

Child Protection Case Management Guidance during COVID 19 – Somalia

This technical guidance aims to support Child Protection agencies providing case management services in the humanitarian response in Somalia to be prepared and to adapt their interventions in response to the COVID-19 outbreak.

During a disease outbreak the disruption in the environment, socio-economic situation, daily routines and life of the families and communities and the measures put in place to prevent and control the spread of the disease heavily affect the children's development and well-being as well (*e.g. fear, distress, possible separation and no recreation/learning due to the suspension of group educational and PSS activities restrictions on movement or mandatory quarantine and isolation*).

Children become more vulnerable to violence and psychosocial distress and might resort to negative coping mechanisms. Among other risks, children might face with increased exposure to violence against children, exploitation, transactional sex, worst forms of child labour or forced early marriage.

The two major considerations the child protection actors need to keep in mind when adapting your case management programming for an infectious disease outbreak are:

- 1. The health, safety, and level risk of for the children and families you work with**
- 2. The health, safety and level of risk for your case workers and staff.**

During COVID-19 there are 5 priority areas that Case Management agencies will have to focus on:

- 1. 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:
 - 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, due to illness of dear ones, quarantine or any sort of physical distancing, this needs to consider:
 - 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.
- 2. Referral pathways:**
 - CP actors to keep the district, sites/camp-level protection referral pathways updated and apply the most recent health referral pathways in the event that a COVID-19 case is suspected in the household.
 - CP agencies to actively promote referral pathways from health actors to ensure that children at risk of violence and abuse identified by medical staff (e.g. in hospitals, health centres, quarantine) are referred to appropriate services.
 - Or in the event that parents/caregivers are admitted for COVID-19 and children are left without adequate support, Health actor to refer the case to CP.

3. Case Management of cases, this includes:

- a) **Current caseload:** Continue to provide the CM services for children currently receiving case management, with a focus on prioritizing cases of children at high risk. All case management agencies need to review their existing caseloads to ensure risk level attribution is appropriate.

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</i>
Low Risk	By phone	By phone
Medium Risk	By phone	By phone
High Risk	Visit with appropriate precautions	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.

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

- b) **Caseload generated by COVID-19:** (e.g. **increased distress, domestic violence and rape, violence, child labour etc.**): to be treated as all other case management cases and in line with overall risk ratings of case management and alternative care, alongside necessary COVID-19 precautions
- c) **For new high risk cases;** Priority should be given to children without family care, children who are separated from their caregivers, including those who would be transferred to medical facilities or 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 stigmatized/rejected by their families and/or communities; and children with family or household members who have contracted the disease.

Establish alternative mechanisms to ensure that children's well-being are followed up and checked on even if communities would face restrictions on movement and/or CP actors have limited or no access to the community.

Caseworkers 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 case workers to wear gloves and masks – in order that they do not become a vector for the transmission of the disease.
- Promote physical distancing - maintain one to two meters distance with the child and if possible and appropriate, perform the visit 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 Ministry Health (get tested if possible) and follow up to date referral pathways for COVID-19. The social worker should only handle case files over the phones.
- In cases where the family asks the Social/Caseworker not to conduct a home visit due to concerns related to the transmission of COVID-19, Caseworkers should be understanding, postpone the visit and try to do the appropriate follow up over the phone. If the case is urgent, it should be referred to an alternate competent colleague.
- 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

- *Consider additional preferred alternative care arrangement (especially for children living with elderly care providers or other vulnerable care providers as well as tri-generational families)*

- *Use of phone is suggested if coverage/signal is satisfactory and Caseworkers should also coordinate with their CM Volunteers if appropriate.*
- *Where possible, home visits and case follow ups in person should be conducted with appropriate pre-cautions*

4.) Family separation and Alternative Care:

Please note that children whose parents have become ill or die should first be processed in terms of mandatory period of isolation by health practitioners before being placed in alternative family care.

- i. Due to COVID-19 caregivers may fall ill, be quarantined, be hospitalized or die and children might face separation. Alternative care solutions need to be identified for children starting from when a caregiver is reported sick (before hospitalization or death).
 - o Agencies with alternative care programme should update the contact list of previously identified and trained foster carers who are ready to foster a child in case of separation. Agencies should confirm their available pool of foster families and the procedure to receive referrals to the CP AoR and the CPWG Focal points at the regional level.
 - o Agencies to provide training to standby alternative carers, particularly with regards to temporary care during COVID-19 (specific PSS support for children, messages, hygiene awareness etc.)
- ii. Other safe alternative care arrangements can be also established (e.g. kinship care) for children separated from their parents/caregivers moved to quarantine or hospital.
- iii. For parents that are quarantined but remain at home in separate living quarters to the children, the case workers should support the family to ensure community care is available to supplement the family. The case worker should conduct daily/weekly follow up visits to ensure the children are supported and facilitate access to available recreation and education programmes and PSS.

5.) Capacity building of Caseworkers and CM Community Volunteers:

- Train Child Protection staff on protection related risks that COVID-19 can pose for children, basic facts including symptoms, modes of transmission, so that they can identify and refer children and combat myths that stigmatize child survivors or children of survivors.
- (Refer to the materials shared by CP AoR in the Dropbox folder.)
- Frontline workers must be educated about hand sanitization before, during and after visits, about physical distancing, how to talk with children about COVID-19 etc.

Further to this guidance note on Case Management, you can find useful materials and guidance developed for the context of COVID-19 outbreak, e.g. 'The Alliance COVID 19 Brief Version 1.docx' or 'COVID-19 Key Messages WG.pdf', please visit the shared Dropbox folder:

https://www.dropbox.com/sh/4eq98gizbt18bea/AAA1_9Jz2p03sQoC19yRBBYKa?dl=0

Please contact the CP AoR for technical advice and support as required Ranjini Paskarasingam at rpaskarasingam@unicef.org and CMTF co-chair Billy Mubarak at ft.somalia@intersos.org

Annex -1

Modalities of Adapted and Remote Case Management:

In situations of containment, when limited movement and contact is a viable option, you may be able to continue face-to-face support, while observing IPC protocols. You may also consider switching to a health-center based caseworker model described below. This is also the opportunity of train all frontline workers on the confidentiality and best interest of the child.

In situations of delay, mitigation, or any severe restriction of movement and access, the following are options for continuing case management support remotely:

1. **Health-centered based caseworkers.** When movement of people is limited, and the majority of efforts are focused on supporting healthcare systems, basing a caseworker at a health center might be a good option. The caseworker could be available to support both care givers and child who are infected with Coronavirus who report to the hospital. You need to be careful not to be seen to be creating an extra burden for staff, but rather child protection should be framed and recognised as a life-saving service in itself.
2. **Mobile phone case management.** Caseworkers may be able to provide case management support by mobile phone. In this case, consider the following:
 - a) Provide additional sim card and/or mobile phone to caseworkers solely for the purpose of providing support.
 - b) Assess and document Electricity sources: What kind of access to electricity do they have? Is maintaining charged phones a challenge? Option to provide battery packs or solar chargers?
 - c) Consider the safety of making and receiving calls for staff, as well as safety of making and receiving calls for clients. **There is a risk that conversations might be overheard and confidentiality breached.** And risk of predators taking advantage of remote systems to groom / recruit children.
 - d) Identify the safeguards based on information movement for remote contact (Personal number / caregiver verification / focal point (if unreachable).
 - e) How is data collected? We want to avoid caseworkers storing paper forms at home or in locations that are unsafe. Colleagues from Somaliland and Puntland, who have CPIMS+ should consider using it.
3. **Involve trained links/focal points** from the community on checking that a child and his/her family are **coping well** and receiving appropriate services and support where possible.
 - a) Establish mechanisms to monitoring the child's situation and identifying any changes in a child or family's circumstances.
 - b) Review how the implementation of the plan is progressing, whether the objectives outlined in the case plan are being met, whether the plan remains relevant, and how to make adjustments to the plan if necessary.
4. **Hotlines:** If a hotline exists already, discuss with that provider how you may link into that by offering staff support, sharing their number, etc. If there is not, you may consider buying additional mobile

phones and creating a shift schedule for caseworkers. Remember that if caseworkers are also on lockdown, they will have duties at home and stress of their own. Therefore, it is important to discuss what is feasible and safe.

5. **WhatsApp communication:** This may be the preferred option for communication both by survivors and case workers. You need to take into account staff stress, home duties, safety, access to electricity and internet, as mentioned above.
6. Limited but **rapid / mobile response team:** Your organisation may maintain a rapid response team during the outbreak with limited staff involved in providing essential services, in accordance with national strategies and IPC protocols. If this is the case, you may advocate for a caseworker to be on that team, if the benefits outweigh the actual and perceived risks.