Case management considerations for children at risk of separation, including recently reunified children, during COVID-19 pandemic.

This guidance should be considered for:

- Children who live with their family or other family environment within a community setting, who may be vulnerable, or at-risk of separation. This could also include siblings of a child who lives in residential care.
- Children who have been recently reunified with their families from residential care including children who were rapidly exited from residential care facilities due to the COVID-19 pandemic.

Process	Changing scenario /changes to anticipate	Guidance
Identification	Households who were previously safe and stable may rapidly become unsafe/unstable in a rapidly evolving context.	This can include households who had previously graduated from case management, as well as children and households who have not previously been enrolled. Important to look for new indicators of vulnerability, for example: ▪ Households with elderly caregivers and/or caregivers who have chronic diseases (for example, diabetes, heart disease, respiratory diseases), those who are immune-compromised or have specific disabilities are at high risk of becoming ill should they be exposed to COVID-19. This may limit their ability to care for children in their household. ▪ Households with caregivers who have exposure to lots of people via their work (for example, market sellers or public transport drivers). ▪ Households with caregivers whose normal income may be limited while communities physically isolate (for example, motorbike taxi drivers).

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		▪ Households who live in close proximity to other households, who may find it difficult to physically isolate from one another (for example, in informal communities). ▪ Households who may not have consistent access to running clean water. Enrolment criteria may need to be widened to accommodate new definitions of which households are most vulnerable.
	Multi-sectoral child protection actors who may have previously led/supported in identification and referral of vulnerable children/households are likely to become less mobile (as they follow physical distancing and reduced mobility guidance) and/or have their time diverted to COVID-19 response services, making them less available to support the identification process.	There will be increased reliance on self and community identification of vulnerable children and households, which requires dissemination of messaging that ensures the community is able to recognize children at risk of separation, and contact details for authorities and supportive services. Consider "piggybacking" off health initiatives that are wide reaching (for example, some health service providers may be conducting IEC via phone – insist that Child Helpline 116 be included in all messaging).
Assessment	Case workers may be limited from physically visiting households to assess a family's situation	It is important that caseworkers try to continue assessments via phone. Caseworkers should be mindful of calling families when it is convenient for them. Ideally, calls should be kept to a maximum of 20 minutes. For new assessments, it will be important to invest time in building rapport – remember, you may feel like a stranger to the family, and the quality of the rapport you are able to build will largely dictate the ability to carry out case management. If a caregiver doesn't answer their phone, caseworkers may not be able to physically go to check on them. Therefore, it will be essential to acquire a list of support people around the family who can be contacted if the household's primary contact becomes unreachable. This will be important for checking the family is safe.

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		Without being able to talk confidentially with children in the household via phone (i.e. it is likely the caregiver will be sitting with them) and without being able to verify information physically, it may be challenging to pick up on signs of violence against children (VAC). Given the increased stress on families during the pandemic, it is critical that case workers are diligent and coordinate with local authorities should they suspect VAC is occurring.
	Needs and urgency of needs may evolve rapidly as the situation progresses.	Conduct family assessments keeping in mind not only current situation but also worst-case scenario. Family assessments should prioritise: ▪ Basic needs – food, shelter, measures that will help to prevent exposure and transmission of COVID-19 (for example access to soap and water) ▪ Violence against children (VAC) - stress from possible loss of employment, children home from school, increased time together can lead to VAC. It will be important to thoroughly assess the strengths and resources available to families and to make sure they are aware of these and how to access/leverage them in times of need.
Case planning	Families will likely need to focus on basic survival needs	It is OK if families' higher-level goals are postponed, to prioritise goals related to basic needs, including: ▪ Consistent access to water ▪ Food security ▪ Shelter which allows for physical isolation ▪ Safety ▪ Care contingency options, especially if the primary caregiver is elderly or another high-risk category It is essential to support families to develop contingency plans to adjust to the evolving situation; imagine 'worst case' scenarios and ensure the family is clear how they can support and protect themselves (i.e., civil unrest, delays in food supply chain, a primary caregiver becomes ill, etc.).
	Children's education may be disrupted as schools close according to	Efforts should be made to ensure that education continues. Children should be supported where possible with education materials (textbooks, notebooks, pen/pencils etc.) and linked to available

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	governments' physical distancing guidelines.	virtual resources (for example, online classes or sessions on TV or radio) to ensure they are able to continue some form of education whilst at home.
	Traditional support from extended family members and community may not be as readily offered or easily accessed.	Relating to care arrangements, there may be fear around agreeing to care for a child from a household where a caregiver was exposed to the virus. Ensure that targeted messaging about how to prevent the spread of COVID-19 is shared. If needed provide hygiene kits to the alternative caregiver. Kinship and foster families should be given additional material support, including financial, health, and education, given the additional expense of caring for a child at a time of crisis, if at all possible. Identifying and securing sources of additional support in conjunction with relevant health authorities to ensure alternative care placements are able to meet the support needs of children with disabilities, special needs and/or those with underlying health issues who may be disproportionately affected by COVID-19, including in the event hospitalisation is required. Case plans (especially 'worst case' scenario contingency plans) should take into account that extended family and community may be less able than usual to provide support.
	Increased stress and pressure on caregivers will see increased risk of violence against children	Parenting support will be an essential component of developing a case plan. Support may include: ▪ Positive discipline ▪ Mindfulness and self-care ▪ Support for speaking to children about COVID-19 especially the importance prevention measures ▪ Support for speaking to children about fear, anxiety and uncertainty
	Physical distancing requirements restrict the mobilisation of groups of people, meaning family group conferencing and case conferencing may not be possible.	Efforts should be made to conduct collaborative decision-making via phone or online.
Referrals	As the situation evolves accessibility of services may change, and service provision may also change.	New health and WASH services could be established as the situation evolves, and governments have been seen to rapidly develop economic relief initiatives. Caseworkers should monitor reliable government information sources (local authorities, Ministry of Health, local coordination mechanisms), and seek services for both children in their care, and families within the community.

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		Keep in mind that service providers who do not typically provide health services may begin to mainstream health-focused elements which may be helpful for children and families (for example, dissemination of IECs about prevention measures).
	Transmission risks are innate within referral process, including exposure to new people, multiple people touching referral documentation, etc.	▪ Handwash before and after touching referral documentation. ▪ Maintain physical distance when possible; where close contact is required, wear masks. ▪ If child is showing symptoms, wear masks.
	Transportation may be limited as many public means may become restricted.	▪ Private transportation may need to be acquired / provided to access referral services. ▪ Ensure driver is equipped with masks and water/soap/hand sanitisers. ▪ Pay attention to local guidance on the number of passengers allowed in a vehicle at one time. ▪ Windows should be down throughout the trip.
Monitoring	Community-level actors normally relied upon to support monitoring of reintegrating children and families may not available (e.g. neighbours, chiefs, schools)	Important to equip children and families with contact information for local authorities and hotlines, as well as encourage caregivers and children to contact case worker directly should they face any challenges.
	Caseworkers may not be able to physically visit households for monitoring.	Efforts should be made to virtually monitor households, see link to guidance here. Cases should be categorised as high, medium or low risk and frequency of monitoring determined accordingly.
Graduation / case closure	Given the numerous risks and vulnerabilities facing many families at this point in time, graduation should not be the immediate goal. Rather, it is important to prioritize cases as low, medium and high risk.	Important to identify low-risk cases to free up case workers' time. However, at this time, it is not recommended to officially close any cases as the socio-economic and health risks will continue for a period of time.
	As the situation evolves, households who have had their cases closed or graduated from a program may suddenly become vulnerable again	Ensure all households are provided contacts for case workers, service providers, local authorities, and other support actors who are geographically accessible to them, should they face challenges.

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Supervision	Case workers' wellbeing may be strained under rapidly evolving personal and professional context, and risk of burnout and secondary trauma are high.	▪ Check-in with caseworkers on their personal/family situations – remember "we cannot care for others if we are not OK ourselves." ▪ Discussion of self-care should be included in all supervision sessions. Facilitate peer-to-peer discussions using Zoom or WhatsApp groups. ▪ If increased one-to-one supervision is not possible, convert to group supervision sessions to allow for increased frequency (observing physical distancing protocols). ▪ Extra support to caseworkers for caseload management will be important, including categorisation of low, medium, high risk cases.
	Administrative and operational procedures may become a bottleneck within rapidly changing context.	▪ Discuss if case worker has necessary resources to carry out their work. Be mindful case workers may require increased resources (for example, more access to private transportation than usual to enable referrals, more airtime than usual to enable monitoring via phone) ▪ Ensure level of flexibility with administrative processes to ensure they do not create delays and affect the timely and efficient response.