# Uganda – Child Protection Sub Working Group (CPSWG)

# Case Management Guidance – COVID19 Response

# June 2020



## 1. Introduction

According to the CPSWG Business Continuity Plan for the COVID19 situation, case management services are considered essential services that should not and cannot be stopped during disease outbreaks such as COVID19, Ebola, etc. Advocacy for child protection services to remain available to vulnerable children at risk is therefore a core activity undertaken by the sector.

As of April 2020, Uganda hosts 1,423,740 refugees and asylum seekers from mainly South Sudan, Democratic republic of Congo as well as Somalia, Rwanda and other countries. Children make up over 59% (840,007 individual children) within the total refugee population. Children also form the largest group identified with specific needs with an unprecedented number of 41,007 unaccompanied or separated children[1] as well as 14,066 children at risk.[2] As such Uganda hosts 37% of all unaccompanied or separated children globally.[3]

Given the large-scale child protection risks in Uganda, prevention and response activities require harmonized procedures and coordination. These guidelines are drafted by the Child Protection Case and Information Management Task Force in Uganda, under the coordination of the CPSWG. This note provides guidance to case management practitioners working in the Child Protection sector on the adaptation of critical case management services to the COVID19 situation.

This note has been drafted in line with the COVID19 CP Case Management Guidelines drafted by the Case Management Task Force at global level. The note is not intended to reflect comprehensively on all case management steps and procedures but is intended to complement the global[4] and national guidance for the specific COVID19 related situation.

## 2. Impact of COVID19 on refugee children

While global reports indicate that children seem less likely to become severely ill with the virus, children may face particular risks during infectious disease outbreaks given their heightened vulnerability, level of maturity as well as high dependency on adults or caregivers. Children also have specific

[1] 'Unaccompanied children' are 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. UNHCR uses the term unaccompanied children. 'Separated children' are those separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members such as aunts, adult siblings, grandparents, etc. See also UNHCR BIP Guidelines, 2020.

[2] Children at risk are those children who are at heightened risk as a result of exposure to risks in the wider protection environment and/or risks resulting from individual circumstances. Children at risk include, unaccompanied and separated children (UASC), as well as other children who are at risk of or have experienced risks of violence, exploitation, abuse or neglect. A non-exhaustive list of risk categories is included in paragraph (c) of the UNHCR ExCom Conclusions, No. 7 of 2007.

[3] See: UNHCR, Global Trends, 2018: https://www.unhcr.org/5d08d7ee7.pdf

[4] For global case management guidance, please see: Child protection working group, Interagency Guidelines for Case Management and Child Protection, 2014.

susceptibilities to infection given their limited awareness and exposure during play and interaction with caregivers or adults. The outbreak of COVID19 has also disrupted the environments in which children grow and develop. Measures used to prevent and control the spread of COVID19 have exposed children to protection risks some of which are outlined below:

- Separation from care givers: due to the COVID-19 outbreak, children might be at risk of becoming separated from their caregiver, as their caregiver may fall sick, die, be quarantined or become unavailable for other reasons. Reports from settlements in Uganda also indicate that due to the containment measures applied, including border closures and movement restrictions, children have been separated from parents or caregivers as they were unable to return from their Country of Origin or got stuck in urban areas with no ability to return to the settlements.
- Children facing violence, abuse or neglect: children may also face greater risk of different forms of violence, neglect, abuse or exploitation due to the increasing burden on families and caregivers. Considering the additional challenges to maintain their livelihoods, children might also be forced to work to support the family potentially exposing them to violence, including SGBV. Existing types of violence in the home may worsen as caregivers find themselves under increased levels of stress, have to find new childcare options or include children in negative coping mechanisms, including child labour and sexual exploitation. A number of children may also witness violence between parents, care givers and others members of the community. In the past few months, child neglect has been reported throughout the settlements with children being left without appropriate care. This has been particularly concerning for children who have been under alternative care prior to the COVID19 outbreak.
- Psychological distress: given the closure of schools and other spaces for development and play such as Child-Friendly Spaces, children's ability to grow, learn and develop positively is impacted significantly by the COVID19 mitigation measures in place. Parents are in demand to take care of their children at home while they also have household and livelihood responsibilities which may lead to children being left without appropriate care. In addition, separation from parents even if temporarily has also led to psychological distress for children. Further, the containment measures itself and the limited engagement with friends also constitute a considerable factor impacting negatively on the household as well as the well-being of children. Restrictions of movements and information on restricted movements does not only cause fear among children but also results in distress amongst children. Containment measures, fear of being infected, tensions at home due to increased stressors amongst parents and the distress related to the inability to see friends and family in quarantine or treatment can negative impact stress levels of children.
- Challenges in accessing (child-friendly) information and child protection services: children, in particular younger children and those unaccompanied or separated, may struggle to access child-friendly information and appropriate care. Often children may not understand the impact of a virus as well as the reasons for the lockdown and its implications (such as school closure, refraining from playing with friends, or hygiene standards to be applied, etc.). It is therefore important that children receive concrete messages adopted to their specific ages and needs. The closure of child protection services also presents concerns to children's protection, particularly for those from vulnerable families or those where previous violence or neglect was reported.

## 3. Critical Prevention and Response activities

- Provide critical life-saving child protection case management services, including provision of multi-purpose cash assistance in line with the child's best interests

- Provide alternative care for children
- Ensure access to psychosocial support for children at risk
- Monitor child protection concerns and child rights
- Empower trained child protection community structures (such as the CPCs)
- Building the capacity of first responders and strengthen intersectoral linkages

## 4. Key Considerations on direct/ face-to-face contact for child protection case workers

- As of 26 March, the GoU has installed measures to prevent the spread of COVID19. Those included halt on any private or public transport as well as social distancing measures and Personal Protective Equipment (PPE);
- Government social workers have not been considered critical/ essential services and their work was suspended at the end of March;[5]
- Through advocacy, resumption of critical humanitarian activities in refugee settlements was permitted without major interruption;
- In light of this directive, child protection case management services provided by CSOs have been maintained in settlements while in urban areas staff has since faced challenges in outreach to children of concern;
    - Within the humanitarian response, child protection services have been considered a critical and life-saving activity and have been maintained; however, the following conditions and resources need to be ensured:
    - Case workers to ensure alignment with MoH directive and to keep abreast of changes in this regard;
    - Case workers to ensure clients/ children are comfortable to engage in direct/ face-to-face contact which should be identified by phone prior to any case management meeting;
    - Appropriate PPE should be available to the case worker (preferably reusable mask (clean or new) available for each HH visit in line with government standards for face cloth masks, pocket size hand sanitizer that is used before every engagement with child/ family);
    - Train case workers on use of PPEs;
    - **If not enough or appropriate protection materials are provided to safely conduct visits to beneficiaries, remote support alternatives should be defined. Ensure staff and beneficiaries are not put at further risk by our intervention!**
- The decision-making tree attached in **Annex 1** provides additional guidance on the necessity and steps to amend the child protection case management procedures during COVID19;

## 5. Resources required to ensure quality case management

- Sufficient staffing should be allocated to support increased case load and changes in modalities;
    - This could be done by training of existing staff an/ or temporary reallocation staff to CP from other sections or linked sectors;

[5] Advocacy has been undertaken to lift this suspension and to ensure social workers are able to move and support children at risk of violence, abuse and neglect. While social work services were officially resumed at the end of May, as of 2 June 2020 social workers of the MGLSD have not yet fully resumed their activities given the transport challenges that remain to date.

  - Reprioritization of the case load may also assist in this process to ensure that prioritized cases and children at heightened risk receive quality and adequate services;
  - Advocacy and fund raising should be enhanced to address the increasing case management requirements;
- Personal Protection Equipment for essential visits (at minimum hand sanitizer, facemask and gloves, thermoflash for each case worker, consider masks and gloves for clients dependent of government/NGO policy);
- Equipment for distant follow-up and counselling (phones, credit, batteries, solar panel etc.);
- If no means of remote communication are available: equipment for community members and foster families to maintain and increase support to children and/ or their families such as to contact the case worker (phones, credit/airtime, material support (shelter, mats and other non-food items, etc.);
- Transport if public transport is no longer available and/or not safe to take;
- Interpreters if relevant;
- Provision of potential cash assistance for most vulnerable and in line with CBI guidelines;
- WASH/NFI/Nutrition/Shelter: update service mapping and coordinate with sector-specific actors to ensure basic needs coverage at household level (wash, shelter, food and NFI). If referrals are not working and the identified household cannot receive timely, essential support from sector-specific actor, caseworker should assess critical needs and consider deliver directly modalities. Note: Child protection caseworkers should not be providing baby formula to families, unless trained to do so. This action could cause harm to children or disrupt country-level supply chains. Coordinate with nutrition professionals for any baby formula requests.[6]
- Liaise with health sector to ensure children continue to access medical care including critical health services as well as immunization for children.

## 6. Amended or Remote Case Management – COVID19

The below outlines detailed steps and procedures on the amendment/ adaptation of case management procedures during the COVID19 situation reviewing each step of the case management cycle.

### 6.1 Review of case assignment and staffing

- Review of cases as well as reassignment of cases to the case workers should be based on revised prioritization criteria;
- Supervisors and case workers should review each case individually and determine ones will require on-going support/frequency etc. based on the prioritization criteria;
- Some cases might require changes in the assigned case worker as case workers might face circumstances restricting their access to the office; case supervisors will need to review the existing case load as well as the new cases in light of the potential restrictions and experience of staff; also movement or health related restrictions might also require changes in case allocation;
- When reviewing and assigning roles, it is advised to consider the global guidance on case management skills, see Child Protection Case Management Quality Assessment Framework;[7] this

[6] See: World Food Programme COVID 19 Cash-based transfers guidance: https://fscluster.org/sites/default/files/documents/wfp-guidance_for_cash-based_transfers_in_the_context_of_the_covid-19_outbreak1_1.pdf

[7] Case Management Task Force, Child Protection Alliance.

framework outlines required skills and capacities to ensure quality and accountability in the case management process.

## 6.2 Prioritization of caseload and reassessment of specific vulnerabilities of children

- In line with the GoU policies on the measures and restrictions due to the COVID19 outbreak, the Child Protection vulnerability and prioritization criteria were amended reviewing risk levels, sensitivities and new cases identified during the COVID19 outbreak, see Annex 2 for the sector prioritization criteria; however, it is worth noting that those criteria are indicative only as each case requires an individual assessment and has different levels of complexities based on which decisions for case management and service provision should be made;
- General intake criteria for Child Protection Case Management services can be useful to better assess whether individual protection services are required or whether referrals to specialized services suffice the response, if there are no protection concerns (this is particularly important during disease outbreak where a larger number of children are facing health related concerns) (see Annex 4);
- Based on prioritization criteria, supervisor and case worker meet in a case review meeting and discuss current case load of case worker and decide on priority, contact and follow up modalities and required action plan;
    - Start with emergency/ high risk cases and then follow with medium and low risk cases
    - Update schedule accordingly and fill case worker schedule based on agreed prioritization
- Questions that guide the review meeting may include[8]:



[8] COVID19 Child Protection Case Management Guidance, Child Protection Case Management Task Force, the Alliance for Child Protection in Humanitarian Actions, 2020.

- ✓ What is the current situation of the child? Have there been any minor or major changes that affect the child and/or their caregivers?
- ✓ When was the last contact with the child/ caregiver?
- ✓ Has the prioritization or urgency changed due to current COVID19 situation?
- ✓ What is the likelihood that the child's safety and wellbeing will worsen due to the current crisis?
- ✓ What type of support does the child require, and how will caseworker and child safety be considered for each action (document in case/ action plan)?
    - Consider communication with the child (phone or face-to-face with child and caregiver based on outlined communication scenarios in 1.3)
    - For high risk cases, consider face-to-face visits if possible and safe; if the caseworker can no longer visit the home, establish a safe place to meet and make available personal protective equipment (PPE);
    - If a face-to-face meeting is planned, where possible, call in advance to determine if the child, caregiver or any member of the household is not experiencing COVID-19 symptoms or believes they have been exposed to the virus
    - Consider follow-up by trusted community members or child protection committee members, only if safe and relevant to do so (see prioritization tool with regards to involvement of community members);
    - Create or update safety plans for the child and/or caregiver and/or trusted adult (See COVID-19 Safety Planning - hyperlink/resource forthcoming)
- ✓ Consider what resources are needed to implement actions proposed (i.e. phone credit, PSS materials, etc.)

## 6.3 Case management steps[9]

While case management steps remain the same (see below graph on standard case management steps), some key considerations in amending the steps are outlined below. It is worth noting that the amendments are under review and might be updated amended, depending on the development of the COVID19 situation. For a more detailed case management SOPs in Uganda, please see BIP SOPs.



[9] While the document focuses on the case management procedures, a BID can be initiated at any time during the case management process and at any stage. This would be particularly relevant in case of separation of children from parents/ caregivers in the context of COVID19 or where separation is required due to violence, abuse or neglect, exploitation of the child.

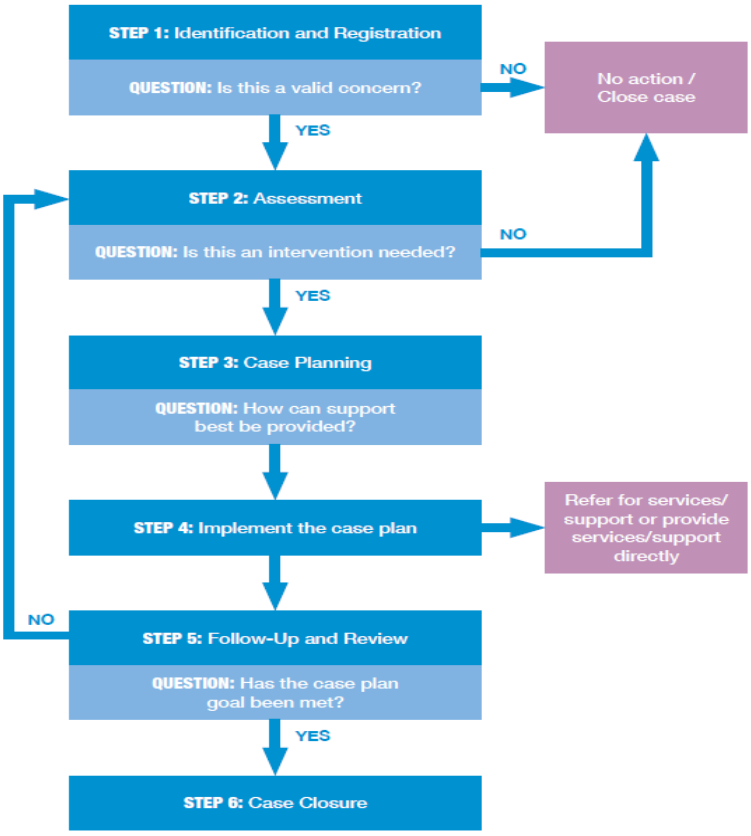


*Figure 1: Case Management Steps, IA CP CM Guidelines 2014.*

## Identification/ engagement and registration or amendment of risk identification

- The COVID19 measures in place in Uganda have impacted the identification of child protection risks and children at risk as schools as well as childcare institutions, CFS and other educational/ developmental activities have been halted (see below amended sources of identification overview);
- Increased identification through community members (see separate note on community engagement and issues relating to confidentiality for case management involving CPC members)
- Identification through CP or other humanitarian workers (depends on contact modalities) – for high risk cases, aim at reaching to the child directly


*Figure 2: Sources of identification of children of risks COVID19 context, IA CP CM Guidelines, 2014*

- If contacted by phone: ask for health-related information to ensure no COVID19 transmission or make referral to health service providers;
- Document new case on proGres V4 (or other IM tool for CP in use);
- Ensure case manager shares relevant contact information to be accessible to the child/ caregiver.
- At an absolute minimum, the following information should be captured:
    - Child's name, age and sex
    - Registration number if available

  - Care arrangement and whereabouts of parents/ relatives
  - Initial protection concerns and needs enabling risk/ prioritization and follow-up
- Identification of unregistered children: child protection actors might become aware of refugee children who are not registered; children should be supported regardless of their registration status but efforts should be made by the case manager to alert UNHCR and OPM immediately to ensure access to registration and protection services in line with the best interests of the child.

## Assessment stage

### Urgency of required assessment based on amended COVID19 situation

| | |
|---|---|
| Emergency cases | ▪ Immediate follow up |
| High risk cases | ▪ Immediate actions and referrals if required within 24-48 hours and bi-weekly follow up (or more frequent based on needs assessment) |
| Medium and low risk cases | ▪ Assessment within 1-2 weeks by phone. Following contact modality as outlined in Annex 2 (Prioritization COVID19) |

- Assessments should include four different stages to ensure a comprehensive assessment of a child at risk; those steps are maintained in the COVID19 context, however, given the limited outreach options, the planning phase is particularly important to ensure Do No Harm;
- Amended steps include:
  - Planning - how to do the assessment, what information to collect, with whom, how to communicate with the child, where to do the assessment; health considerations; safety and confidentiality related aspects to be thought through for each individual child before contacting the child/ caregiver;
  - Gathering information – according to the planned assessment; amend where necessary;
  - Verification of information – review other or additional resources and trusted resources/ family members, community members (if appropriate and only if this does not stigmatize or harms the child/ family)
  - Analysis – review all information and conclude best interests of the child
- See also communication with children based on risk and prioritization criteria (Annex 2)
- If face-to-face contact is maintained, document information once access to office is made and update relevant databases and CM tools in use;
- Aim at reaching trusted caregivers/ persons in the child's life while ensuring information on health risks are available;
- Document all interactions with the child and family through the regular case management processes. This will help keep a record of what was shared and allow for someone to take over the case if the case worker is unable. If using an electronic information management system, remote supervision and online messaging is available
- If assessment is only possible remotely, see if telephone contact is safe for the child and whether it is the appropriate tool; for cases listed as highly sensitive, including SGBV, a note

has been prepared by the SGBV SWG on remote case management procedures in the COVID19 context in respect to confidentiality standards;

## Case Care Plan

- Considering confidentiality standards and challenges in contacting/ outreach modalities, developing can be challenging and communication/ modalities in communicating with all involved in developing the case plan needs to be carefully prepared;
- Developing a comprehensive care plan addressing the child's protection risks and needs while listing the priority actions and responsibilities and times lines is one of the most important steps in the case management process;
- An example of a comprehensive case plan can be found in Annex 5;
- As participation in the case care plan is critical to ensure the child's wishes are respected and to ensure buy-in from all involved parties, the case worker needs to outline the amended procedures to obtain the information from the child/ caregiver to be included; for high risk cases, this should be done in a safe space and preferably only through face-to-face communication;
- Involvement of community-based CP support needs to be carefully considered; for further information on community-based involvement in CM, please see additional note in Annex 7;
- Case care plan should include immediate, short term, medium- and longer-term actions, i.e. on alternative care or family reunification.
- For emergency or urgent cases, please discuss with supervisor.

### Case Plan urgency

| Level of risk | Timeline for assessment | Timeline for care plan |
|---|---|---|
| Emergency cases | ▪ Immediate follow up | ▪ Within 48 hours |
| High risk cases | ▪ Immediate actions and referrals if required within 24-48 hours and bi-weekly follow up (or more frequent based on needs assessment) | ▪ Within 72 hours up to 1 week |
| Medium and low risk cases | ▪ Assessment within 1-2 weeks by phone. Following contact modality as outlined in Prioritization COVID19 (Annex 2) | ▪ Within 2-4 weeks depending on the case |

## Implementation of Case Care Plan

- In line with the risks identified and the urgency, referrals to relevant services and implementation of other relevant services such as parenting skills building should be provided in line with the urgency outlined in the amended prioritization list for CP/ COVID19 (see Annex 2);

## Follow-up and Review

- Depending on the urgency and in line with the care plan, the case worker should follow up on the services provided and reviews needs of the child;
- To further monitor the child's case and given the increasing role of community-based child protection committee members, the case plan should identify the option to include a CPC member who is then also supporting the monitoring of the child's risks and needs and reports to the case worker (for further information see Annex 2 on the prioritization criteria including

considerations to involve CPCs as well as Annex 7 on considerations involving community-based volunteers in child protection case management).

### Case Closure

- Case closure can be done as a final step in the case management process once it has been rigorously assessed that the child is no longer at any risk of harm. All the goals laid out in the Case Plan should have been reached, their care situation and well-being is well supported by their caregivers, and there are no additional concerns.
- Case closure can be more effective when it occurs as part of a process between service providers and any others involved in the case. This includes taking into account the feedback of those who have provided services and agreement that the goals in the Case Plan have been achieved and risks have been eliminated. Children and their caregivers should also be supported to take part in this decision-making process.
- Given the limited outreach options and limited interaction with the child/ caregivers, during the COVID19, careful consideration should be placed on closing cases (unless child has passed away);
- For the old caseload, only low risk cases where CP risks where addressed and where several sources confirm the absence of any protection of the child, cases may be closed following similar closure procedures and documentation of case closures (see Annex 6 for a sample form);
- Case closure needs to be approved by the supervisor which can be done through online-case review meetings and electronic signatures if access to the office is not provided;
- Contact between case workers and supervisors should be made in line with the agency/ office measures in place with regards to working modalities and BCP under COVID19 response; if face-to-face interaction is not permitted, case review meetings and discussions should be done using online modalities, such as Microsoft teams;
- Case may also be closed if agencies' lack capacity to support the child in certain location or due to capacity, etc. the case shall then be properly transferred to the new case manager following obtaining the consent from the child/ caregiver and with full referral note (for high risk cases, case workers should discuss if a face-to-face handover can be done).
- Once a case is closed, all the information related to that case should be stored in a safe place for a specific period of time. This period should be in accordance with your agency's data protection protocol as well as taking into consideration national legislation.

## 7. Communication Modalities with Children and Caregivers

| Risk Level | *In case there is no indication of COVID-19 in the family or close community* | *In case there is confirmation of COVID-19 in the family or close community* |
|---|---|---|
| High Risk | - Maintain case management support<br>- Visit with appropriate protective equipment/ identified community resources (with PPE)<br>- In urban areas where no access to community is available due to movement restrictions, for specific urgent and high-risk cases, advocacy with the relevant authorities should be undertaken and need for involvement of law enforcement actors should be involved. | - *Based on MoH/ Government of Uganda guidelines, no direct contact to be maintained but close liaison with Health Unit;*<br>- During admission to health care facilities, follow-up by phone, daily check-in to ensure that child/ family are ok.<br>- Once the family is cleared from a health actor case worker to visit immediately. |

| | | |
|---|---|---|
| Medium Risk | - Maintain case management support by phone and review changes in the risk level and amend accordingly;<br>- Schedule cases for phone meetings accordingly; | - *Based on MoH/ Government of Uganda guidelines, no direct contact to be maintained but close liaison with Health Unit;*<br>- Once case is cleared and discharged, regular follow-up by phone. |
| Low Risk | - Maintain case management support by phone and review changes in the risk level and amend accordingly;<br>- Schedule cases for phone meetings accordingly; | - *Based on MoH/ Government of Uganda guidelines, no direct contact to be maintained but close liaison with Health Unit;*<br>- Phone follow up once child/ family member is discharged and can be reached. |

### When contacting children/ families, the following information should be provided:

- Information about the CP agencies current working modalities, ensure to use child-appropriate language to explain changes in the working modalities and the reasons and potential duration;
- Ensure you inquire about the health situation of the child and other household members or close relatives; ensure information is shared on health services where required or answer any general questions in line with MOH COVID messaging (see Communication material in shared folder or see Annex 10);
- Information on their case and any future follow up (frequency and any agreements made with child/ caregiver);
- For children who have experienced separation or loss from a family member, provide comforting messages.

### Information for parents/ caregivers:

- Check in with parents and ensure they have required community support where desired and appropriate;
- Parenting messages to support vulnerable families and caregivers distressed (see Annex 4) and ensure dissemination of referral pathways (developed separately under CPSWG);
- Ensure information on case management services as well as other support structures need to be made easily accessible to parents/ caregivers or community members on contacts of case workers to reach out for support (see Community-based Referral Mechanism in CPSWG shared folder);

## 8. Confidentiality

- In line with the global Child Protection Case Management Guiding Principle, confidentiality is one of the most important principles, for general confidentiality considerations, see the IA CP CM Guidelines, 2014;
- In the context of COVID19, maintaining confidentiality around child protection risks as well as health related concerns is critical to ensure the safety, dignity of the children as well as to prevent or avoid any stigmatization or further harm;

- Regardless of the COVID19 situation, the principle to ensure children and caregivers provide consent to receive services;[10]
- Case workers shall ensure that sensitive child protection concerns are discussed with the child and trusted caregivers/ adults in a safe and confidential space; if that is not possible, the case worker needs to discuss with his/her manager how to address the needs of the case and where to best seek information;
- Importantly, confidentiality is limited when caseworkers identify safety concerns and need to reach out to other service providers for assistance (e.g. health care workers), or where they are required by law to report crimes. These limits must be explained to children and parents during the informed consent or assent processes. Supervisors and caseworkers should work together closely to take decisions in such cases where confidentiality needs to be broken.
- Considering the challenges facing CP actors in Uganda to access the population and the measures put in place exacerbating the access to children at risk, community volunteers have played a crucial role in the identification, referral and support of case workers of agencies;
- The amended COVID19 prioritization tool for child protection case work outlines in detail considerations on when and how to involve community members in the support of cases;
- Prior to involving a community volunteer/ CPC into case management, the consent/ assent of the child/ caregiver should be thought outlining roles and responsibilities in the case management process and on sharing information from the volunteer with the case worker;
- Community members should have signed the Code of Conduct and shall agree to refrain from sharing any information on individual cases with a third party; in addition, CPCs/ community volunteers should be alerted on general information management principles, including the need-to-know principle[11] and storing of information; as such CPC/ volunteers should not document in writing information on cases if those documents could be accessible and read by any third party;
- In particular sensitive cases, including on SGBV or where a potential community retaliation could result from community-based support in a case, the case worker should refrain from involving community support volunteers.

**Tips for case workers to maintain confidentiality during remote case management:**

- Caseworkers communicating by phone to ensure they are doing this from a private space away from others hearing (e.g. if working from home). Same applies to community workers
- Use case numbers/codes (ask the child to use codes if needed);

[10] See IA CP CM Guidelines, 2014: 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 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. Informed assent is the expressed willingness to participate in services12. 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.

[11] The term "need-to-know" describes the limiting of information that is considered sensitive and sharing it only with those individuals and sharing it only with those individuals who require the information in order to protect the child. Any sensitive and identifying information collected on children should only be shared on a need-to know basis with as few individuals as possible

- Never communicate information about cases in group text messages;
- Delete messages from both phone after confirmation that the transmitted information has been transferred to a secure file (child's case file);
- When working from home, do not leave child's files open when stepping away from the workspace. Same applies for databases/file on the computer. Always close the file and put computer to sleep when leaving the desk.

## 9. Resources and Wellbeing of frontline workers

- While the above guidance is focusing on the child and the need to maintain case management procedures, it is similarly important to increase attention to staff welfare issues and needs of case workers;
- In all steps taken to implement child protection case management service, the health, safety, mental health and psychosocial wellbeing of the case management team should be given high importance;
- Provide the necessary tools including PPE for all case workers;
- CP CM managers/ supervisors should ensure to:
    - Maintain case review meetings and ensure the case load is not steadily increasing and respect to a rough calculation of the case worker/ case ratio should be maintained;
    - Provide teams with regular, updated information only by verified sources and limit the amount of information shared to avoid overload
    - Ensure caseworkers fully understand the information that is shared with them and are able to ask questions openly;
    - Reinforce or create an emergency communication system (such as a referral pathways) and ensure that all team members understand communication channels;
    - Ensure all team members have clear contact information on who to reach out to in case of necessity;
    - Create or reinforce the existing peer support system amongst team members (in addition to regular supervision) to encourage supporting one another and raising concerns;
    - Establish a plan for the case management team, how to access information should a case worker or supervisor become ill or need to self-isolate.
    - Ensure a staff rotation system to ensure that staff are able take rest and dedicate time to their own home life situations.
- Encourage non-work-related phone calls with the team to catch up and reflect on team members' needs;
- Share resources on stress managing (see shared folder - CPSWG);
- Ensure leaves and breaks are taken to avoid burn-out;
- Ensure regular check –ins with CPCs and case management staff including online in places where managers in different stations encourage phone or online.

## 10. Capacity building of case workers and supporting staff/ volunteers

- Training and capacity building for case managers has been impacted by the COVID19 outbreak as group meetings and gatherings have been prohibited; similarly shadowing or observations of case workers has been reduced given the need to maintain GoU instructions and to support the measures in place to contain COVID19;

- However, various additional capacity building initiatives can be undertaken with regards to case management that do not require group gatherings, including:
    - Online coaching of case workers by managers or HQ staff;
    - Webinars at the global level (serious was undertaken by the Alliance and UNHCR with regards to refugee case management and alternative care);
    - Providing reading material to case workers and schedule time for self-study;
    - Given the increase use of phone communication, train case managers on how to talk to children by phone, how to maintain confidentiality/ data protection remotely, safeguarding issues, how to seek supervisor support on critical case, how to manage hotline;
    - Train case management staff on the Infection, Prevention and Control measures to safeguard their own safety. Also train them on how to explain the measures to children and their families, why they are taking them, and why children and their families should too;
    - Train on Information management tools to ensure proper use and documentation of cases through remote working modalities;
- Community-based networks have also been trained and further training should be provided on:
    - CPCs should be trained on CP risk identification, including protection risks related to COVID-19 and safe referrals;
    - CPC roles and responsibilities;
    - How to properly wear masks;
    - Sensitize and raise awareness on increase of CP concerns and specific persons at risk (such as children with disability);
    - Basic facts including symptoms, modes of transmission, so that they can combat myths that may stigmatize children and their families.
    - Train staff and community-based volunteers on PFA/ Psychological First Aid Training Manual for Child Practitioners;[12]

## 11. Supervision and coaching

- Despite remote supervision, case review meetings and coaching sessions should be scheduled at regular level (weekly meetings with the team and at least case review meetings/ coaching sessions on weekly/ bi-weekly basis);
- While zoom has not been proven to be secure to discuss confidential protection concerns, it is recommended to use Microsoft teams or WebEx-based communication;
- For more information and samples of COVID19 related supervision templates and modalities, please see: https://pscentre.org/wp-content/uploads/2020/04/Supportive-Supervision-for-MHPSS-Volunteers_Interim-Guidance.pdf

[12] Access training material: https://resourcecentre.savethechildren.net/document-collections/save-children-psychological-first-aid-training.

## Annexes

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|---|---|
| Annex 1: Decision Making Tree on amendment of Child Protection Case Management Procedures | Annex%201%20flow%20chart%20remote |
| Annex 2: Prioritization Criteria for Child protection Case Management during COVID19 | Annex%201_COVID19%20Reprioritization |
| Annex 3: Intake Assessment for Child Protection Case Management Services/ Intake | Eligibility Criteria for Child Protection Case |
| Annex 4: Parenting / communication messages -COVID19 | UNICEF Tips for parenting during COV<br>CP AoR Breaking bad news to children_EN ( |
| Annex 5: Sample Case Care Plan | 3.A.%20Case%20Plan.docx |
| Annex 6: Case Closure Form | 6.A.%20Case%20Closure%20Form.docx |
| Annex 7: Community-based support on CP Case Management – Uganda CMTF | Engaging%20Community%20Structures% |
| Annex 8: Interagency Emergency Child Protection Referral Pathways – COVID19 situation | Child%20Protection%20COVID19%20Em |
| Annex 9: Community-based Emergency Child Protection Referral Pathways – COVID19 situation | Needs updating<br>Communitybased%20Child%20Protection |
| Annex 10: MOH approved communication guidelines and Q&As on COVID19 for children and caregivers | C4D%20Comms%20COVID%2019%20Me |