

Child Protection Sub Working Group

Child Protection Sub Working Group Business Continuity Plan – COVID 19 risk in the Uganda refugee response

02 April 2020

1. Objective of sector Business Continuity Plan

The Child Protection Sub Working Group's Business Continuity Plan (BCP) outlines critical prevention and response activities. It also classifies the different program criticality levels and determines which activities will continue to be implemented when the BCP is activated, which ones will be halted and which ones will be continued in a different operational mode. The guidelines outline measures to be taken in the affected locations to mitigate related risks to both Child Protection actors and Persons of Concerns (PoCs), and continue the provision of child protection services, particularly critical life-saving child protection services in a safe manner.

The overall aim is to provide guidance to Child Protection actors on critical and life-saving activities in the event of an outbreak of COVID-19 while considering health and safety concerns of child protection staff. In addition, the documents shall include practical guidance to field coordinators on core child protection activities and procedures to ensure well-coordinated prevention and response activities.

2. Principles

Child Protection principles to be respected when counseling children/ vulnerable care givers by phone/ distant include:

- **Best Interests of the child:** decisions taken for the child need to follow the best interests principle, meaning that they should benefit the child's physical and emotional well-being and positive development; this also includes, children and caregivers shall not be kept in crowded places or waiting areas, unless an emergency cases, including child survivors of SGBV, require an immediate attention and access to security/ health services;
- **Safety and life-saving service provision:** safety of refugee children is a priority and risks should be identified and outlined; urgent and emergency cases need to access life-saving services, including law enforcement/ security services, medical services and psychosocial services; for emergency cases, life-saving activities for children and response services should be maintained and may require a case worker to engage with a child;
- **Confidentiality:** as most information will be obtained by phone, always consider confidentiality related aspects and whether it is safe and appropriate to obtain information;
- **Consent/ assent to share information with third parties:** trusted caregivers shall remain to provide consent for responses and information to be shared with third parties; this can be obtained by phone but shall be documented on ProGres V4 (consent form at the end of the case, BIA, BID);
- **Non-discrimination:** reduce stigma and social exclusion that may result from the disease;

3. Activation trigger

Scenarios by MOH

The COVID-19 risk analysis for the refugee response in Uganda borrows from the scenarios established by the Ministry of Health who coordinates the response.

Scenario 1: No COVID-19 cases have been confirmed (not applicable anymore)

Scenario 2: COVID-19 cases have been confirmed in one location limited in numbers (not applicable anymore)

Scenario 3: COVID-19 cases have been confirmed in several different settlements (current scenario and hence the document focuses on response scenario 3 with expected widespread cases of COVID-19)

The first case of COVID-19 was confirmed on 21 March 2020, the Business Continuity Plan shall be activated as of 22 March 2020. The activation of the BCP, declared by the refugee response leadership in Uganda (OPM/UNHCR) in consultation with the Ministry of Health and triggers the prioritization of critical activities. Overall guidance by the Ministry of Health and WHO is followed.

The refugee response inter-agency Business Continuity Plan (BCP) will be activated to ensure the continued delivery of essential, life-saving services to refugee children, provides guidance on ongoing critical action whilst reducing the risk for staff health and safety in that location.

Other considerations:

- In most areas, a large number of women and children are residing in the settlements;
- Schools and child-friendly spaces are closed and children/ families have to provide 24/7 care and activities to children
- High numbers of separation of children from care givers are expected and response measure need to be put in place;
- Alternative care will be challenging to be maintained due to the high risk of contagion amongst the families; traditional alternative care measures are disrupted (i.e. family-based care of grandparents or other family members)
- Increase in cases of violence against and neglect of children due to COVID-19 outbreak is expected, hence critical response services need to be maintained;
- Psychological distress is likely to rise among children and caregivers arising from the distress caused by COVID;
- Due to disruption in the livelihood/economic source of income that may led to shortage of food supplies at home, children may end up being exposed to COVID-19 as they move around in the community to look for what to feed on.
- **Staffing and outreach:**
 - Staffing is severely reduced to critical staffing in the field
 - Staff welfare mechanisms in place and staff to be reaching emergency cases on rotational basis

- Staff is provided support in transportation and protective equipment

4. Core areas on response for Child Protection/ COVID-19¹

Critical activities	Detailed activities	Responsible actor	Time frame
Child Protection coordination (establishment of prioritization, list available child protection services and update situation specific Referral Pathways, etc.)	<ul style="list-style-type: none"> - List critical services including case management protection/ security, legal, health and social services; Psychosocial support services for children and caregivers - Alternative care services (listing actors who operate foster family programs for temporary care placements) - Community-based networks and support - New referrals for critical health services need to be known to CP actors - Ensure knowledge of number and whereabouts as well as ways to contact vulnerable children/ children at risk and those unaccompanied are known and regular contact is established - Continue case management services for particular vulnerable children/ families - Remote ways of case management and service provision 	CPSWG coordinators with inputs by partners	<p>To be finalized until 30 March</p> <p>Ongoing, depending on partner and location and development of the situation</p>
Provision of critical and life-saving child protection case management services (see below on prioritization)	<ul style="list-style-type: none"> - Review list of high-risk cases: prioritization of most critical case load by location (including children unregistered or without documentation) - List children with vulnerable caregivers - Maintain service provision for emergency and urgent cases; map out option of contacting children and service provision - New referrals or identification of cases based on prioritization criteria; duly documentation medium and low priority cases on V4 or other IM tools 	All child protection case management actors, including: UNHCR Save the Children/ ARC WVI/ IRC DRC Hijra LWF Cafoumi	<p>Ongoing and based on agency-based business continuity plans</p> <p>Critical and lifesaving/ ongoing</p>

¹ Those areas highlighted in blue include core activities to be maintained by all CP actors.

<p>Alternative Care for unaccompanied children, children separated due to violence or abuse, neglect as well as COVID-19 affected families²</p>	<ul style="list-style-type: none"> - Need to be considered as possible consequences of COVID-19, this means: - Due to COVID-19 caregivers may fall ill, be quarantined, be hospitalized or die. Alternative care solutions need to be identified for children starting from when a caregiver is reported sick (before hospitalization or death). - Adapted referral pathways for alternative care will be shared for each location in order to ensure appropriate care of children - Identify and document a new bank of alternative care givers who are able to take care of children on emergency basis. 	<p>All agencies providing alternative care, including:</p> <p>DRC Save the Children/ ARC WVI/ IRC DRC Hijra LWF Cafoumi</p>	<p>Ongoing and services based on agency-based business continuity plans</p> <p>Critical and lifesaving/ ongoing</p>
<p>Develop and disseminate communication and awareness material</p>	<ul style="list-style-type: none"> - Develop/ amend and distribute child-friendly messages on COVID-19 - Develop/ amend awareness materials such as parenting skills material - Embedding CP messaging and CP into community messaging developed by health sector or other humanitarian responses - Outline role of child helplines and other resources 	<p>Compilation by CPSWG coordinators</p> <p>All Actors to provide good practices and samples</p>	<p>Messages to be shared by latest 27 March and ongoing activity</p>
<p>Communication with community and community support structures</p>	<ul style="list-style-type: none"> - Identify new or existing Community-based Child Protection Focal Points that can support with messaging and referrals; - Develop clear messages for children, parents and community members on COVID-19 and service provision, including on alternative care 	<p>All CP agencies with CPCs and other RWA and volunteer programs</p>	<p>Communication material to be shared until of 30 March</p> <p>Activity is critical and hence ongoing until further notice</p>

² Children hospitalized or quarantined under 15 years of age should always have a caregiver present at all time who would be equipped to support them to prevent spreading of COVID-19 where possible. This caregiver should be a parent or close family member, however, for unaccompanied minors and if allowed the designated social worker should visit the child regularly.

	<ul style="list-style-type: none"> - Protection monitoring on child protection concerns to be undertaken by community members/ CPCs; - Communication in child-friendly language for children separated from parents or for children whose parents have died; - If new focal points are identified, ensure these focal points are trained on child protection principles, identification and referral - Identify mechanisms through which communities can access information e.g. use of Bodaboda talk-talk, community radios, settlement drives as physical contact with PoCs is restricted. 		
Provision of urgent psychosocial support	<ul style="list-style-type: none"> - Group counselling on halt - Individual support to critical/ high risk and life-saving cases to be maintained, e.g. staff to support with proper PPE - Strengthen capacity of community workers e.g. CPCs to provide Psychological first aid. - Develop and popularise a clear referral pathway for critical cases requiring Psychosocial support to existing service providers. - Explore options for phone counselling. 	All CP actors with PSS activities	<p>Ongoing but reduced to severe/ high risk cases</p> <p>Halt for group/ CFS activities</p>
Protection Monitoring	<ul style="list-style-type: none"> - Ongoing where possible and in line with GoU - To be maintained through available CP actors/ CM on the ground, CPCs, and other sector staff members 	<p>CP actors in field locations</p> <p>Close coordination with other humanitarian sectors</p>	Ongoing

5. Child protection prioritization criteria - life-saving case management services

Risk Level	Case profiles (non-exhaustive)
High risk (emergency and urgent cases) which is lifesaving	<ul style="list-style-type: none"> - Child survivors of SGBV; - Children exposed to physical violence by caregivers; - Children being severely neglected by caregivers; - Children who have been separated from family members and have no care arrangement (unaccompanied children); - Children with vulnerable caregivers; - Unregistered children at high risk or lack of access to services; - Children living with extremely vulnerable households - Children and caregivers at the risk of refolement - Unregistered children unable to access critical life-saving services including health and security; - Children who have been severely affected by COVID-19 and are in need of urgent medical attention;
Case load generated by COVID-19 (e.g. increased psychological/emotional distress, violence against children, children witnessing violence against close family members, child marriage as well as intimate partner violence and rape, child labour etc.):	<ul style="list-style-type: none"> - to be treated as all other case management cases and in line with overall risk ratings of case management alongside necessary COVID-19 precautions - For new high risk cases, special considerations should be given to children who are separated from their caregivers, including those in observation centers, treatment centers, or in need of alternative care; children in households affected by restrictions on movement or lack of access to services; children with disabilities, chronic illnesses, child victims and survivors of the disease who may be rejected by their families and/or communities; and children with family or household members who have contracted the disease.

6. Communication modalities with refugee children and families³

Risk Level	<i>In case there is no indication of COVID-19 in the family or close community</i>	<i>In case there is confirmation of COVID-19 in the family or close community – based on MoH/ Government of Uganda guidelines</i>
High Risk	Visit with appropriate protective equipment/ identified community resources (with PPE)	By phone, daily check-in to ensure that child/ family are ok. Once the family is cleared from a health actor case worker to visit immediately.
Medium Risk	By phone	By phone
Low Risk	By phone	By phone

³ If restrictions are applied by Government entities requiring physical distancing, all follow-up will be done by phone.

Case Workers MUST:

- Wash/sanitize their hands before, during and after every visit.
- Explain physical distancing through considerate communication – this means explaining why physical distancing is important to protect the child and family, as well as the case worker during COVID-19.
- No handshaking during the visit – please explain to the child and family kindly why these are necessary measures to take.
- Promote physical distancing - maintain one to two meters distance with the child and ensure the visit is performed in a ventilated room or open safe space. Adopt potential playful methods of explaining these precautions using child friendly language.
- If a social worker feels any of the COVID-19 symptoms he/she should call the MoH line as recommended or any other update referral pathways for COVID-19. The social worker should then ask if they families she/he has been working with would like someone else to visit them.
- In cases where the family asks the social worker not to conduct a home visit due to concerns related to the transmission of COVID-19, case workers should be understanding, postpone the visit and try to do the appropriate follow up over the phone.
- Always have and be up to date regarding the referral pathway for Health Services in order to inform families of the safest way to refer any case.
- Ensure their phones have sufficient data, recharge cards etc. in order to maintain services for extremely vulnerable groups and also informed the families they can call them when needed.
- Have regular debrief (even if remotely) to listen to the concerns and fears of case workers and provide information/guidance accordingly.

7. Program criticality and detailed activities

	Scenario 3: wide-spread COVID-19 cases in all different urban and settlement areas
Staffing scenario	<ul style="list-style-type: none"> • Staff is not present in the field • Contact with refugee children and families is undertaken for emergency/ life-saving activities • Follow-up undertaken by the phone and with relevant stakeholders • For life-saving activities (emergency cases), staff is provided support in transportation and protective equipment • Staff welfare support needs to be provided
Program criticality 1: Critical activities to be maintained	<p>Case Management for high risk (emergency/ urgent cases)</p> <ul style="list-style-type: none"> • Staff is reaching out to emergency cases only (children at high risk) • Ensure daily follow up on the phone where relevant • Ensure information sharing on FRRM as well as other outreach mechanisms (social media, child helplines, etc.) <p>Alternative care for unaccompanied children</p> <ul style="list-style-type: none"> • Ensure list of foster families to be contacted and updated by staff working from home;

	<ul style="list-style-type: none"> • Emergency placement for unaccompanied children or other children at high risk of neglect, abuse (physical, sexual and severe emotional abuse) or exploitation, and referral to medical services for health, nutrition and/or protection related needs, are considered urgent/ immediate is maintained; • For COVID-affected parents with mild and moderate symptoms, children shall be provided with protective equipment as children may remain with parents/ caregivers; • For COVID-affected parents with severe/ life-threatening symptoms, children might be placed with a caregiver (following consent of mother and the caregiver); • Potential group home for children separated from parents/ caregivers due to COVID outbreak, a temporary shelter should be established with nurses and community volunteers present with special PPE; • Identification of persons/foster/interim families in affected communities who are best placed to care for unaccompanied children as a result of the COVID outbreak. Such persons may include those who know about COVID or may have survived. This may include developing alternative strategies to the fostering model such as group homes for children separated from parents; • Last resort: institutional care for children separated from parents or when alternative care is not to reach; • Ensure children are supported to maintain contact with their family member/caregivers in isolation/quarantine. <p>Awareness activities on risk communication</p> <ul style="list-style-type: none"> • Ensure refugee children/ families have sufficient information on COVID-19 prevention and response • Awareness raising whilst following up on cases is key to ensure relevant messages are repeated over time for the purpose of prevention and detection of COVID-19 as well as mainstreaming psychosocial support in all our work with families. This awareness raising includes: <ul style="list-style-type: none"> a) Information on how to prevent COVID-19, such as hand washing and physical distancing; b) Information on how to recognize signs and symptoms of the disease and the importance of reporting without fearing any repercussions; c) Information about modes of transmission and risks of infection, so that they can effectively combat myths that stigmatize child survivors or children of survivors; d) Dissemination of COVID-19 specific health referral pathways and hotline numbers; e) Support to caregivers in distress and support to children in distress as a result of COVID-19, be it due to illness of dear ones, quarantine or any sort of physical distancing, this needs to consider: <ul style="list-style-type: none"> ○ Ensuring that children receive clear and child friendly and gender-sensitive communication about COVID-19; ○ Ensure that adults in the families receive clear messages regarding how to communicate to children regarding COVID-19, to mitigate stress to children.
<p>Program criticality 2 (non-lifesaving activities but essential activities)</p>	<p>Case Management services for medium risk cases</p> <ul style="list-style-type: none"> • Medium risk cases shall be followed up by phone and the child/ caregiver should receive clear instructions on expected follow up; Cases should be duly documented on ProGres V4 and scheduled for phone follow up at least once a month;

	<p>Provision of psychosocial counselling services for children and families</p> <ul style="list-style-type: none"> • Limited or potentially halt of provision of group based psychosocial support; • Continue the provision of individual counseling for critical cases; • For individuals who otherwise would receive group based psychosocial support in need of continuity of care, alternative individual sessions or peer support can be offered, if urgent, i.e. children or caregivers with high levels of emotional distress; • Where group-based PSS must be halted due to the COVID-19 outbreak, in close coordination with health and social welfare actors determine the way forward for resumption of safe community-based psychosocial support activities. This shall include development of additional measures to be put in place in collaboration with health actors (e.g. taking temperatures, handwashing/disinfection measures); • For children and families who received individual psychosocial support an individual assessment is needed and only the ones who critically need this kind of assistance will continue to receive it. For others, peer support networking and remote management will be offered. • Provide training to PSS community volunteers on the identification of COVID-19 related protection concerns before/during/after an outbreak to support the identification and referral of children in need (including aspects on stigma and fear, misinformation, taboos, etc). PSS volunteers may function as social mobilisers and COVID educators. Training needs to include aspects on hygiene practices (handwashing, cleaning, taking care of cuts, limiting contact between children, means of COVID transmission) • Community messaging (on COVID, separation of children from caregivers, etc.) should be provided based on the attached Annex for caregivers and community members as well as with children; Conduct awareness raising of all child protection case workers on how the infectious disease outbreak can impact on child protection and on COVID-19 outbreak and response related protection concerns; training of caseworkers on the basic facts about the COVID-19, including modes of transmission and risks of infection, so that they can effectively combat myths that stigmatize affected children or children of affected caregivers; • Outreach activities are limited but remain to be in place at limited rate;
<p>Program criticality 3 (non-lifesaving activities, to be deprioritized or to be undertaken from home – low priority/ non-urgent cases)</p>	<p>CP case management services for low risk cases (non-COVID related)</p> <ul style="list-style-type: none"> • Non-urgent and low risk cases shall be delayed but will be documented and added on V4/ tracking sheet and registered as CP cases. Follow-up shall be undertaken by phone; • Cases will be recorded during registration and information passed on to CP actors within the settlement where children will be living for follow-up; • Alternative strategies for remote monitoring will be employed to continue provision of support and follow-up: follow-up through the phone, activation of community-based networks, etc. <p>Community meetings on child protection with CPC, etc.</p>

- Community meetings on CP shall be put on hold; community awareness-raising and sensitization sessions/workshops/meetings; community-based sensitization campaigns/outreaches/dialogues
- Halt the provision of community-based child protection group activities, especially mass gathering like awareness-raising on CP, sensitization/outreach campaigns, to control the COVID-19 outbreak
- Keep regular contact with community leaders and community-based child protection committees, either through periodic telephone communication or individual visits
- In close communication with health actors, determine to what extent and under which modality community-based child protection group activities may be resumed

Training and capacity building

- Training activities in the field will be put on hold (as non-lifesaving activities),
- Training on PPE and other COVID-19 related issues need to be maintained but potentially through alternative media/ tools;
- Staff is encouraged to undertake self-development activities;

Child-friendly Spaces

- Temporary closure of Child Friendly Spaces to control the COVID-19 outbreak
- In close coordination with health and social welfare actors determine the way forward for resumption of safe operation of CFS (in line with GoU directive). This shall include development of additional measures to be put in place in collaboration with health actors (e.g. taking temperatures, handwashing/disinfection measures before accessing the playground/ CFS)
- Revise continuation of stipend to CFS facilitators during the COVID-19 outbreak to ensure retention of trained volunteers (if they are staying in communities) for the time following the outbreak
- Provide training to CFS volunteers on the identification of COVID-19 related protection concerns before/during/after and outbreak to support the identification and referral of children in need (including aspects on stigma and fear, misinformation, taboos, etc.); CFS facilitators may function as social mobilisers and COVID-19 educators. Training needs to include aspects on hygiene practices (handwashing, cleaning, taking care of cuts, limiting contact between children, means of COVID-19 transmission)

8. Emergency Referral System and Operating Child Protection Agencies

The below outlines referral staff for emergency/ urgent cases during the COVID-19 response with regards to child protection cases (children at risk of abuse, neglect, all forms of violence; children separated from parents or caregivers; child/ forced marriage, child labour, children with disability without access to support; children with extremely vulnerable families, etc. see prioritization criteria).

A separate Emergency Referral Pathways has been established.