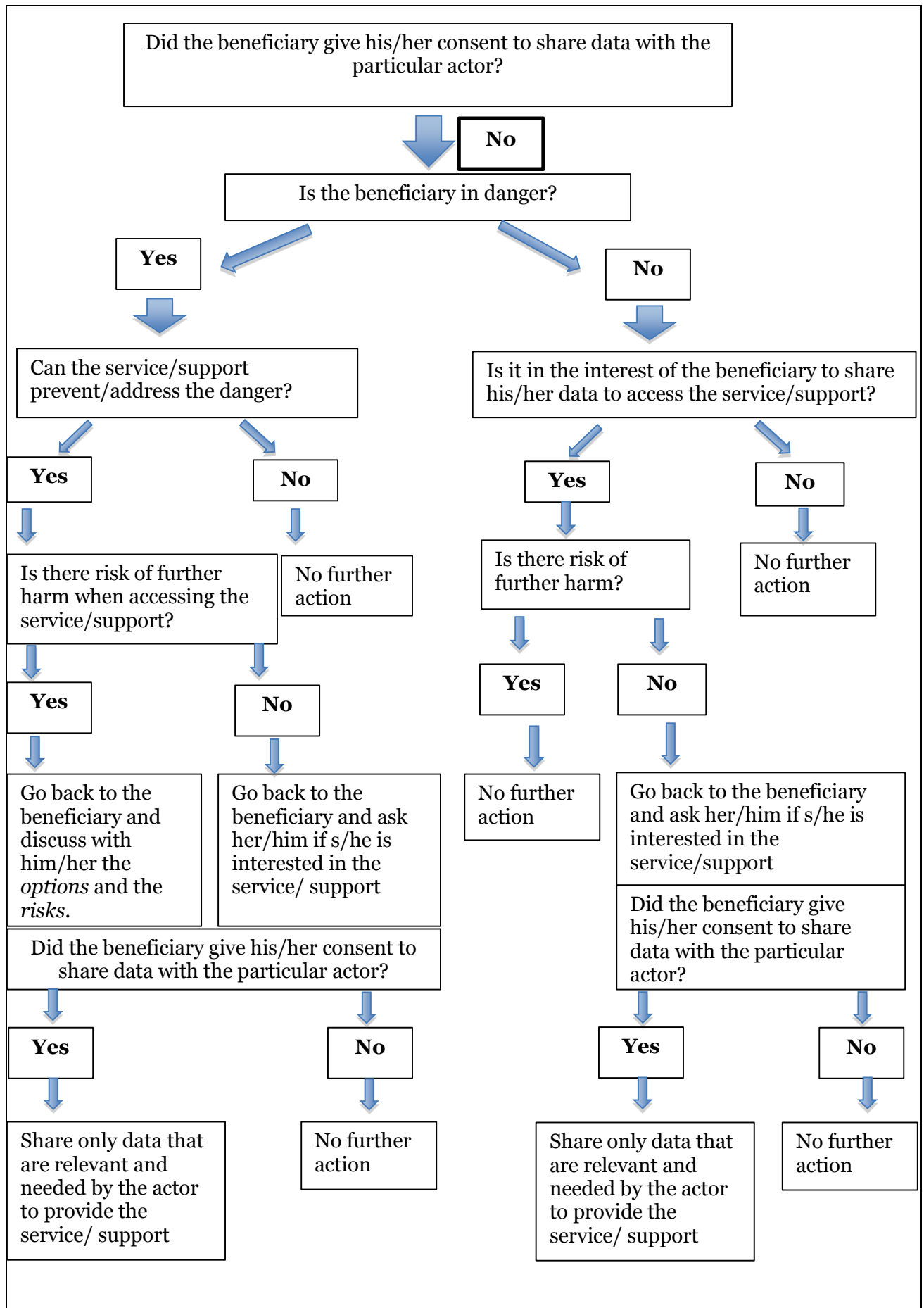
- a) Information sharing with other agencies for the purpose of referral should be on a need to know basis; limited to information required to provide services and enable protection of the child, with the informed consent of the child and/or parent/caregiver.
- b) All staff should be aware of data protection protocols and the security implications of sharing sensitive data.
- c) Children should be given the opportunity to highlight any information that they do not want disclosed to any particular person. For example, they may not want their family to be told personal details about them that they would rather communicate face-to-face.
- d) However, there are limited **exceptional circumstances** when caseworkers may break confidentiality without the consent of the child and/or parent/caregiver:
 - When the child's own life is at risk (from themselves or others)
 - When someone else is at risk of serious harm (from the child or others)

In these exceptional circumstances, information can be shared with an organization that is best placed to provide timely protective services to the client or other people. There should be careful evaluation that it is in their best interests to do so, and the reasons for doing so must be clearly explained to the child. As the circumstances may be subjective, each case should be considered individually, and decisions to disclose information should be taken at the highest level of the agency or agencies involved.

- e) Managers should ensure that data protection protocols are being followed through regular monitoring and mentoring of staff, and that they are updated when needed.

Data sharing decision making tool: Based on the need to know principle





6.0 Dispute Resolution Mechanism

All agencies and inter-agency groups engaging in child protection case management services should have an official mechanism to resolve misunderstandings and disputes in the handling of children's cases.

- Within an agency, this can involve informal discussions with a senior manager or coordinator when disagreements arise between caseworkers and their supervisors.
- At an inter-agency level, focal points for each agency should be identified at the local, regional and national level to resolve case management disputes.
- If issues cannot first be resolved at the local level, they can then be appealed at the governorate or KRI level according to agreed upon procedures.

7.0 CASE MANAGEMENT GUIDELINES

The following sections provide guidance on case management for specific types of harm and children at risk, in conjunction with the guiding principles and the prioritization and risk assessment table (Annex 3). However, case management should always consider the specific circumstances of each case; while these serve as guidelines, action should only be taken following an assessment and in line with the guiding principles outlined above.

7.1 CHILD MARRIAGE

Child marriage has disastrous and life threatening effects on the health, protection, economic, social and psychological development and wellbeing of children. It limits their access to education, sexual and reproductive health care and increases their isolation.

A girl under 15 is 5 times as more likely to die in childbirth than a grown woman; young girls are at increased risk of contracting HIV due to a lack of negotiation power for safe sex and are more likely to experience domestic violence than those who marry later.

*Refer to the detailed Interagency Guidance Note on Prevention of and Response to Child Marriage for KRI, 2015

Legal Framework

- Iraq has ratified the Convention on the Rights of the Child (UNCRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).
- CEDAW Article 16 (2) states that the betrothal and the marriage of a child shall have no legal effect, and all necessary action, including legislation, shall be taken to specify a minimum age for marriage. However, Iraq ratified CEDAW with the reservation not to be bound by the provisions of Article 16.
- The CRC and CEDAW Committees issued a joint general comment (No. 31) deeming child marriage – any marriage where at least one party is under the age of 18 - to be a harmful practice and a form of forced marriage since both parties are unable to give informed consent to the union. The Committees allowed for exceptions to be authorized by a judge for children between 16 and 18, where they were found to be mature enough (General Comment No. 31, paragraph 19).
- In Iraq the amended Law on Personal Status No. 188 of 1959 sets the minimum age of marriage in Iraq at 18 years. However, a judge is able to authorize the marriage of a child 15 years and older where the legal guardian consents. In KRI judges are only able to authorize marriages for children over the age of 16 (Article 5).

- MoLSA have the responsibility of providing shelters for the victims of domestic violence,; **Domestic Violence law in KRI no. 8 of 2011 Art.3**
- DCVAW specializes in pursuing cases of domestic violence. Hotlines: Erbil: 066-256-7272 / 0750-759-8172 (DCVAW), Sulaymaniyah: 199 *Asiacell only* (DCVAW), Dohuk: 062-165 (DCVAW)

Case management steps

Identification	<p>Person under 18 who is married, either formally or traditionally, or engaged to be married.</p> <p>When there are clear indications of risks or signs of abuse, neglect, exploitation or violence and the child is at imminent risk of marriage, measures should be taken to ensure the safety of the child, e.g. through referral to a safe house.</p>
Assessment	<ul style="list-style-type: none"> ✓ Consider the child’s age and maturity and the environment she is living in. ✓ Was the marriage forced; did the child provide informed assent or consent to the marriage? ✓ How old is the child’s spouse? ✓ What are the child’s feelings towards the marriage/husband? ✓ Does the child’s appearance and manner seem normal and healthy? ✓ Does the child receive any support from family members (child’s and spouse’s)? ✓ Does the child attend school? ✓ How does the child spend his/her day? What activities are they involved in? ✓ Is she showing signs of sadness or distress? ✓ What factors led to the child’s marriage?
Case planning	<p>CHILDREN AT RISK OF BEING MARRIED:</p> <p>Delay Marriage: for girls who are identified as engaged to be married or report to Child Protection or GBV actors their engagement to be married, it is crucial to initiate case management services as soon as possible with the consent of the child (refer to informed</p>

	<p>consent and assent guidelines on page 18). Once the girl is registered with a case management service provider an action plan to delay the marriage should be considered with the child and family. <u>The action plan may include:</u></p> <ul style="list-style-type: none"> ○ Prevent or delay marriage through counselling with the child and trusted family members ○ Cash assistance ○ Livelihoods opportunities ○ Psychosocial support ○ Recreational activities, life skills and non-formal education
	<p>CHILDREN ALREADY MARRIED:</p> <ul style="list-style-type: none"> - Reproductive health and family planning counselling - Awareness raising on health, relationships and housekeeping with child and family - Support the child within their environment, including extended family - Access to education - Psychosocial support - Recreational activities, life skills and non-formal education where formal education is not possible - Access to appropriate legal information and support (e.g. civil status registration)
	<p>CHILDREN WHO ARE PREGNANT:</p> <p>Girls who are pregnant are at high risk of health issues particularly if they are below 15. Case management services would focus on medical support as well as psychosocial counselling and would ensure the presence of a strong social network.</p> <ul style="list-style-type: none"> - Support the child within their environment - Access to appropriate health and reproductive health services - Access to appropriate legal information and support (e.g. birth registration) - Psychosocial support - Awareness raising and support in developing parenting skills

7.2 CHILDREN WITH DISABILITIES

Children with disabilities are especially vulnerable in emergency situations. They are often the first to be abandoned by families and usually the last to receive emergency relief and support. Children and adolescents with impairments may be separated from their families for long periods, with devastating long-term psychological consequences. Even the most caring of parents will be challenged in a situation of displacement in providing proper care for their children with disabilities.

Guiding Principles for working with children with special needs and disabilities

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons:
- Non-discrimination:
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.
- Equality of opportunity and accessibility
- Equality between girls and boys
- Respect for the evolving capacities of children⁴⁵

Legal Framework

- Iraq has ratified the Conventions on the Rights of the Child and on the Rights of Persons with Disabilities (CRPD).
- CRPD Article 7 requires states to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children. It also requires that states ensure children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.
- Article 32 of the Constitution of Iraq states that “The State shall care for the handicapped and those with special needs, and shall ensure their rehabilitation in order to reintegrate them into society, and this shall be regulated by law”.

⁴⁵Minimum standards for child protection in Humanitarian Action

- Law 38/2013 on the Care of Persons with Disabilities and Special Needs, the Social Protection Law of 2014 provides for rights and entitlements of people with disabilities. In 2012, guidelines for rights and privileges of people with disabilities were issued in KRI.

Case management steps

<p>Identification</p>	<p>Child has a disability or serious medical condition which limits their ability to function physically or socially.</p> <p>As children with disabilities who have limited mobility, and those 'hidden' (and possibly even physically restrained) because of cultural stigma, are especially vulnerable to sexual and other forms of exploitation and abuse, work at the community level to identify families with children with disabilities ensuring confidentiality and do no harm approach.</p>
<p>Assessment</p>	<ul style="list-style-type: none"> ✓ Is the child receiving required treatment for the disability or medical condition? ✓ Does the child's family offer adequate care and support? What is their attitude towards the child? ✓ Are the child and family able to cope in their current living and socio-economic circumstances? ✓ Does the child need additional medical, therapeutic, technical assistance or devices? ✓ Is the child going to school or attending any recreational, PSS activity?
<p>Case planning</p>	<p>Provide information about available support in accordance with specific needs (egg. mobility devices, legal, health, psychosocial support, mental health support (child psychologists who are trained in various child-centred therapies), cash assistance, education, etc.)</p> <p>Parents caring for children with disabilities should be provided with guidance on how to best support the child's development, and their legal rights. If needed, parents or caregivers should be supported to access emotional support.</p> <p>Provide awareness to parents of children with disabilities of the importance of creating an environment which is non-discriminatory, inclusive, and accessible in order to reduce the disability associated with the child's impairment.</p> <p>If consent is provided, refer children and family members to appropriate services such as:</p> <ul style="list-style-type: none"> - Recreational activities with other children - Formal or non-formal education

	<ul style="list-style-type: none"> - Specialized equipment - Medical services - Parenting skills for parents/caregivers - Cash assistance
	<p><u>CHILDREN WITH ADDITIONAL PROTECTION CONCERNS</u></p> <p>Children with disabilities are more vulnerable to abuse, neglect and exploitation, particularly during displacement when family and community-based protection mechanisms break down. Consider additional interventions in accordance with guidance provided for these types of harm.</p> <p>Children with disabilities are at a particular risk of not being registered at birth which exposes them to further protection risks.</p>

7.3 UNACCOMPANIED CHILDREN

Legal Framework

- Iraq has ratified the Convention on the Rights of the Child.
- CRC Article 20 states that a child temporarily deprived of his or her family environment shall be entitled to special protection and assistance provided by the State.
- UN General Assembly, *Guidelines for the Alternative Care of Children*, adopted by the General Assembly, 24 February 2010, A/RES/64/142
- DOLSA is responsible for the registration and protection of unaccompanied Iraqi and Palestinian children in Iraq. If a child needs to be removed from their current care arrangements and placed in a shelter or formal foster family, this must be approved by the Juvenile Judge. Formalized standby foster parents/caregivers may also be able to provide safe accommodation in the future as long as additional training is provided. Placing children in shelters should be a last resort and a temporary measure. Although procedures remain unclear regarding refugee children and non-Iraqi children, DOLSA should still be consulted when determining care arrangements for such cases, and a BID process initiated by UNHCR refugee children.

Case management steps

Identification	Child who has been separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so.
Assessment	<ul style="list-style-type: none"> ✓ Best interest assessments must be conducted for all unaccompanied children, and Best Interests Determinations considered for long-term solutions and care arrangements. ✓ What is the child's age and maturity? ✓ What is the child's current care arrangement? Is it safe and appropriate? Is the child happy in the care arrangement? Are current adult caregivers able and willing to continue to care for the child? ✓ Where are the child's parents? What were the circumstances of separation? Is the child in contact with them? If not, when did they last have contact with the child?

	<ul style="list-style-type: none"> ✓ Does the child have any siblings or adult family members in Iraq, or elsewhere, who would be appropriate to involve in the child's care arrangement? ✓ What are the child's wishes with regard to care arrangements?
Case planning	<p><u>ALL UNACCOMPANIED CHILDREN</u></p> <ul style="list-style-type: none"> - Family tracing and reunification - In all cases, refugee children should be referred to UNHCR for registration and support for durable solutions - Alternative care arrangements for children currently not in safe and appropriate care (e.g. foster care, kinship care, institutions) – institutionalization should only be a measure of last resort. - Formalisation of existing care arrangements through DOLSA - Psychosocial support - Access to education and recreational activities - Cash assistance - Support, counselling and guidance for current or potential caregivers - Monitor and follow-up on the implementation of BIA recommendations or BID panel decisions.
	<p><u>CHILD-HEADED HOUSEHOLDS</u></p> <p>In addition to the above interventions, child-headed households should be prioritized, continually be monitored and supported.</p>
	<p><u>CHILDREN WITH ADDITIONAL PROTECTION CONCERNS</u></p> <p>Unaccompanied children are more vulnerable to abuse, neglect and exploitation. Consider additional interventions in accordance with guidance provided for these types of harm.</p>

7.4 SEPARATED CHILDREN

Legal Framework

- Iraq has ratified the Convention on the Rights of the Child.
- CRC Article 20 states that a child temporarily deprived of his or her family environment shall be entitled to special protection and assistance provided by the State.
- UN General Assembly, *Guidelines for the Alternative Care of Children*, adopted by the General Assembly, 24 February 2010, A/RES/64/142
- DOLSA is responsible for the registration and protection of separated children in Iraq. DOLSA is responsible for the registration and protection of separated children in Iraq. If a child needs to be removed from their current care arrangements and placed in a shelter or formal foster family, this must be approved by the Juvenile Judge. Formalized standby foster parents/caregivers may also be able to provide safe accommodation in the future as long as additional training is provided. Placing children in shelters should be a last resort and a temporary measure. Although procedures remain unclear regarding refugee children and non-Iraqi children, DOLSA should still be consulted when determining care arrangements for such cases, and a BID process initiated by UNHCR refugee children.

Case management steps

Identification	Child who has been separated from both parents / legal or customary caregiver and is staying with another adult who is a blood relative.
Assessment	<ul style="list-style-type: none"> ✓ Best interests assessments must be conducted for all separated children, and Best Interests Determinations considered for long-term solutions and care arrangements. ✓ What is the child's age and maturity? ✓ What is the child's current care arrangement? Is it safe and appropriate? Is the child happy in the care arrangement? Are current adult caregivers able and willing to continue to care for the child? ✓ Where are the child's parents, what were the circumstances of separation? Is the child in contact with them? If not, when did they last have contact with the child?

	<ul style="list-style-type: none"> ✓ Does the child have any siblings or adult family members in Iraq, or elsewhere, who would be appropriate to involve in the child's care arrangement? ✓ What are the child's wishes with regard to care arrangements?
<p>Case planning</p>	<ul style="list-style-type: none"> - Family tracing and reunification - In all cases, refugee children should be referred to UNHCR for registration and support for durable solutions - Alternative care arrangements for children currently not in safe and appropriate care (e.g. foster care, kinship care, institutions) – institutionalization should only be a measure of last resort - Formalisation of existing care arrangements through DOLSA - Psychosocial support - Access to education and recreational activities - Cash assistance - Support, counselling and guidance for current or potential caregivers - Monitor and follow-up on the implementation of BIA recommendations or BID panel decisions.
	<p><u>CHILDREN WITH ADDITIONAL PROTECTION CONCERNS</u></p> <p>Unaccompanied children are more vulnerable to abuse, neglect and exploitation. Consider additional interventions in accordance with guidance provided for these types of harm.</p>

7.5 SURVIVORS OF CHILD SEXUAL ABUSE

Case management for child survivors requires case workers to have specialized knowledge and skills for working with children.

Legal Framework

- Iraq has ratified the Conventions on the Rights of the Child.
- CRC Article 43 requires states to protect children from all forms of sexual abuse and exploitation.
- **MoLSA** have the responsibility of providing shelters for the victims of domestic violence,; **Domestic Violence law in KRI no. 8 of 2011 Art.3**
- **DCVAW** specializes in pursuing cases of domestic violence. Hotlines: Erbil: 066-256-7272 / 0750-759-8172 (DCVAW), Sulaymaniyah: 199 *Asiacell only* (DCVAW), Dohuk: 062-165 (DCVAW)

Case management steps

Identification	Child who has been involved in sexual activity which he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent.
Assessment	<ul style="list-style-type: none"> ✓ Assessments must be in line with the SGBV SOP, and conducted by caseworkers designated for SGBV cases. ✓ Consider health, safety, psychosocial and legal/justice consequences during the assessment. ✓ Health: has the child received timely and appropriate health services to address the abuse faced? ✓ Safety: is the child at risk of further abuse? What measures can be taken to ensure the child's safety? ✓ Psychosocial: what has the psychological impact of the incident been on the child? Does the child have a strong peer and family network of support? ✓ Legal / Justice: does the child / parent want to report the incident to the police?

<p>Case planning</p>	<p><u>HEALTH</u></p> <ul style="list-style-type: none"> - Urgent referral for medical services, prior to any other action. If possible and appropriate, caseworkers should accompany children and families, with their consent, when this would help to ensure survivor and child-friendly services - Medical facilities should have safe space for children and trained personnel able to adapt the medical exam and treatment for a child⁴⁶ <p>Ministry of Health (MoH) (in coordination with MoLSA) provides health care for survivors. Trained Clinical Management of Rape (CMR) providers in KRI include:</p> <p>Dohuk Dohuk emergency hospital Zakho emergency hospital Amedye. Hospital Akre emergency hospital Women s Health Centre (within Dohuk preventive Health Unit)</p> <p>Erbil Erbil Maternity Hospital Razgari Hospital Forensic medicine Emergency Unit</p> <p>Sulaymaniyah Sulaymaniyah Maternity Hospital Karar Hospital</p>
	<p><u>SAFETY</u></p> <ul style="list-style-type: none"> - Conduct ongoing child safety assessments in the family and social contexts after disclosure of abuse. Take decisive and appropriate action when a child needs protection.

⁴⁶Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and IDPs, WHO, 2004 provides a clear protocol on the health response to survivors and highlights the specific needs of children.

	<ul style="list-style-type: none"> - Where there are continuing safety issues for the survivor, develop a safety plan with the child and family. There should be a way for the child / family to contact the caseworker in the event of an emergency, or in case further needs arise. Depending on the circumstances, the caseworker may provide a phone unit for this purpose. - Find strategies that enable the survivor to stay with their family, when appropriate, always prioritizing safety. - Provide emergency numbers (UNHCR: 066-2643913, 066-2586252) to be used in case of emergency. - Provide interim alternative accommodation, pending long term solutions, providing financial support and transport to the safe location whenever possible. Always assess the security risks related to this option and ensure ongoing monitoring of protection risks.
	<p><u>LEGAL / JUSTICE</u></p> <p>In KRI, GBV cases, specifically cases of sexual violence against all survivors and other cases of violence in the family against children and women, can be referred to DCVAW with survivor consent or following mandatory reporting procedures. For cases involving asylum seekers or refugees, a GBV survivor or their caregiver can report directly to DCVAW – in this case when the survivor/caregiver consents, DCVAW will inform UNHCR.</p> <p>Specific DCVAW procedures, in case of physical assault or sexual assault against children (felonies) are described below:⁴⁷</p> <ul style="list-style-type: none"> - In cases of felonies, the survivor (or their caregiver) can decide whether they wish to file a complaint or not against the alleged perpetrator. If they wish to file a complaint, then the judicial proceeding described below will be followed; - If they do not wish to file a complaint, DCVAW will still refer the case to the public prosecutor who will decide whether or not to refer the case to the court proceedings. In this case, their statement can be used by the public prosecutor and they may be called to testify; - As such, all cases of physical assault against women and children perpetrated by family member and sexual assaults against adults (women and men) and children are referred by DCVAW to the public prosecutor. <p>Legal responses include providing legal counselling, assistance, and representation for adults and children, when the survivor wants to press charges against the perpetrator or in cases related to personal status (e.g. custody law issues). This includes:</p> <ul style="list-style-type: none"> - Child survivors being consulted on the option for legal justice and made aware of the available services and their limitations. The child's needs, wishes and feelings are taken into consideration and every effort is made to enable the child to express himself/herself and to take part in the decision-making process;⁴⁸ - The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing and is provided with legal representation before the court.

⁴⁷Interview with FPD staff on 25/3/2013

⁴⁸ Ibid

	<p><u>MENTAL HEALTH and PSYCHOSOCIAL</u></p> <ul style="list-style-type: none">- Depending on the assessed needs, provide psychosocial care or referral to a psychologist or psychiatrist, to support the survivor and family members where appropriate- Provide healing education, relaxation training, teaching coping skills and problem solving. ⁴⁹

⁴⁹Caring for Child Survivor Survivors of Sexual Abuse. IRC/UNICEF. 2012.

7.6 CHILD LABOUR

Legal Framework

- Iraq has ratified the Convention on the Rights of the Child in 1994, and ILO Conventions No. 138 and No. 182 on the minimum age for admission to employment and work, and the Elimination of the Worst Forms of Child Labour.
- CRC Article 32 requires states to protect children from all forms of economic exploitation and from performing any work that is likely to be hazardous or interfere with the child’s physical, mental, spiritual, moral or social development.
- ILO Convention No 138 sets 16 as the minimum age for admission to employment (13 for light work), and 18 as the minimum age for admission to hazardous work. It provides for the lower minimum age of 15 (12 for light work) for countries in the phase of progressive economic development.
- ILO Convention No 182 define the Worst Forms of Child Labour as all forms of slavery or practices similar to slavery (sale and trafficking of children, debt bondage, forced or labour, including forced or compulsory recruitment of children for use in armed conflict); using children for prostitution and/or pornography; using children for illicit activities (e.g. drugs) and work likely to harm children’s health, safety or morals. The worst forms of child labour are prohibited for all children under the age of 18, even those who have reached the legal working age of 16. States party to ILO Convention No 182 are required to take measures to eliminate the worst forms of child labour.
- The Amended Labour Code, Law No 71 of 1987 makes reference to Iraq’s ratification of ILO Conventions No 138 and No 182, requiring states to take affirmative steps towards eliminating child labour.
- Article 90.1 of the amendments to the Labour Code: “The minimum age for admission to any kind of employment or work within the territory of Iraq and on means of transport registered in the territory of Iraq shall be 15 years”.

Case management steps

Identification	Child engaged in employment below the age of 15. Child engaged in hazardous employment between the ages of 15 and 18.
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	*Remember that is it the employer violating the law, not the child. In order to ensure the safety and well-being of the child, do not interview the child at their workplace.
Assessment	<ul style="list-style-type: none"> ✓ Is the child being forced to work? What is the parent's attitude to the child working? ✓ Does the child work with close family members? ✓ Is the child regularly attending school? ✓ Is the child being exploited by the employer? Is the employer following employment laws? ✓ Does the child have time to engage in recreational activities? ✓ What is the general situation of the parents and family? ✓ Are there other protection concerns or vulnerabilities?
Case planning	<ul style="list-style-type: none"> - It may not always be possible to disengage the child from working, given the difficult economic situation faced by many families in an emergency context. If this is the case, it may be more practical to focus on the conditions of work faced by the child, and work with the employer and family to encourage the child to do less dangerous work. - Counsel parents and children on Iraqi labour law and risks of working, in particular employment of a hazardous nature, long working hours and exposure to protection risks (e.g. working on the street). - Awareness raising amongst employers of Iraqi labour law, and advocacy for working conditions in line with the law (bearing in mind the safety implications for the child of approaching the employer) - Cash assistance or other material support for the child and family. - Provision of information to child and families about education and vocational training options, and referral to those services as appropriate. - Participation of children and/or families in psychosocial services including child and youth friendly spaces. - Work with the family to encourage them to re-enrol the child in School. <p><u>WORST FORMS OF CHILD LABOUR (in addition to the interventions above)</u></p> <p>Legal counselling and assistance</p> <p>Referral to DOLSA and explore BIA for alternative care arrangements, where the parent / caregiver is forcing the child to engage in WFCL.</p>

7.7 PHYSICAL ABUSE

Legal Framework

- Iraq has ratified the Convention on the Rights of the Child.
- CRC Article 19 requires states to protect children from all forms of abuse, including physical abuse.

Case management steps

Identification	Physical use of force against a child, resulting in harm and injury to the child.
Assessment	<ul style="list-style-type: none"> ✓ Details of the physical abuse – severity, location, frequency, risk of further abuse, alleged perpetrator. ✓ Is the abuse within the family? ✓ What is the parent/caregiver attitude or involvement in the abuse? ✓ Is the life of the child at risk?
Case planning	<ul style="list-style-type: none"> - Health services for injuries sustained. - Psychosocial support for the child and family members as appropriate. - Counselling for parent / caregiver on the negative impact of physical harm against the child. - When the abuse has taken place at school, counselling of teachers / school staff. - Where this is a continuing risk of abuse, develop a safety plan with the child / family. There should be a way for the child / family to contact the caseworker in the event of an emergency, or in case further needs arise. Depending on the circumstances, the caseworker may provide a phone unit for this purpose.

ABUSE RESULTING IN SEVERE HARM AND/OR TAKING PLACE WITHIN THE FAMILY (in addition to the interventions above)

Where abuse is taking place, or has taken place, within the family or care arrangement, removal from the current care arrangement may be required for the child's safety. Cases should be referred to the mandated government authority, DOLSA, who have authority to apply for protective orders for temporary guardianship. In such cases, alternative care arrangements should also be sought.

Legal counselling, assistance and representation, including an explanation of available processes and limitations. The child should be accompanied through all legal processes, by a family member and/or the caseworker if they wish.

Cases of physical abuse can be reported to the Directorate for Combatting Violence Against Women, who can refer the case to the Public Prosecutor to file a complaint against the alleged perpetrator. Where the child / family does not provide consent to file a complaint, DCVAW will still refer the case to the Public Prosecutor when the alleged perpetrator is a family member.

8.0 ENDOREMENTS

This SOP has been endorsed by the following organizations:

- ACTED
- Child Protection Sub-Cluster Co-leads
- International Rescue Committee
- INTERSOS
- Kurdistan Save the Children
- Save the Children
- STEP
- Tawa Organization
- Terre des hommes, Italy
- UNFPA
- UNHCR
- UNICEF
- War Child UK