



JORDAN

Review of Health, Justice and Police, and Social Essential Services for Women and Girls survivors of Violence in the Arab States



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Disclaimer:

The photos of women and girls used in this publication do not imply that those depicted are survivors of gender-based violence and/or have received any related services.



Acronyms

CMR	Clinical Management of Rape
CoC	Code of Conduct
DGO	Data-Gathering Organization
ER	Emergency Room
FPC	Family Protection Committees
FPD	Family Protection Department
FPU	Family Protection Unit
GBV	Gender-Based Violence
GBVIMS	Gender-Based Violence Information Management System
HIS	Health Information System
IFH	Institute for Family Health
IMS	Information Management System
ISP	Information Sharing Protocol
JNCW	Jordanian National Commission for Women
JRF	Jordan River Foundation
JRP	Jordan Response Plan
JWU	Jordanian Women's Union

LGBTI	Lesbian Gay Bisexual and Transgender
MISP	(Minimum Initial Service Package)
MOH	Ministry of Health
MOJ	Ministry of Justice
MOSD	Ministry of Social Development
NCFA	National Council for Family Affairs
NGO	Non-Governmental Organization
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PRC	Palestinian Refugee Camps
PSD	Public Security Department
PSS	Psycho-social Support
SGBV	Sexual and Gender-Based Violence
SGBV-WG	Sexual and Gender-Based Violence Working Group
SIGI	Sisterhood is Global Institute
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nation Relief and Works Agency
UN Women	United Nations Entity for Gender Equality and the Empowerment of women
WHO	World Health Organization

Context of Gender-Based Violence

In Jordan, gender-based violence is a major protection concern in a context of adverse patriarchal social norms and a massive, protracted crisis of refugees from neighbouring countries. Women and girls face domestic violence, where over a quarter (26%) of married women aged 15-49 have experienced spousal physical, sexual, or emotional violence; 21% experienced emotional violence; 18% physical violence; and 5% sexual violence. Paradoxically, 46% of married women, and more than two-thirds of men aged 15-49, consider wife-beating to be justified under certain circumstances. A great proportion (67%) of women neither sought help nor told anyone about the violence they had suffered.¹ In a sim-

ilar fashion, women refugees have been experiencing various forms of GBV, which is aggravated by displacement and loss of socio-economic support systems.

Due to the protracted Syrian crisis, women and girls comprise more than half of the refugee population in Jordan and are the main survivors of GBV in reported incidents. During 2017, 95% of survivors assisted by case management agencies of the GBV IMS taskforce were female, a trend that has been consistent over the last three years. Reported cases of violence included psychological/emotional abuse (44%); physical assault (25.3%); child marriage, predominantly affecting girls of 15-17 years (18.2%); and, sexual assault and rape (6.1%).² Women and girls ex-

¹ Department of Statistics. Jordan Population and Family Health Survey 2017-18 Available at <https://dhsprogram.com/publications/publication-FR346-DHS-Final-Reports.cfm>

² Jordan GBVIMS TF Annual Report 2017-Jordan available at <https://reliefweb.int/.../jordan-gbv-ims-task-force-annual-report-2017>

posed to various forms of sexual violence, including marital rape and sexual exploitation refrain from reporting incidents to avoid social stigma and/or because they fear possible honour killings or reprisals by perpetrators. Mandatory reporting of incidents to police and the resulting protective administrative detention of survivors under Jordanian law also serve as barriers that deter women from seeking help. In addition, LGBTI in Jordan face the threat of honour killings and overall physical and emotional violence from family members, a plight compounded by lack of protection from the authorities. The prolonged crisis and worsening socio-economic situation for Syrian refugee families in Jordan forces many to resort to child marriage as a negative coping mechanism, as daughters are perceived as an economic burden to the family. Child marriage was also a common, harmful traditional practice in Syria prior to the conflict, especially in rural areas. Some families marry their adolescent

daughters to preserve the family “honour” out of concerns that girls might engage in extramarital relationships. Families believe that actual or perceived extra-marital relationships bring shame to their families. Girls are then also at risk of forced marriage or honour killing if their families find out about extra-marital relationship³

The Jordanian Government has made a strong commitment to eliminate violence against women and girls and has gone a long way towards improving their situation. However, deeply-rooted negative attitudes towards women persist, and more will need to be done to respond to the problem, to sensitize the public, and to address the underlying causes of gender inequalities. The protracted nature of the refugee crisis in the region has greatly complicated the context of sexual and gender-based violence in Jordan, exacerbating risks and adding pressure on available services.

³ *ibid*



Review results

Health

Continuum and characteristics of services

The Ministry of Health (MOH) is the lead agency and key service provider of health care in Jordan with an institutional mandate to respond to GBV. National and international NGOs are key partners in the sector, providing a wide range of services including GBV health care to refugees and the host community. For Palestinian Refugee Camps (PRC), UNRWA provides the health response to GBV. The MOH policy commitment to address GBV is evident in its strategic plan that includes targets and

activities on early detection of violence, the formation of a steering committee on family violence, and development and implementation of internal guidelines for managing cases of GBV, including the Clinical Management of Rape (CMR) protocol. In addition, MOH has a specialised Family Protection Unit (FPU) under the Woman and Child Directorate in the Primary Health care section and Family Protection Committees (FPC) in public hospitals. Health sector NGOs also show a similar commitment to addressing GBV health priorities by providing services for refugee survivors under the Jordan Response Plan (2016-2018) and in host communities to women and girls of different nationalities living in Jordan.

GBV health services are available at national level from some comprehensive health care centres and hospitals, including emergency medical care and treatment of injuries, psychological First Aid, and sexual and reproductive health services. However, PEP, HIV and STIs testing are not routinely performed and emergency contraception is not systematically provided. Forensic medicine is available at MOH for survivors of sexual violence but the only free CMR services are offered through NGOs⁴ operating in refugee camps and in a few urban areas, including Amman. Lack of CMR in remote and rural areas results in a gap in service provision and unevenly distributed facilities. Case management and psychological support services are provided by NGOs across the country, but mental health services and MOH referrals to NGOs providing PSS services are limited, rendering services inconsistent and inadequate. Health services provided by MOH ceased to be free of charge for survivors of SGBV in 2018, following a sector policy⁵; however, a new policy in 2019 restored free services. Around one third (32.5%) of refugee survivors declined referrals to health services knowing that reporting GBV incidents to police is mandatory and fearing compliance would put them at risk of possible reprisal by perpetrators and potentially expose them to further harm.⁶ This is in addition to survivors' fear of social stigma, particularly in cases

of sexual assault and rape, where society perceives them not only as dishonouring their families but also blames and isolates them. In addition, as there is no guaranteed law enforcement measures and practical protection mechanisms available, service providers' have no assurances about their own safety either.

In order to ensure the privacy and confidentiality of survivors, hospitals equipped with family protection units make rooms available for GBV service provision. However, since the facilities are multipurpose, these safe spaces must answer to other pressing needs as well, so confidentiality requirements cannot always be accorded priority. Similarly, primary health care facilities cannot guarantee space dedicated to GBV service provision confidentiality. This limits infringe upon the rights of women and girls to privacy and confidentiality, and potentially exposes them to further social stigmatization. Among NGOs that provide inclusive GBV health services, minimum standards for private rooms are available, some being responsive to the needs of women with disabilities in terms of accessibility. Safe referral of survivors to other services within the sector is generally limited; however, NGOs that provide case management services offer safe and free transportation, as well as, accompaniment to services.

Awareness-raising materials on GBV services including IEC leaflets and posters are available at MOH facilities but are inaccessible to non-Arabic speakers. Also, a majority of women and girls from hard-to-reach and rural areas have limited access to services and information. Women and girls in southern parts of Jordan are

4 Institute for Family Health, International Rescue Committee and Jordan Health Aid Society, International Medical Corps with support from UNFPA

5 A new health policy issued by the Government of Jordan on 24 January 2018, which requires uninsured persons in Jordan including refugees to pay for health services.

6 Jordan GBVIMS TF Annual Report 2017-Jordan available at <https://reliefweb.int/.../jordan-gbv-ims-task-force-annual-report-2017>

less likely to access GBV services, as they may be unaware of their existence and/or unable to commute to locations far from where they reside. Travel costs and safety risks are barriers to accessing distance locations, especially given the cultural reservations and limitations about women's mobility in their communities. Sector NGOs have been raising awareness among women and girls, including those in refugee camps, about the availability of GBV services. NGOs have also launched community-based initiatives including home visits and behavioural change activities and campaigns in hard to access areas. These activities have been credited in part for the increasing number of disclosures over the past three years, an indication that women and girls are getting to know more about their right to seek help and how to get it. Although a joint campaign was developed in 2015 to inform communities about available services and NGOs continue to invest in outreach, there are still groups of women and girls, including refugees, who remain unaware of GBV services and/or of their right to claim them. In addition, information on CMR services and timely access is still limited.

Frontline health workers at Ministry of Health facilities and national and international NGOs have received considerable capacity-building training on treating GBV survivors. However, there is a need for continued mentorship, designed to overcome judgmental and victim-blaming attitudes and practices that are still prevalent among frontline health workers and service providers. Adverse attitudes and beliefs undermine the ability of frontline health workers and professionals to provide empathetic and ethical GBV care, re-

inforce women and girls' distrust in service providers, and discourages survivors from approaching services in the first place. In order to address some of those challenges in 2018, UNFPA and WHO partnered with GBV and SRH Working Groups to start a series of training sessions to address health service providers' adverse attitudes and build their capacity in safe referral to GBV case management agencies.

Foundational elements

GBV public health services in the sector are regulated by the MOH internal guidelines for managing GBV cases and the recently developed CMR protocol.⁷ The MOH internal guidelines are currently under review to be harmonised with the new national SOPs for domestic violence, GBV and child protection. Each specify the inter-sectoral roles and responsibilities of health service providers and other sectors in addressing GBV incidents within the NCFA National Framework for Family Protection against violence. However, implementation of the tools is inconsistent and the health sector face challenges related to lack of clarity of roles and responsibilities, scarcity of accountability mechanisms, and poor coordination with other sectors including in the humanitarian setting, all of which raise concerns about the efficiency of referral pathways. Linkages between public, national, and humanitarian referral pathways are frail where they exist. This makes them parallel rather than mutually reinforcing processes and hampers institutionalization

⁷ Clinical Management of Rape (CMR) guidelines developed under the umbrella of the NCFA with technical support from UNFPA and UNICEF in 2017.

of good humanitarian protection practices in GBV national systems.

In the Ministry of Health, the Family Protection Unit (FPU) is operated by three staff members and 12 specialised trainers. In contrast, FPCs are set up in 102 comprehensive health care centres and 32 public hospitals and operated by a total of 160 staff including a limited number of female doctors. FPCs are comprised of selected teams (emergency doctor, gynaecologist, paediatrician, forensic doctor, nurse and social worker). They provide services on a 24/7 working cycle in hospitals and for limited working hours in comprehensive health care centres. MOH selection of staff is more likely to be based on medical capacity and specialization rather than GBV standardised criteria and an assessment of readiness to handle GBV incidents. Moreover, staff are frequently rotated which can adversely affect performance. Despite training teams in safe identification of women and girls affected by GBV, disclosure and referral to PSS services remain extremely limited. CMR services are only available in 10 service delivery points run by four NGOs. Each has an equipped facility and at least one gynaecologist trained in CMR. Nonetheless, daily working hours are limited and turnover of trained staff is high requiring a constant investment in capacity building. Interruption of service provision and referral of survivors can compromise their safety and delay forensic evidence collection critical for pursuing legal action. In addition, lack of CMR services in MOH facilities is a great drawback when it comes to providing a full package of essential health services to women and girls survivors of GBV in the public sector.

The capacity of health professionals, including those in the humanitarian setting, has been enhanced in MISP for reproductive health in crises, CMR, Psychological First Aid, child protection and safe referral training, through various training courses and the IFH training centre with support from UNFPA, UNICEF, and recently SGBV-WG together with WHO.

Monitoring and complaint mechanisms in the public health sector are insubstantial which undermines efforts to address weaknesses or misconduct in GBV service provision and therefore adversely impacts the quality of GBV services and minimises service providers' accountability towards survivors. In marked contrast, monitoring of GBV services for refugees is specific and undertaken by NGO GBV service providers and relevant coordination structures to ensure quality of services for refugee women and girls. For instance, an assessment tool has been developed and used to map and improve CMR services. Despite efforts to enhance quality of GBV health services at national level, inconsistency of regulatory tools, referral pathways, and monitoring approaches in different contexts make it difficult to build a cohesive protection system for women and girls.

GBV service provision in the public health sector is provided as part of the health budget through MOH. NGOs are largely dependent on external funding from donors and UN agencies. Short-term donor-driven funding was instrumental in providing training but reliance on this approach jeopardises sustainability and reinforces a project rather than an informed programmatic approach.

Information management systems

The MOH Health Information System (HIS) does not have a specific component on GBV and the ministry does not have a national register for recording GBV cases in the public and private sectors. In fact, suspected cases of GBV arriving at ER and healthcare centres are not necessarily classified as GBV, but rather registered as regular patients regardless of the context. This makes it difficult to separate and categorize incidents and derive trends. Nevertheless, there is a way to collect data since FPCs record GBV cases separately and send data for aggregation at the central level. Information concerning survivors is collected manually, using standard forms customised to health sector needs, then sent by fax machine to FPU at central level to be entered and consolidated electronically. Meanwhile, survivors' paper reports are kept in cabinets in the unit. FPU reports generated on GBV are shared with the MOH steering committee on violence. However, reports do not always adhere to set procedures and may not be regularly shared with the MOH, and as such these inconsistencies are detrimental to the quality and availability of GBV data. Most importantly, protection of data and confidentiality of information throughout the process is minimal, considering that the coding is not confidential, and the likelihood of unauthorised persons gaining access to paper-based reports or even computer reports cannot be ruled out. In such circumstances, this can compromise survivors' safety and potentially aggravate stig-

ma. Nevertheless, the newly developed national SOPs for domestic violence, GBV, and child protection have been designed to address many of the existing gaps, including an incident classification tool and standardised forms, which are to be implemented in 2019. In addition, a national tracking system that combines data on national and non-national GBV survivors is currently being piloted in El Bashir Hospital.

On the other hand, data on GBV incidents among refugees and the host community are being collected using GBVIMS, consolidated and analysed by the GBV IMS taskforce chaired by UNHCR and UNFPA. Five DGOs engaged in GBV response nationwide have been using GBVIMS since 2015 where tracking and reporting tools including incident classification are standardized and "anonymized". The DGOs,⁸ members of the taskforce, and signatories of the Information Sharing Protocol, safely collect, store, analyse and share data on GBV incidents at all levels. Trends in the collected GBV data are mainly used to inform programming and advocacy. A yearly report is widely shared with information on trends while upholding strict confidentiality and ethical standards for data management.



⁸ DGOs include IFH, NHF, IRC, JWU, and JRF with support from UNHCR, UNFPA and UNICEF

Justice and police

Continuum and characteristics of services

Strengthening the legal framework for protection of women and families from violence in Jordan has reinforced the role and authority of law enforcement actors in the police and justice sector to address GBV. This has been demonstrated in amendments to the Penal Code such as criminalising rape, eliminating exoneration of perpetrators who marry their survivors and mitigating measures for honour crimes. Similarly, amendments to the "Protection from Domestic Violence Law" broadened police and judiciary authority to provide protection services for survivors of GBV including the assignment of specialised judges to fast-track courts for urgent domestic violence cases.⁹ Examples of the long-standing commitment of the Public Security Directorate (PSD) and the MOJ to deal with GBV include the establishment of the police Family Protection Department (FPD) to handle domestic and sexual violence, and the recently created Legal Aid Department within the MOJ. However, full implementation of the legal framework is held back because survivors are often referred to family reconciliation committees before taking any protective or legal measures. Another much-used option to avoid legal proceedings involves turning

to protective administrative detention for women at risk of GBV or honour killing (as per Crime Prevention Law).

FPD and law enforcement actors in the police and justice sector provide a wide range of prevention and response GBV services, such as investigation and follow-up of cases, safety and security, legal and judicial support, access to safe shelters and psycho-social services, forensic services and referrals to other sectors. FPD has a national geographical coverage and a toll-free help line for reporting GBV incidents in addition to charge-free services intended to enhance availability and accessibility of services for women and girls. However, survivors of GBV are sometimes treated with disrespect and scepticism by police, security personnel, and administrative governor's employees. They are often blamed for the violence they experience. All of this deters women and girls from reporting GBV incidents.¹⁰ In addition, police and prosecutors often encourage women to accept mediation and to reconcile with perpetrators, rather than pursuing legal proceedings. This institutional culture reflects dominant patriarchal social norms that are biased in favour of family reconciliation mechanisms even though they are seldom fair to women and girls, in preference to helping them pursue their rights through the judicial process. Those women who do opt to take their cases to court face a costly litigation process or must take their chances with the limited availability

⁹ UNDP, 2018, Jordan Gender Justice, Assessment of laws affecting gender equality and protection against gender-based violence

¹⁰ Jordanian Coalition for Shadow Report. The Jordanian CEDAW Shadow Report. Submitted to CEDAW Committee, 66th Session. Jordanian Women's Union 2017

of legal aid and court representation. The MOJ restricts free legal assistance to cases authorised by Criminal Procedure Law.¹¹ The paradox here is that the judicial council created a team of specialised judges to handle fast-track litigation for urgent cases of violence in order to ensure women get greater access to speedy protection measures and safety. Conversely, access remains limited for vulnerable groups such as migrant domestic workers and elderly women, as well as, LGBTI. Women who are disabled face the challenge of accessing physical settings that are non-user-friendly in addition to the limited capacity of service providers to offer required support and protection.

On the other hand, semi-governmental and NGO services for nationals, refugee women, and girls who are survivors of GBV include free legal aid, mediation and court representation, referral to social, psychological assistance and rehabilitation, awareness-raising and information-sharing. NGOs have become critical providers of free legal aid in Jordan. They have mobile teams for legal support and deploy specialized lawyers in women and girl's safe spaces in refugee camps. Although this brings services closer to vulnerable women and girls and offers greater access to legal services, demand outstrips availability. Furthermore, the availability of GBV services does not necessarily ensure that refugee survivors will make use of such services. For instance, 87% of reported cases among refugees declined refer-

ral to security services, fearful of possible reprisals by perpetrators and the stigma arising from lack of confidentiality plus victim-blaming attitudes common among service providers. Additionally, many had real fears of deportation or losing custody of their children.¹² Once the prosecution process gets underway, protective measures, such as FPD police escorts, are available for referrals to other services and court sessions to ensure the safety of survivors and witnesses of GBV. However, no such measures are in place for women and girls who are referred to reconciliation committees, an omission which potentially puts them at risk of further harm. When it comes to their overall role, it is not clear if law enforcement personnel have been subject to any threats to their safety.

A majority of survivors and at risk groups of women and girls do not know about the services or their right to receive them, despite efforts by police and law enforcement actors and NGOs to inform the, about available GBV and health services through awareness-raising campaigns. In addition, sensitization activities and training sessions have been implemented to address judgmental attitudes of service providers in the police and justice sector. However, they remain inadequate and have had limited impact on behavioural change among service providers bearing in mind the lack of regular monitoring and assessment of staff work and readiness and effective accountability mechanisms.

11 UNDP, 2018, Jordan Gender Justice, Assessment of laws affecting gender equality and protection against gender-based violence

12 Jordan GBVIMS TF Annual Report 2017-Jordan available at <https://reliefweb.int/.../jordan-gbv-ims-task-force-annual-report-2017>

Foundational elements

FPD GBV services are regulated by its own internal operating guidelines for dealing with women and girls survivors of GBV. As with the health and social development sectors, the internal guidelines are currently under review as part of efforts to harmonise them with the new national SOPs for domestic violence, GBV and child protection that spell out the inter-sectoral roles and responsibilities of the three sectors when it comes to addressing GBV incidents within the NCFA National Framework for Family Protection against violence. In addition, FPD has a Code of Conduct that sets an ethical basis for FPD staff behaviour with survivors of GBV. The Judicial Council, meanwhile, adopted guidelines for judges on how to respond to cases of violence against women. NGOs providing GBV services to refugees follow humanitarian UN and international standards in their work.

FPD provides GBV services over a 24/7 working cycle in all governorates. These are operated by teams in which females account for around 45% of the workforce. These services are located in separate premises, geographically accessible to women and girls, but challenging for women with disabilities and elderly women. FPD centres have private rooms for interviewing survivors of GBV to ensure confidentiality and safety of women and girls. Staff are regularly trained in house on responding to GBV incidents including international standards, SOPs, sensitivity and confidentiality issues and the newly established GBV data tracking system. Service providers' capacity varies considerably and frequent rotation of FPD officers adversely affects the qual-

ity of FPD team service delivery making targeted specialised capacity building all the more essential. On the other hand, the High Judicial Council appointed 107 judges specialised in litigating urgent GBV cases across Jordan and has already trained 80 judges on the GBV guidelines. The Law on Protection from Domestic Violence enables judges to hold special sessions on evenings and holidays, which extends their working hours and ensures uninterrupted service provision within the sector. Nonetheless, law enforcement agencies and judicial institutions lack training and sensitization on gender issues. Also, women are poorly represented in the judicial system, with females accounting for only 19% of all judges.¹³

Roles and responsibilities among service providers in the FPD police and justice sector are clear, although not fully defined in relation to the other two sectors. The lack of adequate performance monitoring and accountability mechanisms adversely influences service quality and improvement of service provision, such as posting police officers in refugee camps. These omissions add to the risks survivors already face and aggravate the distrust women and girls have about the formal justice system.

The budget of the FPD is part of the overall PSD allocated budget and does not cover FPD's emerging needs. To try and offset this, international NGOs, UN agencies, and donors contribute to developing police and justice sector capacity in GBV service provision, including that of the FPD.

13 UNDP, 2018, Jordan Gender Justice, Assessment of laws affecting gender equality and protection against gender-based violence

Information management systems

The police and justice sector lacks a central registry for GBV data similar to the other two sectors. The FPD is, however, mandated to gather information on all reported incidents of domestic violence and sexual assault. Accordingly, FPD staff collect data manually, using standardised forms, which have been adapted to meet the data needs of the police. These are eventually entered in the electronic database of the Public Security Directorate. Since it is not clear if the data is coded or precisely which personnel are authorised to access the paper-based reports, sensitive data remains accessible to all using the system, a disturbing factor that increases the risk of breaching privacy and confidentiality and therefore threatening the safety of survivors. Collected data is shared with other law enforcement actors as well as partners in the other two sectors, but the quality of data gathered from different sources in the sector varies considerably. FPD staff capacity leaves much to be desired in terms of data collection and protection and ISP is lacking. Other law enforcement actors, including prosecution and judiciary, maintain their systems in the sector's own records, contributing to further fragmentation and adding to the challenge of creating an integrated data system that would allow for effective tracking of survivors. The aim is that successful implementation and roll out of the Family Violence Tracking System will serve to address this gap.

FPD uses data mainly to inform service delivery and referral of survivors to the other two sectors, but rarely for policy/strat-

egy development or programme design. This indicates how limited capacity is in generating essential information and vital input to help the work of the FPD evolve. The absence of a standardized data collection format and data sharing methodology among service providers in the police and justice sector compromises data quality when shared, thus interfering with interagency analysis and making it difficult to derive trends and inform policymaking and programming at sectoral and national level. However, the hope is that the newly developed national SOPs for domestic violence, GBV and child protection will provide a basis for using standardised forms across sectors, including FPD, and this will generate improved capacity in data management.



Social services

Continuum and characteristics of services

The Ministry of Social Affairs (MOSD) has the mandate to provide social protection and GBV prevention and response services to women and girls survivors of violence. The commitment of the ministry can be seen in the Communication Strategy on Gender-based Violence (2015-2025) it has unfolded, its lead role in the drive to ensure sheltering service in the country, and in the gender unit and family protection directorates it has set up to address GBV-related services for women and children. Moreover, the SGBV-WG's lead role in coordinating GBV prevention and response services carried out by NGOs and UN agencies for refugees and affected host communities is underlined in the Jordan Response Plan for the Syria Crisis 2016-2018. Also, the Jordanian National Commission for Women JNCW has committed to provide legal and social services through its Sham'a Network.

MOSD, in collaboration with JNCW, JWU and sector NGOs, and the UN, provides a wide range of social services for women and girls survivors of GBV. These include protection, psycho-social and legal counselling services, shelters, round-the-clock, toll-free child protection and GBV helplines, and economic empowerment and referrals to other sectors. The services offered are free of charge, available at national level and also cater to the refugee population. Admittedly, some vulnerable groups have

only limited access (if any) to these services – among them, women with disabilities, the elderly, and LGBTI. Other than mandatory reporting of GBV incidents to police, FPD discourages women and girls from reporting violence, aware that they may not wish or choose to do so out of fear of the social stigma associated with referral to shelters and the often judgmental attitudes of service providers prone to indulge in victim blaming.¹⁴ The ministry runs five dedicated shelters for FPD-referred survivors of domestic violence. There is a strict entry policy that does not allow the shelter to accommodate boys older than 5 years, thus making it inaccessible to women with older male children. This policy denies many other vulnerable and at risk groups of women and girls the haven and safety of such accommodation services. The shelters provide vital social services to protect survivors on a temporary basis for up to six months. This can be extended in cases where the subject's safety continues to be at risk. However, the services lack effective reintegration plans and provide slim opportunities for economic enablement of women and girls. The Jordanian Women's Union (JWU) runs two shelters for survivors of sexual violence and human trafficking, which provide protection, counselling and rehabilitation services and include nine service delivery points in their centres.

Access to sustainable livelihoods continues to be difficult for refugee women with 9.3% of survivors unable to access livelihood services due to their total unavailability. Meanwhile, 39.9% declined

¹⁴ GBVIMS TF Annual Report 2017-Jordan available at <https://reliefweb.int/.../jordan-gbv-ims-task-force-annual-report-2017>

referrals to livelihood interventions that were deemed difficult to access because the absence of safe transportation alternatives left them at risk of sexual harassment if forced to use public transport.¹⁵

MOSD does provide GBV case management and referral services through child protection committees and temporary therapeutic centres for protection and rehabilitation of child survivors. Also, there are legal provisions and procedures in place to protect the safety of survivors when receiving services. However, once they have reported GBV cases, social workers and service providers are at risk of harm and reprisal by perpetrators since there are no legal frameworks or other mechanisms to protect them from such events.

UNRWA also provides essential GBV services for vulnerable groups of women and girls in the Palestinian Refugee Camps through six case management and referral pathways. Other UN and key I/NGOs provide broad GBV case management services and other empowerment and prevention activities through different service delivery units, both static and mobile. UNFPA supports key national and international partners in providing case management through safe spaces. These include reproductive health, psycho-social support, legal services, livelihood training, and, in a few locations, income-generating activities and cash assistance. One NGO is running a 24-hour, free hotline service. It also undertakes early interventions to mitigate risks and ensure the safety of women and girls. Safety of survivors of GBV in Syrian refugee camps is ensured through

risk assessment, safety planning, and mitigating risk factors at camp sites. Periodic safety surveys of camp and non-camp sites are carried out to reduce risk of GBV. In addition, case management agencies in safe spaces maintain the confidentiality and privacy of survivors by adhering to the Case Management Minimum Standards and Guidelines when interviewing and providing services to survivors of GBV. To ensure this, they use private rooms and deploy same sex case managers upon need. Again, service providers' safety is limited, although GBV case management agencies have installed safety measures. SGBV referral pathways are available in different locations and SGBV WG has developed an application called Amaali to disseminate information about its availability.

Extensive prevention efforts by GBV services in the social sector have targeted communities and vulnerable groups of women and girls. These include various national campaigns to mark special events such as "16 days of activism" and International Women's Day by highlighting issues of national relevance ranging from child marriage to sexual violence. National campaigns are driven by JNCW and SGBV WG. UN Agencies, national and international NGOs, and local women's Community Based Organizations (CBOs) organize awareness-raising activities featuring religious leaders and community-based prevention activities with emphasis on the involvement of men, boys, volunteers and youth. In addition, the MOSD Communication Directorate has implemented awareness-raising lectures and sessions at governorate level. Information, Education, and Communication (IEC) materials draw-

ing attention to available services were specifically designed and disseminated to women and girls at service delivery points including those situated in refugee camps. These efforts notwithstanding, some women and girl survivors and at risk groups, including those inside refugee camps, remain unaware about these services and/or their right to receive them.

Attempts to counter adverse attitudes among service providers towards GBV survivors have included specialised training on how to deal with GBV "clients", on the existing Code of Conduct about responding to GBV, as well as on strengthening capacity in case management and referral of survivors. While the intention is commendable, the reality falls short of raising both the competency and readiness of MOSD service providers to the required level in order to deliver GBV services in full. This is partly attributable to the fact that some MOSD staff lack qualifications in social work specialization and is compounded by the high turnover of trained service providers.

Foundational elements

GBV services in the social sector are currently guided by the Inter-Agency Emergency SOPs for Prevention and Response to Gender-Based Violence and Child Protection which were scheduled to be replaced by new, updated SOPs in late April, for which training has been launched already. Despite the fact that the SOPs define roles and sector responsibilities, case management and inter-sectoral referral responsibilities continue to lack clarity, which is why MOSD is to develop internal

guidance. The new SOPs assign case management role to FPD in collaboration with others, including MOSD social workers.

Unlike hospitals, the police FPD, hotlines and shelters, MOSD, local NGOs and specialised GBV stakeholders provide services to women and girls survivors of GBV within limited working hours. This curtails after-hours service provision and referral of survivors and potentially exposes them to further harm. Few UN agencies and NGOs have service providers available on call. MOSD services are provided by 147 social workers including 120 female staff through 19 social service offices within FPD, as well as five shelters and other family protection services at governorate level. The ministry signed a protocol with police FPD to regulate referral and follow up survivors of domestic violence. The number, infrastructure and accommodating capacity of shelters are relatively limited and their policy is restrictive. In addition, around 40 NGOs and UN agencies, members of the SGBV-WG, provide GBV support services to refugee population including five NGOs that provide specialized case management services for survivors of SGBV. Workforce size varies among the different case management NGOs, but minimally they operate within teams composed of a case manager or a psychologist, a community volunteer for outreach, a PSS worker and, if applicable, a centre manager.

JRF and MOSD staff have given regular trainings to GBV service providers of MOSD and humanitarian NGOs in SOPs for GBV and Child protection. However, MOSD staff training is not mandatory for service providers responding to GBV

¹⁵ *ibid*

cases. Indeed, selection criteria for trainees are unclear. Moreover, the absence of monitoring frameworks and accountability mechanisms means that the benefits and impact of training on staff performance are not tracked. In effect, quality control of GBV service is rather general and part of the MOSD overall monitoring and evaluation system. For instance, JRF assesses the MOSD social services while the National Centre for Human Rights monitors sheltering conditions and whether survivors are provided venues for complaint.

Inception training is mandatory for most NGO GBV service providers. In 2018, SGBV-WG disseminated and promoted a competency framework to standardize recruitment and capacity development of GBV providers and managers. In addition, case management NGOs use feedback forms and client satisfaction surveys to ensure quality of services and accountability of service providers. A toolkit for inclusion of people with disabilities in SGBV services was developed in Jordan, and a few NGOs trained their staff accordingly, but it has yet to become standard practice.

Since the MOSD budget for GBV protection is very limited, the ministry seeks external funding to support some of its GBV programmes and activities, but the uncertainty of relying on outside sources renders these programmes unsustainable. Similarly, the GBV sector is subject to recurring funding gaps for GBV-related activities because it is so dependent on external funds channelled through the JRP. Intermittent funding makes budgets for strengthening the protection on offer from the GBV system rather limited and unpredictable and

consequently reinforces a project rather than a programmatic approach to addressing GBV issues.

Information management systems

The information system in the social sector is underdeveloped and lacks a central database for GBV. MOSD service providers and social workers collect GBV data manually using customised forms and prepare survivors' reports at governorate level. Sharing data is regulated by the National Framework protocols but is inconsistently implemented by service providers, which undermines data management ethics and raise concerns related to confidentiality and data security and protection.

Under the umbrella of the Syria refugee crisis, an information management system was established with five DGOs using GBVIMS to report GBV incidents, standard tools to produce periodical reports, and a GBV dashboard in line with international standards, with support from UNFPA and UNHCR. The DGOs effectively and safely collect, store, analyse and share data about reported GBV incidents in line with ISP. Data is collected at field level and aggregated at national levels where trends are analysed and used to reinforce coordination and inform programming and advocacy. Nonetheless, DGOs do not have full coverage of served communities knowing that GBVIMS is an interagency initiative in a humanitarian setting that does not involve government.

Lack of harmonised tools and approaches

in data collection and the absence of systematic consolidation at sector level adversely affect the quality of data generated and restrict sectors' ability to analyse and derive trends to inform programmatic interventions. Furthermore, this divergence is most likely going to continue once the anticipated national tracking system and its SOPs are launched. Due to different incident classification criteria, the humanitarian GBVIMS and the national information systems will remain disconnected. This will jeopardise sustainability of the former in the long run and restrict the capacity of the latter to generate comprehensive national GBV data on all persons residing in Jordan. If MOSA capacity is to be developed and strengthened, it is vital to focus on learning from GBVIMS experience about safe data management and to advance national systems rather than to continue running parallel processes.



Coordination and governance of coordination

Several coordination and interagency forums in Jordan work at different levels to combat GBV in development and humanitarian settings including governmental, civil society organizations, and international and UN agencies. At national level, three significant entities in Jordan shape GBV protection policies, programmes and services: the Jordanian National Commission for Women (JNCW), the National Council for Family Affairs (NCFA), and the National Centre for Human Rights. JNCW is the official national monitoring mechanism on women's rights and its network for combating violence against women (Sham'a) providing legal and social services; NCFA is the national lead on issues related to domestic violence and coordinates a multi-agency task force for preventing and responding to domestic violence and sexual abuse; and the National Centre for Human Rights has a complaint mechanism for human rights' violations including GBV. In addition, there are the national task forces and ministerial steering committees. These entities demonstrate the nation's commendable interest and commitment to combatting GBV against women and girls

These national coordination mechanisms have generated notable outcomes in terms of GBV policy and legal frameworks including the Law for Protection from Domestic Violence, the National Strategy to Combat Violence against Women (2014-2017), and the 2016 updated National Framework for Family Protection against Violence,

with its multi-sectoral SOPs for domestic violence, GBV and child protection. However, partners in the three sectors emphasized **lack of coordination in service provision as well as limited understanding of sectoral responsibilities and therefore accountabilities across sectors.** Other coordination mechanisms are largely humanitarian with a specific focus on the Syrian refugee population under the JRP that includes SGBV WG and its GBVIMS Task Force, as well as the Child Protection Sub-Working Group. These structures are chaired by UN agencies - mainly UNFPA, UNHCR and UNICEF - in collaboration with government stakeholders. A child marriage taskforce chaired by NCFCA has been established to provide limited follow up on the national strategy to combat Early and Force Marriage.

The humanitarian coordination mechanisms for protection of women and girls from GBV encompass a wide range of national and international NGOs that have managed to develop standardised multi-sectoral guiding policies and protocols, SOPs, case management, referral pathways, and GBVIMS. **Nevertheless, they tend to pursue a parallel path with national GBV coordination platforms resulting in limited engagement in advocacy, awareness-raising.** Coordinated efforts have enabled member organizations, including the government, to implement effective national awareness-raising and behavioural change campaigns against early marriage and to combat abusive behaviour, as well as participate in the "16 Days of Activism" campaign against GBV. Other key achievements resulting from the coordination process include setting up the GBVIMS in data-gathering NGOs and

the development of SOPs. **However, overall use of GBVIMS remains limited and separate from the sectoral information systems mechanisms of in the MOH, Police and Justice and Social Development sectors.**

SGBV-WG enhances the technical capacity of member organizations and monitors their commitment and investment in a coordinated response against set indicators in periodical meetings and through multi-level reporting mechanisms, in addition to the annual performance appraisal of SGBV-WG members. **However, national coordination platforms continue to lack clear monitoring and evaluation mechanisms and there is a persistent gap between required GBV interventions and individual sector's technical and financial capacities to fulfil tasks assigned to them in the coordination process.** Humanitarian coordination mechanisms are largely dependent on donor funding, which is relatively short term. Likewise, national coordination forums have limited access to national budgets and donor funds, which puts a limit on their ability to fulfil long-term mandates and build national GBV programmes and necessitates them having to rely on a project approach that is of more limited duration. Thus, while acknowledging the limited linkages between national and humanitarian coordination mechanisms, it remains vital to build the capacity of relevant ministries leading GBV coordination to enable gradual nationalization of the processes and ensured sustainability. Despite recognition of these shortcomings, too often, humanitarian and development coordination mechanisms remain separate and parallel.



Conclusion

The Government of Jordan's long-standing commitment to address GBV continued to be evident in the recent evolution of legal frameworks that criminalise violence against women, children and families, and in sustaining its support for national bodies and advancing policies to combat violence, including its emergency response to the Syria crisis. However, inadequate synchronisation of policy frameworks, roles and responsibilities of government and NGO entities, as well as, a scarcity of resources and necessary capacities, undermine full realisation of the national system for protection from violence. Moreover, there is a potential overlap of mandates from various national entities. The commitment of government and the aid community can

be seen in the Jordan Response Plan that guides the humanitarian GBV prevention and response effort for displaced Syrian women and girls, keeping in mind that these policy steps have limited sustainability.

The MOH, in keeping with its institutional mandate to address GBV, has established specialised committees in health facilities and developed internal guidelines and a CMR protocol to guide service provision. However, PEP, HIV and STIs testing are not routinely performed, emergency contraception is not systematically provided, and CMR services are mainly located in urban areas and provided only by NGOs. MOH services are free of charge, including for refugees, but users are bound mandatorily

to report to the police, and mental health assessment is limited, rendering services less accessible and uneven. Moreover, safety of service providers as well as survivors is not guaranteed in health facilities. Private spaces for GBV service provision do not exist in primary health care facilities and their working hours are limited, a combination which denies women and girls their right to privacy and confidentiality and potentially exposes them to further social stigmatization. The police and justice sector has specialized Family Protection Departments (FPD), specialised judges, and fast track courts to handle urgent GBV cases. FPD provides free security and protection GBV services on a 24/7 work basis at national level. However, entrenched bias found in the patriarchal attitudes of many service providers pre-disposes them to direct women towards traditional modes of resolution for GBV-related situations that tend to pay more attention to the demands and concerns of the family and husbands than to the actual rights of the women who have been victimised. This propensity only serves to discourage women and girls from approaching GBV services in the first place.

Access to legal aid is limited for vulnerable groups of migrant domestic workers, elderly women, LGBTI, and women with disabilities well. The costly litigation process is a further impediment for survivors seeking access to justice. NGOs became critical providers of free legal aid in Jordan using mobile teams and specialized lawyers in women and girls' safe spaces in refugee camps. GBV survivors and witnesses are protected once the prosecution process gets underway. This does not apply if the case is referred to reconciliation

mechanisms, an alternative that may even expose survivors and witness to further harm. Conversely, protective administrative detention for women at risk of GBV or honour killing strips them of their right to liberty. In light of this, offering sanctuary in temporary safe shelters is an improvement provided the women retain their right to mobility. On the other hand, MOSD and numerous NGO stakeholders provide a wide range of GBV specialised services free of charge at national level, mainly in safe spaces to vulnerable groups including Syrian refugees. However, these services are inaccessible for women and girls with disabilities, elderly women, and LGBTI. At-risk groups do not approach services that demand mandatory reporting to FPD while some are denied access because shelters operate a strict entry policy that leaves many vulnerable groups of women and girls underserved. Moreover, economic enablement and livelihood opportunities for women and girl survivors and the services available to them are very few and far between and difficult access when they do exist. Once social workers and service providers report GBV incidents, they have no assurances about personal safety since there are no measures or mechanisms in place to protect them.

Inter-agency national tools guide GBV services in the three sectors, yet the implementation of case management and inter-sectoral referral responsibilities is inconsistent among the sectors - a failure which adversely affects both the quality of services and the accountability of service providers. New national SOPs are anticipated to remedy this issue, but they too are flawed since they are incompatible with the humanitarian interagency regulatory tools

and therefore they sustain discrepancies and parallel processes. The limited working hours of services in the three sectors, with the notable exceptions of FPD, hospitals, JWU hotline, and UNCHR on call, remain a barrier for referral of survivors after official working hours and jeopardise client safety. The propensity of most service providers to be judgmental and indulge in victim-blaming despite being trained not to combined with the frequent rotation of personnel which limits their capacity and ability to provide confidential, empathetic and ethical GBV care impedes survivors' access to services. Unlike in humanitarian setting, monitoring and complaint mechanisms are either lacking or do not have specific components to address weaknesses or misconduct in GBV service provision, which minimises their effect in improving GBV services and reinforcing accountability of service providers towards survivors. Advancement of GBV service provision in the three sectors is largely dependent on external funds from donor and UN agencies. This makes sustainability all the more difficult to attain and reinforces a project rather than an informed programmatic approach. The Information Management Systems (IMS) in the three sectors are underdeveloped and are neither standardized nor harmonised in terms of data collection tools and information-sharing mechanisms. Protection of data and assuring the confidentiality of information throughout the process is minimal at best. This is a main factor preventing the generation of reliable and standardized national GBV data. For instance, information management systems in the health sector are customized to sectoral needs, and in the absence of a specific GBV component, many

incidents are recorded without distinction making it difficult to isolate incidents and track survivors. GBV data-gathering organizations in the sector use GBVIMS and ISP, which undoubtedly improved GBV data collection and reporting in the humanitarian context. However, the coverage and use of GBVIMS remains limited and isolated from sectoral information systems and reporting mechanisms, which adversely affects the quality of the GBV data generated, and interagency information-sharing and analysis.

Coordination mechanisms exist at all levels for both national and humanitarian GBV work, yet they run on parallel paths, lacking the necessary linkages and vary in their capacities and standardization of coordination processes. They also suffer from limited financial resources. Joint efforts in some national advocacy and behavioural change interventions have achieved visible results for policy and legislation reforms and generated open dialogue on a few GBV thematic areas, including child and early marriage. However, national and humanitarian information management systems for GBV vary considerably and remain separate from each other. Sectoral information systems are still under-developed and in need of improvement if they are to help set up a national central information system for GBV capable of providing national data on vulnerable groups of women and girls, including the refugee population. GBVIMS is not a national system nor is it linked to an existing one, and as such cannot be sustained as is. The absence of a national coordination POA for all GBV actors reinforces fragmentation and hampers accountability.



Recommendations

National level

- To develop and enhance tangible **enforcement mechanisms of existing GBV-related legislation, particularly the recently enacted “Protection from Domestic Violence Law”** and the amended Penal Code, **national policies, strategies and protocols** (i.e. by-laws, sector-specific guidelines, SOPs, tangible action plans and standardized capacity-building/training etc.)
- To advocate for **GBV-sensitive national planning and budgeting** to ensure implementation of sectoral GBV man-
dates and reinforce partnerships with relevant national and international organizations and donors
- To further develop **partnerships with credible faith-based organizations, religious scholars and community leaders**, and institutionalize these partnerships by producing joint guidance documentation at country level for combating GBV
- To **integrate GBV humanitarian successful practices in national GBV sectoral systems** to reinforce national capacity and ensure programme sustainability

Common to the three sectors

- To **advocate** at all levels for waiving **mandatory reporting for adult women** from a human rights’ perspective – a violation of the basic right of choice, **capitalizing on the newly enacted law against violence** as basis for legislative review
- To **reinforce prevention efforts and** raise public awareness of the availability of GBV services (particularly among at risk groups of women and girls) and to combat **adverse attitudes of service providers** by including GBV service provision in job descriptions and performance evaluations as relevant. Additionally, to develop standards for selection of GBV staff and assessment of their readiness to work with women and girls survivors
- **To increase the number of female frontline service providers** and professionals in GBV service provision, particularly in the health, police and justice sector coupled with gender-biased recruitment and female staff advancement policy
- To **standardize implementation of the inter-agency GBV SOPs and referral pathways** across sectors **and train GBV frontline workers accordingly** with clear guidance for roles, responsibilities and **accountabilities** in the three sectors
- To prepare a **consolidated multi-sectoral capacity-building plan** for the sectors that is responsive to each sector’s immediate training needs and to the required knowledge and skills for collective work by prioritizing integrated GBV case management and referral through collective training sessions.
- To **explore gradual extension of limited working hours** of GBV service provision to reach a 24/7 cycle using a round-the-clock shift system and assigning on-call staff nationwide
- To **devise strict performance monitoring mechanisms** to ensure quality of GBV services and **accountability mechanisms** in cases of under-performance or misconduct i.e. complaint mechanisms and disciplinary measures
- To develop **protection mechanisms for both survivors and GBV service providers** that include risk mitigation measures and on-call protection teams from law enforcement personnel and community leaders and influencing bodies
- To **standardize GBV data reporting mechanisms and information management systems** in the three sectors - including a standardized component for GBV data, **information-sharing guidelines and tracking mechanisms**
- To make GBV services across sectors **accessible for women and girls with disabilities using national tools and best practices** available in the country

Health

- To implement the developed **strategy to rollout the CMR protocol in the public health sector** as a priority to operationalize CMR service delivery in health facilities in all governorates
- To undertake a **review of the structure and function of the FPU at hospitals** and consider reforms necessary for optimal function and sustainability
- To undertake a **review of the medical and nursing curricula** and explore ways to incorporate training **modules on GBV health service delivery** in medical training and continuous education interventions for medical and health staff
- To **reinforce mental health service provision** and referral for GBV survivors potentially by outsourcing and subsidizing services

Justice and Police

- To undertake a **review of legal provisions** in other laws that might be **contrary to** Protection from Domestic Violence Law and amended Penal Code, **and advocate for annulment of such provisions coupled with a justice sector policy that ensures the superseding authority of the newly enacted laws** over other laws in cases of GBV
- To **explore creating mobile MOSD teams capable of providing GBV ser-**

vices to women and girls in rural, remote and hard-to-reach areas, in addition to looking into the feasibility of creating **community-based security initiatives** in these areas

- To **set up specialized prosecutors** for handling GBV cases and to build their capacity and that of lawyers in general in litigation of GBV cases of women survivors and to reinforce availability of free legal aid
- To **reinforce the capacity of NGOs'** mobile teams **providing free legal aid** to reach rural and hard-to-reach areas and unserved vulnerable groups

Social Sectorw

- To develop an **inclusive strategy and guidelines for sheltering services** for protection of survivors of SGBV and at risk groups **without discrimination**, including for **safe housing services** replacing administrative detention, coupled with a phased action plan and fund-raising mechanism.
- To undertake an **action-oriented assessment of the MOSD role in case management** with the aim of defining clear roles and responsibilities and to **develop a capacity- building plan** to enable the ministry to provide competent survivor-centred GBV services
- To **reinforce economic enablement and livelihood skills programmes** for survivors through inclusion of vulner-

able women and girls in MOSD social protection schemes and the livelihood programmes of other sectors and to explore partnerships with women micro-financing programmes, banks and private sector businesses, as feasible

Coordination and Governance of Coordination

- To **reinforce harmonization and integration** of GBV work among relevant **national entities** through a **short-term strategy to converge GBV coordination mechanisms** with potential for amalgamation of coordination efforts under a single body
- To **build the capacity of sectoral ministries in leading GBV coordination mechanisms in the sectors** to enable gradual **nationalization of the processes** and ensure sustainability
- To **build the capacity of member stakeholders**, government and NGOs, in specialized GBV- related skills and knowledge required for effective collective functioning in humanitarian and development settings
- To **develop a national information system/observatory** for violence against women and girls, based on agreed national and sectoral indicators in order to create official data on GBV, evidence for targeted advocacy and awareness-raising efforts





Country Summary

Country:

Jordan

The colour-coded tables are used to indicate the **level of effort and support required** to strengthen GBV services to attain the standards set by the Essential Services Package. In no way should they be interpreted as a reflection of the type or quality of services provided in a country.

■ **Red** means **major efforts** are needed to strengthen the capacity of GBV ser-

vices since few or no programmes/services are available, or that access to these services is extremely limited. Red can also mean that response systems in place are not victim/survivor-centered

■ **Yellow** means **moderate efforts** are needed where some limited interventions/services are available.

■ **Green** means **very limited efforts** are needed since GBV services are in place that are closer to ESP standards but that capacity and quality need to be maintained and strengthened.

Law criminalising violence against women and girls	■	Jordan has a law that criminalises domestic violence		
Review questions	H	J&P	SS	
Continuum and characteristics of GBV services				
Policy and legislative frameworks	■	■	■	<ul style="list-style-type: none"> MOH institutional mandate to address GBV, CMR protocol exist; enforcement capacity to be enhanced Long-standing commitment of police FPD; current legal framework improved notably MOSD enforcement of policies to be enhanced
GBV specialized units/teams for provision of GBV services	■	■	■	<ul style="list-style-type: none"> MOH has specialized FPU and FPCs Police FPD exists, specialised judges, lack of GBV specialised prosecution MOSD FP Directorates
Availability of GBV services	■	■	■	<ul style="list-style-type: none"> Mental health services are constrained, PEP, HIV and STIs testing not routinely performed, emergency contraception not systematically provided CMR services do not exist in MOH facilities, provided by a limited number of NGOs Legal aid services inadequate; protective administrative detention of women at risk of GBV or honour killing; safety measures do not exist if referred to reconciliation mechanisms Lack of effective reintegration plans and limited economic enablement opportunities
Geographical coverage and vulnerable groups	■	■	■	<ul style="list-style-type: none"> Geographical coverage at national level for the three sectors; however, some vulnerable groups are either under- or un-served (WWD, LGBTI, elderly women, etc.) CMR services are urban based
Accessibility of GBV services	■	■	■	<ul style="list-style-type: none"> The institutional culture in three sectors predominantly judgmental reinforcing stigma and victim-blaming Many women and girls do not know about the existence of services in the three sectors Services are free of charge for all GBV survivors but tied to mandatory reporting to police Sheltering services have strict entry policy Limited access to legal aid - costly litigation process - reconciliation encouraged over litigation
Risk assessment and safety planning	■	■	■	<ul style="list-style-type: none"> Health sector lacks protection mechanisms to maintain safety of GBV survivors and service providers; safe referral of survivors to other services within the sector generally limited Social sector has legal provisions and procedures in place to protect survivors; social workers and service providers are at risk

Privacy and confidentiality	■	■	■	<ul style="list-style-type: none"> Family clinics exist in hospitals; spaces in PHC centers provide inconsistent safety and privacy; access to data likely FPD has a GBV CoC, staff patriarchal attitudes; placing FPDs within police stations; limiting confidentiality and privacy from the outset
Foundational elements				
Intersectoral SOPs and Referral pathways	■	■	■	<ul style="list-style-type: none"> Inter-agency national tools guide GBV services in the three sectors; however, among the sectors, implementation of case management and inter-sectoral referral responsibilities is inconsistent Newly developed national SOPs expected to remedy this issue
GBV units' infrastructure and or teams/working hours	■	■	■	<ul style="list-style-type: none"> Physical setting of women and girls interview spaces and shelters vary in meeting minimum acceptable standards in the three sectors Limited working hours of services in the three sectors, apart from police FPD and hospitals and a few NGO services
Workforce and training	■	■	■	<ul style="list-style-type: none"> Training is sporadic, tailored to sector needs and less so to inter-sectoral required capacities; nor is, it is not necessarily mandatory Staff selection criteria for GBV work and readiness is inconsistent
Monitoring and complaint mechanisms	■	■	■	<ul style="list-style-type: none"> Performance-monitoring and complaint mechanisms are either lacking or do not have specific components to address weaknesses or misconduct in GBV service provision across sectors
Budget of GBV services	■	■	■	<ul style="list-style-type: none"> GBV services in the three sectors have limited access to national budgets and external donor funds, which constrains budgets for advancement of GBV work - health and social sectors most affected
Information Management System (including GBV IMS)				
GBV data reporting system/s	■	■	■	<ul style="list-style-type: none"> The Information Management System (IMS) in the three sectors is under-developed and neither standardized nor harmonised in terms of data-collection tools and information-sharing mechanisms Impossible to generate reliable and standardized national GBV data; police and justice sector actors have different IMS within the sector.
GBVIMS	■	■	■	<ul style="list-style-type: none"> GBVIMS used by humanitarian NGOs but remains limited and separate from sectoral information systems and reporting mechanisms in MOH, police and justice sectors

Harmonised standard data collection tools across sectors	■	■	■	<ul style="list-style-type: none"> Forms neither standardised nor harmonised across sectors; incidents recorded as per sector classification tools and requirements Divergence is going to continue after anticipated national tracking system is introduced since its incident classification criteria differ from that of GBVIMS
Protection of data/info	■	■	■	<ul style="list-style-type: none"> Protection of data and confidentiality of information throughout collection and sharing process is minimal IMS in the three sectors are incompatible with GBVIMS standards and ISP
Information use and management	■	■	■	<ul style="list-style-type: none"> FPU reports are for internal MOH steering committee use and not regularly shared Absence of systematic consolidation at social sector level restrict sector's ability to analyse and derive trends to inform programmatic interventions FPD data mainly inform service delivery and referral to other sectors, rarely used for policy/strategy development or programme design
Coordination and governance of coordination				
Coordination mechanisms exist at national and sub-national level	■			<ul style="list-style-type: none"> Absence of a sole coordination mechanism to lead implementation of the national strategy to combat VAW and GBV programmes Inadequate harmonisation in policy frameworks and coordination platforms of various national entities Lack of coordination in service provision and limited understanding of sectoral responsibilities hence accountabilities Humanitarian coordination structures including the SGBV-WG have parallel paths and weak linkages with national efforts
National Strategies and policies	■			<ul style="list-style-type: none"> National policies and strategies exist but implementation in the sectors is hampered by lack of necessary resources and capacities for enforcement at service provision level
Resources (financial, technical and authority) available	■			<ul style="list-style-type: none"> A persistent gap between required GBV interventions and sector technical and financial capacities to fulfil tasks assigned to them in the national coordination mechanisms Limited access to national budgets and donor funds,
Coordination plans, monitoring and accountability mechanisms in place	■			<ul style="list-style-type: none"> An agreed national coordination plan of action for GBV is lacking whereas a humanitarian coordination response plan does exist National coordination platforms have authority but lack clear monitoring and evaluation mechanisms





UNFPA

Arab States Regional Office

70 A Al nahda street

intersection with street # 22 New Maadi,

Cairo, Egypt

Phone: +202 25223900

Web: arabstates.unfpa.org

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