

Guidance for Alternative Care Provision During COVID-19

The development of this Technical Note was coordinated by Better Care Network, Save the Children, The Alliance for Child Protection in Humanitarian Action and UNICEF

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CONTENTS

INTRODUCTION	1	
I. UNDERSTANDING THE CONTEXT	3	
II. ENSURING APPROPRIATE CARE FOR CHILDREN DURING COVID-19	6	
A. PREVENTING FAMILY SEPARATION DURING COVID-19	7	
<i>Mexico Case Study</i>	8	
<i>Señora Clara, Gustavo and José's story</i>	9	
B. SUPPORTING SYSTEM LEVEL RESPONSE AND GATEKEEPING	11	
<i>Tanzania Refugee Camp Case Study</i>	14	
KEY PRINCIPLES FOR SUPPORTING ALTERNATIVE CARE PROVISION DURING COVID-19	15	
III. KEY CONSIDERATIONS FOR PLACEMENT IN ALTERNATIVE CARE	16	
A. FAMILY-BASED ALTERNATIVE CARE	16	
1. Considerations for Kinship Care	18	
<i>Ukraine Case Study</i>	22	
<i>Igor's Story</i>	24	
2. Considerations for Foster Care	26	
<i>Cambodia Case Study</i>	33	
<i>Srey Oun's Story</i>	34	
B. RESIDENTIAL CARE	35	
1. Considerations for Residential Care	38	
2. Considerations for Isolation Treatment Centres (ITCs) and Quarantine Centres	43	
<i>Kenya Case Study</i>	50	
<i>Mary's Story</i>	52	
SPECIFIC CHALLENGES FOR ALTERNATIVE CARE ACROSS BORDERS	56	
SPECIFIC CHALLENGES FOR ALTERNATIVE CARE FOR STREET CONNECTED CHILDREN	58	
ANNEXES	60	
Annex I: Example SBCC Strategy for Recruiting Foster Carers	60	
Annex II: Example Information for Non-CP actors to assist in Family Tracing	63	
Annex III: Example Form for Health Workers to Document FTR Information	65	
Annex IV: Example Informed Consent Script for entering an Isolation Treatment Centre	66	
ACKNOWLEDGEMENTS	69	



INTRODUCTION

This document provides practical guidance to actors in humanitarian and development contexts on the adaptations and considerations needed to support children who are either currently in alternative care or are going into an alternative care placement during the COVID-19 pandemic.

It expands on the guidance provided in the [Interagency Technical Note on Children and Alternative Care Immediate Response Measures](#)¹ by providing more detailed guidance for the medium and long-term response, recognising that the current pandemic and measures to address it are likely to continue over prolonged periods of time, and also to be reoccurring in phases. It should be read alongside the [Technical Note: Adaptation of Child Protection Case Management to the COVID-19 Pandemic](#).

International standards and guidelines on children's rights and alternative care always remain applicable,² including in the context of this pandemic. However, COVID-19 poses specific challenges and risks to children with regards to appropriate care both at the policy or system level and in work with individual children. This includes: the potential temporary need of alternative care when caregivers become ill or die, the availability of placements including at borders or while children are in transit, the increased risks in residential care settings, and the strain on existing child protection and child welfare services.

Emergency situations can also increase the risk of inappropriate recourse to alternative care and result in an influx of children into residential care and the establishment of new childcare institutions. This can happen during the crisis and post crisis, if residential care is promoted as the primary means of providing support to children who have lost a caregiver or been made vulnerable due to COVID-19. Efforts to pre-emptively scale up and strengthen the capacity of family-based care and social protection systems are critical to enhance family resilience and prevent the unnecessary recourse to residential care. As there are already existing resources available related to the provision of alternative care services, this guidance focuses specifically on how alternative care provision needs to be adapted in light of COVID-19. Broader resources and tools to assist in implementation and decision-making are referenced but not restated.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



1 [The Technical Note](#) is framed by applicable international standards. See footnote 2 (below) for a list of the international standards.

2 The [UN Convention the Rights of the Child](#), the [Convention on the Rights of Persons with Disabilities](#), the [Guidelines for the Alternative Care of Children](#), and the [2019 Minimum Standards for Child Protection in Humanitarian Action](#) including Standard 18 on Case Management and Standard 19 on Alternative care. The [2019 UNGA Resolution on the Rights of the Child](#) with the theme of children without parental care also underlines important agreed global commitments. The [Alternative Care in Emergencies Toolkit](#), The [Minimum Standards on Child Protection in Humanitarian Action](#) and The [Field Handbook on Unaccompanied and Separated Children and its Toolkit](#) also provide important practical guidance on how to apply international standards.



This guidance provides

- **Key principles and adaptations** needed to prevent family separation and facilitate decision making about care placements.
- **Key considerations** for each type of alternative care placement including:
 - System-level responses
 - Individual child-level responses including for:
 - Children currently in family-based alternative care who may be at risk of their placement breaking down due to COVID-19.
 - Children in need of alternative care.
 - Children who are leaving residential care either due to family reunification or placement, or the closing of a facility.
 - Children who are being placed in existing or new residential care centres in the context of the pandemic, including quarantine or other types of facilities used to isolate children.

As we learn more about the virus, modes of transmission, and who is most at risk, public health advice will continue to evolve. **It is critical that child protection workers, be it government and non-governmental workers, follow and adapt to the most up-to-date factual public health guidance and information.**

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES





I. UNDERSTANDING THE CONTEXT

While this guidance focuses specifically on alternative care during the pandemic, it also recognises the need for any response to be framed within the existing child protection system and deinstitutionalisation strategies, taking into account specific considerations for longer term alternative care solutions within a country, and the opportunities to lay the foundations for longer-term care reform. Given that COVID-19 is present in low, middle, and high-income countries with a variety of care systems in place, child protection and child welfare actors as well as key stakeholders need to first understand the context in which they are operating.

Interim Care

The complex and urgent nature of this pandemic and its impact means that families, child protection practitioners, and service providers have to make important decisions about children's care in a fast-changing environment. Interim care arrangements—often in response to an urgent need for care identified—must be available to address this situation and secure children's rights to care and protection, this can take the form of emergency placements.

The provision of formal alternative care for children should always be a temporary measure whilst permanent solutions are sought, and it should have the clear purpose of offering children a stable, protective, and nurturing environment.

Whether an unaccompanied child is being placed in foster care whilst family tracing and reunification processes are undertaken, or alternative care is sought for a child whose primary caregiver has died as a result of falling ill to COVID-19, the process of determining appropriate care and the placement choice should always be looking towards longer-term solutions given the temporary nature of alternative care. Care planning should be an integral and ongoing part of the provision of alternative care, with a clear time frame and the overall goal of ensuring the child can be reintegrated into to care of his/ her family or provided with a longer-term, stable, and nurturing family environment.

This includes:

- The context in which containment and distancing measures are to be implemented and how this may affect the care placement, including understanding what is realistic in terms of self-isolation (e.g. crowded camps/settlements or households with a large number of family members, child care institutions with large numbers of children and staff in rotation.)
- The availability of health services, testing for COVID-19 (where it is being done, who is eligible, potential costs involved, and barriers to access), and **personal protective equipment availability (PPE)**.³⁻⁴
- The availability of social services, capacity of the social service workforce, and any restrictions or limitations they may face (e.g. barriers to access, personal protective equipment etc)
- The formal child protection system (its legal and policy framework and the role of government agencies in supervising and operating child protection and alternative care services, including the quality of these services, the extent to which they are operational, and the capacity of alternative care services to offer interim care).
- The existing community-level mechanisms, and positive endogenous care practices and how these are being impacted by the virus and containment measures.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



3 World Health Organisation. (March 2020). [Rational use of personal protective equipment \(PPE\) for coronavirus disease \(COVID-19\)](#)

4 World Health Organisation. [Advice for the public on when and how to use masks.](#)



- The availability and accessibility of family strengthening and supportive services.
- The role of national coordinating bodies and technical working groups with responsibility for children’s care and care reforms. In humanitarian contexts, this will include the coordinating bodies such as the appropriate clusters and UNCHR in refugee contexts.
- The availability and access to social protection schemes, cash and voucher assistance and support available for vulnerable families, including foster and kinship families, to meet basic needs and prevent future debt or resorting to coping strategies that may have a harmful impact on the child and family.
- The availability and accessibility of education, both remotely and when schools reopen.
- Gender dynamics and how these interplay with risk and health factors, as well as access to services should also be considered.
- The extent to which laws, policies and services recognise the rights of both children and adults with disabilities and have put in place mechanisms to ensure persons with disability full access to services and support in order to practically fulfil those rights.
- The extent to which laws, policies and services recognise the rights of migrant and displaced children regardless of their legal status in a country.

CONTENTS

INTRODUCTION

CONTEXT

APPROPRIATE CARE

KEY PRINCIPLES

CONSIDERATION FOR PLACEMENT

FAMILY BASED CARE

RESIDENTIAL CARE

CARE ACROSS BORDERS

STREET CONNECTED

ANNEXES

The role of government, civil society actors and local communities will differ significantly in each of these contexts. The following table outlines some of the various ways in which each of these actors may engage with alternative care during COVID-19. In each section there are examples of the roles that government, civil society, and local communities may play in these contexts. These are not mutually exclusive, and several can be applicable in the same context at the same time.



<p>Government</p>	<ul style="list-style-type: none"> • Mandated to protect children without adequate family care, including providing support to vulnerable families to adequately care for their children. This includes providing the authorisation to remove a child at risk of significant harm and make appropriate care placements. • Regulates alternative care providers, including establishing gatekeeping mechanisms, issuing regulations and national standards, and the accreditation and licensing of the social service workforce. • Monitors quality care provision and gathering relevant data. Provides oversight to civil society and the local community to ensure quality services are provided. • Coordinates government departments, multiple services providers, and cross-border placements as well as those awaiting cross-border reunification. • Delivers support and services for family strengthening and prevention of separation as well as direct alternative care provision. • Funds and provides other forms of support to key actors in service provision.
<p>Civil society (national and international NGOs and CBOs, faith organisations, disability networks etc)</p>	<ul style="list-style-type: none"> • Strengthens the child welfare system and alternative care provision, including community-led prevention strategies. • Supplements the government system when formal or informal capacity is limited or has gaps. This could include contexts such as refugee settings. • Delivers direct child protection services on behalf of the State with government oversight and/or funding. • Supports community-level measures to prevent unnecessary family separation. • Advocates for a strengthened child welfare system, including appropriate alternative care provision, locally and/or internationally.
<p>Local community (community child protection mechanisms, local groups)</p>	<ul style="list-style-type: none"> • Strengthens the existing child welfare system through referrals and follow up with vulnerable children and families. • Supplements formal service provision by monitoring children’s care and safety and wellbeing, and referring to formal services when appropriate. • Delivers basic child protection services through local mechanisms like community-based child protection mechanisms and/or in coordination with local government. • Identifies potential foster care providers. • Supports government and civil society actors. • Strengthens existing positive endogenous practices supportive of safe and nurturing family care such as placement with a trusted family member or family friend when alternative care is needed, as well as raising awareness within a community on societal issues like discrimination that may lead to the abandonment or maltreatment of children. • Advocates for community foster carers and appropriate care options; holding government accountable for the provision of services.



II. ENSURING APPROPRIATE CARE FOR CHILDREN DURING COVID-19

There are many reasons why children may need alternative care placements or may need additional support in their current placements due to COVID-19. This guidance considers:

- Children in families who may be facing care challenges as they have either been infected, are symptomatic, or have been exposed to COVID-19;
- Children who may need alternative care because their primary caregiver(s) has been infected, is symptomatic or exposed to COVID-19 and cannot continue to care for the child;
- Children who are already in alternative care, as well as children who are without family care during the pandemic including: migrant and displaced children, unaccompanied children, and children detained at border crossings, and children living and working on the street.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES





A. PREVENTING FAMILY SEPARATION DURING COVID-19

All efforts should be made to prevent the separation of children from their caregivers. Prioritising family-based care during COVID-19 includes: providing support to vulnerable families to prevent separation by, among others things, increasing and supporting access to benefits such as cash transfers and the expansion of social protection schemes; pre-emptively scaling up the capacity of family-based care; contingency planning for back up carers with the child's family, or trusted family friends who could provide care should the primary caregiver fall ill; and planning how the child can keep in contact with family members should he/she need to be separated temporarily due to virus.⁵

If a child or family was in contact with child welfare or child protection services or identified as vulnerable and in need of services prior to COVID-19, **it is essential not to discontinue support but adapt the response to ensure the needs of the caregivers and the child are prioritised in this particular context.** This includes not only adapting the methods of communications and service delivery but also identifying new needs and working with the family to address them.⁶ New service plans should be discussed and agreed with them, including the provision of additional emergency support during the pandemic. These plans should be reviewed regularly in collaboration with the family and the child.

Proactive and regular follow up should occur by social or case workers with children and their caregivers where concerns have been identified based on the severity of issues the child is facing. For more information on categorising risk, please see the [Technical Note: Adaptation of Child Protection Case Management to the COVID-19 Pandemic](#).

When working with a family, case workers should support caregivers to discuss, decide, and document whom they want to care for their child should they become ill. Contingency plans should also include: steps to be taken if a child needs to be hospitalised and organising for a caregiver who is not at high-risk for developing complications from the virus to accompany the child to the hospital. If this is not possible, establishing steps to ensure the child has contact with his/her family during the period of isolation.



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CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



⁵ Interagency Technical Note on the Protection of Children During the COVID-19 Pandemic: [Children and Alternative Care - Immediate Response Measures](#); The Alliance for Child Protection in Humanitarian Action [Technical Note: Protection of Children during the Coronavirus Pandemic v2](#).

⁶ [Technical Note: Guidelines for virtual monitoring of children, their families and residential care facilities during the COVID-19 pandemic](#), Changing the Way we Care.



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Mexico Case Study

The JUCONI Foundation has been working in Mexico for 31 years and supports marginalised girls, boys, adolescents, and their families in situations of violence and poverty, using an educational-therapeutic model based on home visits.

The COVID-19 pandemic represented a huge challenge for the organisation as it needed to continue to engage and provide support to these families by reaching them remotely.

The JUCONI team developed different strategies to adapt to lockdown and ensure its services continue to reach these families: face-to-face sessions in the home were replaced with phone calls, since the families it works with do not have either access to internet or the equipment to enable them to connect online or use digital platforms such as Zoom or Google Meets.

The families are receiving one to three calls per week from their 'educators', based on their needs. In these calls, the families have conversations or carry out activities relating to the problems or challenges they face during the lockdown.

The sessions with girls, boys and adolescents have also been adapted in order to be able to conduct them by phone and JUCONI has also developed audiovisual content using WhatsApp. In addition, it is also providing televisions to families who don't have them, so that the girls, boys and adolescents in their programs can continue to access distance learning on TV.

With the support of UNICEF Mexico, JUCONI has developed a Manual based on this experience, in order to share it with teams in the Federal System that support families, as well as other organisations providing services to families that need to adapt their practice to 'remote support'.





Señora Clara, Gustavo and José's Story



Señora Clara's family is one of the users of the JUCONI Program's services in the Family Support Center. In addition to working with families in their homes, JUCONI also offer services through this center to girls and boys aged 0-6 and 6-12, including educational support, recreational and sporting activities, among other things.

The family includes Señora Clara and her 2 nephews, Gustavo aged 7 and José aged 5. The children's mother left the family home and their father was jailed. This made the situation very difficult for the children who experienced it as abandonment. However, Señora Clara, their aunt on their father's side, took charge of the children. At that point, the children were clearly upset and became aggressive and Señora Clara found them very difficult to manage. She was unable to set boundaries in a peaceful manner and became violent towards them. She came to JUCONI on the advice of a friend who knew of the Family Support Center.

JUCONI started working with the family face-to-face in 2019 and during the period leading up to the beginning of the pandemic, the family made good progress and participated actively in the activities of the JUCONI Program.

When the pandemic started, all 'non-essential' activities were suspended (family and educational therapy are considered by the authorities to be non-essential). The team attending the family had to suspend its visits to Señora Clara's home. The family educators had to adapt rapidly to the new situation in order to respond to the needs of this family and developed new ways of engaging with them via

phone, "meeting with the family where they are located", using the available technology.

JUCONI has been working with Señora Clara individually by phone and the team has been holding weekly sessions with her and the children in order to strengthen the relationship and build on the advances which already existed. In those sessions, the family has managed to channel its anxiety about the pandemic, the changes and the new situation, and has shown its resilience by rapidly adapting to telephone meetings and the use of other distance support resources.

In some sessions, other members of the family such as uncles and cousins also took part in the conversations and activities proposed by the educators.

Señora Clara has also participated in sessions which are part of the services offered by the Family Support Center, through clips developed by the educators and sent via WhatsApp to the family. In those clips, JUCONI shares information about the development of children 0-6 years old and afterwards the educators speak on the phone with Señora Clara to discuss how this information can be helpful in her process with the children.





Continued

The JUCONI team also supports remote reading sessions, which in addition to sharing stories, help the family members reflect on their emotions in the present context. Señora Clara has learnt to identify how she feels, and this has allowed her to reflect on her emotions and to know how to act accordingly. It has also allowed her to help her nephews with actions, not just words. These services have ensured that no unnecessary separation takes place between Gustavo and José and their aunt Clara. It has kept them united and safe under lockdown, and has given them the possibility of resorting to JUCONI as part of their support network in these difficult times.

The JUCONI team has also continued to conduct some face-to-face meetings to enable the delivery of material support to families in their communities, following public health protocols, and they are also providing support for medical attention, whenever there is a possibility of COVID-19 or any other illness during this time.

Working with families over the phone has been very useful in attending to the support needs of families being served through the Family Support Center and JUCONI's other programs, and in maintaining the relationship and the educational therapeutic process. There has been less use of on-line communication due to the difficulty many of these families face in accessing the internet and other technological resources. So traditional telephone calls have been the best tool for continued meetings with these families and for maintaining the progress achieved through the face-to-face intervention programs.





B. SUPPORTING SYSTEM LEVEL RESPONSE AND GATEKEEPING

This guidance covers both formal and informal placements given that, in most contexts, informal care placements with relatives or individuals known to the child are the most common forms of care provision.

When considering any placement in the context of this pandemic, child protection and child welfare practitioners and other key stakeholders should consider the safety and wellbeing of the child as well as the safety of caregivers. This includes protecting children and adults who are considered most at risk for suffering severe illness from COVID-19.⁸

As noted in the [Technical Note](#) on Immediate Response Measures, **emergency plans covering alternative care services** should be developed by the child welfare authorities in partnership with service providers and community leaders taking into account the fluidity and likely duration of the pandemic. The system and the service providers will be affected by its impact and it is essential for the mandated government agencies to clarify how this system is going to operate during this period, including changes in roles and responsibilities, and support available to ensure effective functioning during this challenging period.

COVID-19 has highlighted the need for localisation and often decentralised action in effective response. Local authorities should make available **Standard Operating Procedures (SOP)** to address interim care needs of separated or unaccompanied children, including clear guidance on steps to be taken in the event such a child has been exposed or has symptoms of the virus and requires a period of isolation. Particular attention should be paid to prevent unnecessary recourse to residential care (*see further detail in the Considerations for Residential Care section below*) in response to COVID-19, including for children with disabilities and the specific circumstances of children on the move, including those whose care status may be impacted by the closure of borders.

In addition, local authorities should review and identify key personnel, including case workers and the essential resources needed for this period of emergency. This should include plans for temporary replacement staff, should staff members need to self-quarantine, and additional funding for child protection authorities to adapt child protection systems and services in response to the crisis.

Messaging on the prevention of separation and recourse to residential care should be circulated to health care facilities, police stations, courts, local councils and community child protection mechanisms.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



8 World Health Organisation. [COVID-19 Vulnerable and High Risks Groups](#); Center for Disease Control. [People who are at Increased Risk for Severe Illness](#).



The key principles of necessity and suitability articulated in the [Guidelines for the Alternative Care of Children](#) remain central to the determination of the most appropriate placement during this pandemic. Before a child is placed into alternative care, practitioners need to ask:

- **Questions of necessity:** “Is this placement necessary?” “Does the child actually need interim care?” “Can the family care for the child if given support?”
- **Questions of suitability:** “What is the most suitable placement for this child’s individual needs?” “What are the child’s preferences?”

Considering COVID-19, we also need to be asking “what is the health status of the child, caregivers, and others in the family?” These questions should be asked in both formal and informal placements and health care providers should be consulted as part of the gatekeeping process.

To ensure this process is done for formal placements and that decisions are recorded and reviewed, a gatekeeping mechanism⁹ should be in place and adapted to be able to function effectively in the context of the containment/restriction measures put in place as a result of COVID-19.

In the context of COVID-19, **formal gatekeeping mechanisms may need to be modified** to include online and telephone screening of referrals to work with families and to assess the necessity and suitability of care placements,¹⁰ as well as authorisation of placement and monitoring by child welfare authorities in the case of formal placements. Accurate and up to date information management practices that record each child and their care arrangement are critical in the often chaotic context of an emergency. Appropriate gatekeeping procedures should also be included in Standard Operating Procedures for residential care centres, Isolation and Treatment Centres and/or Quarantine Centres. Service providers should be required to immediately and formally notify authorities in the event a child is brought to their facility outside of formal gatekeeping mechanisms.

In many contexts, families will make their own arrangements and use **informal systems**, such as sending their child directly to live with a relative or friend temporarily in order to address current challenges they face. It is important for child protection actors to provide information and support to enable family to follow up with their children during this time and ensure they are being cared for appropriately.

9 Gatekeeping is “A recognised and systematic procedure to ensure that alternative care for children is used only when necessary and that the child receives the most suitable support to meet their individual needs”. This procedure helps to determine the child’s needs, ensuring the most appropriate services and responses for that child, including keeping the child with his or her biological family. See: Better Care Network and UNICEF. (October 2015). [Making Decisions for the Better Care of Children: The Role of Gatekeeping in Strengthening Family-Based Care & Reforming Alternative Care Systems](#).

10 [Technical Note Children and Alternative Care - Immediate Response Measures](#); [Technical Note: Protection of Children during the Coronavirus Pandemic v2](#); [Guidelines for virtual monitoring of children, their families and residential care facilities during the COVID-19 pandemic](#). Changing the Way we Care.





Who is at increased risk for severe illness when contracting COVID-19?

Everyone is at risk of contracting COVID-19 if they are exposed to the virus, however some people are more likely than others to become severely ill. According to public health advice, the term “high-risk” refers to children and adults with pre-existing medical conditions such as respiratory issues, autoimmune diseases, diabetes and those over the age of 60 which make them more susceptible to having severe complications if they contract the virus.



For more information on gatekeeping procedures specifically related to COVID-19, please refer to: the [Technical Note](#) and [Gatekeeping Considerations in the COVID-19 pandemic – Changing the Way We Care](#); or to better understand gatekeeping in a range of contexts, refer to: [Making Decisions for the Better Care of Children - Better Care Network & UNICEF](#)





Tanzania Refugee Camps Case Study¹¹

Prior to COVID-19, the Government of Tanzania referred unaccompanied refugee children for a Best Interest Assessment to determine the most appropriate care option for that child.

Government officials from the Ministry of Home Affairs (MHA) participate in Best Interest Determination (BID) panels which are sometimes required in complex alternative care cases and cross border reunification for Unaccompanied Children. The BID panels are convened by UNHCR which also include Plan International case workers, the Government of Tanzania, and the Tanzanian Red Cross and ICRC as well as any other agencies connected to the case. MHA also runs protection villages in the camps which have been instrumental in ensuring that children in need of alternative care due to complex issues such as ethnic clashes, violence, separation cases, are provided alternative care within the protection villages with full time security thus preventing or mitigating harm against children. In situations where there is need for government to make decisions to change an existing policy in relation to children in need of alternative care, it is handled during the BID panel on a case by case basis and exceptions are sometimes made if it is in the best interest of the child.

At the beginning of the COVID-19 crisis, the existing caseload was analyzed to identify the most vulnerable children who might need alternative care and those already in care. Community volunteers were supported to conduct follow up of all children in alternative care both existing and new placements as well as support tracing and reunification. Case workers and volunteers also operate a child protection help desk in various centers where they can receive, document and respond to any cases and concerns affecting children.

Plan International provided intensive capacity building for agency case workers, community volunteers and standby foster parents to ensure quality alternative care services. Orientations and refresher training sessions are conducted on an ongoing basis both remotely and face to face on a variety of critical topics. Civil society worked to develop and contextualise tools for case workers and community volunteers to support alternative care implementation, making the process less overwhelming for community-based child protection (CBCPMs) volunteers to support.



Case worker mentoring community volunteer in interviewing foster parent. ©Plan International

In addition, Plan International provide working and safety gear and tools for infection prevention control (IPC) for case workers, personal protective equipment (PPE), as well as ID badges and visibility vests along with phones with airtime and bicycles to enable easier movement between homes. Children in alternative care are supplied with some non-food items including basic materials to care for children (soap, sleeping mat, blankets, water bucket, toothbrush etc) and menstrual hygiene materials if needed.

Refugee community leaders in Nduta, Mtendeli and Nyarugusu camps are engaged in mobilization and selection of community members as potential foster parents. These are then screened by Plan International if they meet the criteria. After proper verification, they are enrolled as standby foster parents. The full involvement of community leaders ensured that even though there is general fear of infection with COVID-19, community members are willing to register as standby foster parents because they trust the leaders who spoke with them about fostering.

Community members, such as Child Protection Committee members, monitor the children in foster care and ensure that they are followed up weekly in order to identify any child protection concerns. Any issues identified in the homes are reported to Plan International case workers immediately for action thus ensuring prevention and immediate response to any concerns.

11 Case study provided by Plan International





KEY PRINCIPLES FOR SUPPORTING ALTERNATIVE CARE PROVISION DURING COVID-19

All decisions and responses, including in the determination of the most appropriate placement option for a child in the context of COVID-19, should be made on a case-by case basis in keeping with the best interests of the child and be informed by public health measures and protocols. Children and caregivers need the most **accurate and accessible information** to make **informed decisions about their health and care**.

During the pandemic this means making decisions based on information that has been issued either by the WHO, UN, or government bodies and being transparent about the availability and quality of services as well as any potential risks in such services.

It is imperative that all measures taken to contain COVID-19 do not undermine children's rights. To make the most appropriate decisions on placement, the following key principles must be considered in light of the specific challenges of COVID-19 and within the wider application of international standards.¹²

<h3>Do No Harm</h3> <p>While the risk of transmission should be limited at all times, efforts should be made to minimise the risk of spreading the virus and particular care should be made to protect high-risk¹³ children, caregivers and staff from contracting the virus as well as protecting children from violence, abuse, exploitation and neglect in either their birth family or alternative care placement. Do no harm is also about specifically recognising the inherent risks of separating a child from his or her family.</p>	<h3>Best interests of the child</h3> <p>In the context of COVID-19, determination of an individual child's best interests takes into account the specific situation of the child including: health risks and mitigation measures available to that individual child and his/her caregivers, the child's family situation, background, and attachments (including siblings), as well as the child's specific needs and views based on his/her age and developmental stage.</p>	<h3>Participation</h3> <p>Children and caregivers have a right to fully participate in decision making, placement options, and care planning. To participate meaningfully, information should be shared in a language and format that is accessible to both the child and caregivers, with particular attention to the evolving capacity of children, and including in ways that are accessible for children and caregivers with disabilities.¹⁴</p>	<h3>Non-discrimination</h3> <p>All children, including children on the move, children in care and children with disabilities, should have access to the same level of health care and other services available to children in the community, without discrimination. Any response to the pandemic, including alternative care placements, should be reviewed to ensure that placement is based on the best interests of each individual child rather than any preconceived notions based on a child's race, ethnicity, gender, immigration or disability status.</p>
<h3>Informed consent</h3> <p>As a rule, placement into alternative care should be done with the caregiver's and child's consent or assent based on accurate and accessible information regarding the nature of the placement, its purpose and length, any risks involved in placement, the review process and communication channels available.¹⁵ Where a biological/adoptive or foster family is concerned about their ability to care appropriately for their child or bringing their child back into the home, every effort should be made to share factual information, dispel rumours, address the concerns of the primary caregivers, and provide them with the support they need to care safely for the child.</p>	<h3>Strengths-based</h3> <p>Even when times are difficult, all parents have strengths they can build on with the right support. When parents thrive, they can give their children what they need to grow up healthy and safe. All caregivers and children should be involved in problem solving and risk management in a respectful and empowering manner. Children and caregivers' fears and concerns should be heard and listened to.</p> <p>For specific resources on strength-based approaches please see: Building Resilience in Troubled Times: A Guide for Parents and Strengths-Based Practice in Troubled Times</p>	<h3>Prevent family separation and prioritise family-based care</h3> <p>Children should never be separated from their parents or other primary caregiver against their will except when competent authorities have determined that such separation is necessary and in the best interests of the child – this can include situations where competent authorities have determined that there is a significant risk to the child or caregiver's health and/or safety.¹⁶</p>	<h3>Prevent the institutionalisation¹⁷ of children</h3> <p>Institutional care is harmful to children and possess additional risks to children during the pandemic due to the potential for disease outbreak, reductions in staffing, and potential delay in monitoring. Strong gatekeeping measures should be in place to restrict new placements into childcare institutions. This is particularly important for young children, especially under the age of three and for children with disabilities who are often disproportionately placed in institutional care.</p>

12 The [UN Convention the Rights of the Child](#), the [Convention on the Rights of Persons with Disabilities](#), the [Guidelines for the Alternative Care of Children](#), and the [2019 Minimum Standards for Child Protection in Humanitarian Action](#) including Standard 18 on Case Management and Standard 19 on Alternative care.

13 World Health Organisation. [COVID-19 Vulnerable and High Risks Groups](#); Center for Disease Control. [People who are at Increased Risk for Severe Illness](#).

14 [COVID-19 Accessibility Campaign](#), [International Disability Alliance](#).

15 [See Annex IV on sample scripts of how to provide accurate health advice and risks of COVID-19](#)

16 As stated under the [UN Convention on the Rights of the Child](#) Article 9(1). See also [Guidelines for the Alternative Care of Children](#) paras. 14, 39-48.

17 According to the 2009 European Commission [Report of the Ad Hoc Expert Group on the Transition from institutional to community based care](#), "an institution is a residential care facility where an institutional culture prevails. The size of the institution matters, but this is not the only defining feature." An institutional culture refers to: the lack of individual support or privacy to children, separation or isolation of children from the wider community, regimented routines for children, discouraging contact with the birth or extended family, and lack of opportunity to form attachment to one or two primary caregivers. Child institutionalization is never compliant with the Convention on the Rights of the Child or in the child's best interests.





III. KEY CONSIDERATIONS FOR PLACEMENT IN ALTERNATIVE CARE



A. FAMILY-BASED ALTERNATIVE CARE

There are some considerations that apply to all family-based care arrangements regardless of whether this is being provided by relatives or through foster care. Child protection actors should ensure case workers and case managers review the cases they are currently managing either directly or working with child protection mechanisms to:

- Assess which children may be at risk of their placement breaking down due to COVID-19 and may require more support.
- Ensure that caregivers, children, and community members understand the benefits of family-based care and the harms of institutional care.
- Ensure all carers and children know how and have the means to contact a case worker or community support if they have concerns or their circumstances change.
- Ensure all kinship and foster families know about available services such as cash assistance, livelihood support, parenting and caregiving support and health services in their areas.



For more information please see: [Integrated Cash and Voucher Assistance and Child Protection during COVID-19](#); [Cash and Voucher Programming for Social Protection During COVID-19 \(World Vision\)](#) and [Working with Communities to Keep Children Safe](#).

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



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- Work with health professionals to ensure all caregivers and children have access to up-to-date information about COVID-19 and how it spreads, local COVID-19 activity and response, key prevention measures, signs and symptoms to watch for, and instructions on seeking medical care.
- Ensure caregivers have the necessary means and supplies to implement key prevention measures (handwashing, cleaning/disinfection, ventilation, masks, etc.), and access to health services, phone/communication services and transport.
 - Kinship and foster families should know:
 - If someone in the family becomes ill, the family should quarantine in their home or isolate a high-risk family member. According to the WHO, a person who is isolating should stay in a separate room from others and if possible, use a separate bathroom. If a separate bathroom is not available, it should be cleaned each time after the isolating person uses it.
 - Any caregiver who becomes symptomatic but is still caring for children, should use a mask when near children and should frequently wash his/her hands before and after contact with children. The surfaces the caregiver has touched should be routinely cleaned and disinfected.¹⁸
- Provide information to children and caregivers about child helplines and hotlines that will be available for emergencies or should face-to-face visits become impossible.



For specific information on preventing the spread of the virus please see: WHO advice for the public to prevent the spread of the disease and [WHO Guidance on home care](#)

For more information on child helplines, please see the [Technical Note on Child Helplines](#)



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1. Considerations for Kinship Care

Kinship care is “family-based care within the child’s extended family or with close friends of the family known to the child, whether formal or informal in nature.”¹⁹ This is the most common form of alternative care and often the most accepted by the community. Given that globally, the majority of care arrangements of children are organised informally within the child’s family, with decisions taken by the child’s parent or primary caregiver, there is no need for a formal review of the suitability of the kinship care arrangement **unless** there are child protection concerns or the family voluntarily reaches out for support.

In informal care placements, the priority should be given to supporting families to identify and arrange for interim kinship care placements or placements with a relative or trusted family friend known to the child and ensuring that caregivers and children know how to access support if needed and are able to report any concerns to the appropriate local authority or child protection actors should a problem arise. In placement decisions, it is important to always consider kinship and family-based placements before residential options and to document these placements, as well as to plan for the child to be reunited with his/her primary caregivers as soon as it is safe to do so.

System Level Response

 Kinship Care : System Level Response	
Topic	Key actions for child protection practitioners and welfare authorities
Supportive services available for kinship care families	<ul style="list-style-type: none"> Review social protection systems and other methods of cash support to identify and address any barriers for vulnerable families to access payment. Ensure communities, including families providing kinship care, have access to accurate accessible information about the virus, modes of transmission, and how to prevent the spread of the disease. Community messaging should encourage local officials and community groups to check on vulnerable families that may be struggling, including those providing kinship care. Contingency planning should include how to support families that are forced to quarantine in their home.
Availability of screening and testing	<ul style="list-style-type: none"> Ensure kinship carers know about the availability of medical screening and testing in their communities and how to access these safely. Where possible, encourage kinship carers to bring the child to the health providers for medical screening of COVID-19 (i.e. signs and symptoms, epidemiological factors/contact history), and testing where indicated. Screening should also include risks factors for severe illness due to COVID-19. Advocate with health actors for free and immediate medical screening for COVID-19 and testing where indicated for children who have been exposed to COVID-19 or whose exposure status is unknown prior to being placed in kinship care.
Transport	<ul style="list-style-type: none"> Identify how children in need of kinship care can be safely transferred to the relative's home.
Contact with biological family	<ul style="list-style-type: none"> Policy statements and SOPs should reflect that where a child is separated from his or her biological family and placed with a kinship family, where safe and in the child's best interests, contact (ideally daily) through technology (mobile phone, computer etc) between the caregivers and the child should be facilitated until reunification can be made and reunification should be made as soon as possible.

19 [Guidelines for the Alternative Care of Children](#)





Child-Level Considerations

Scenario	Key actions for practitioners
<p>For children currently living with a kinship family and no one in that family is considered high-risk²⁰</p>	<ul style="list-style-type: none"> • Determine appropriate ways of follow up (either remotely or maintaining physical distance) and identify formal or informal support mechanisms. • Support family to create plan should a family member become sick. • Ensure family is aware of existing services and how to access those services. • Identify any need for support and/or any additional concerns. • Determine if there is any need for follow up and the urgency/frequency of follow up.
<p>The primary caregiver in existing kinship care arrangement is considered high risk</p>	<ul style="list-style-type: none"> • Ensure that child and family understand health protocols, and basic hygiene prevention measures (e.g. handwashing, cleaning surfaces etc) • Discuss options and risk to ensure decisions taken by the family are fully informed and contingency plans are agreed for the child's care should the primary caregiver fall sick. • Identify care arrangements within family to reduce risk of transmission, including support needs to enable this (Personal Protective Equipment (PPE)²¹, daily supplies and mechanism for isolation within family if feasible) • If placing a child who has been exposed to COVID-19 or is exhibiting any symptoms, advocate for testing the child prior to placement. If testing is unavailable, determine if the child could have an alternative placement with a low-risk family member for the 14-day period of quarantine.
<p>Someone other than the primary caregiver in the family is considered high-risk</p>	<ul style="list-style-type: none"> • As much as possible reduce close contact with high-risk family member, especially if child has any symptoms or has been in contact with someone with COVID-19. • Identify care arrangements within family to reduce risk of transmission, including support needs to enable this (PPE, daily supplies and mechanism for isolation within family if feasible).
<p>The child and or caregiver has significant needs²²</p>	<ul style="list-style-type: none"> • Work with the child and family to help to support caregiver to learn how to provide for the specific needs of children (this may include occupational therapy, hygiene, or other support). • Make sure the child and family understand if child has any underlying conditions that may make him/her more high-risk.

Child currently in kinship care



20 High-risk refers to children and adults with pre-existing medical conditions such as respiratory issues, autoimmune diseases, diabetes, and those over the age of 60 which make them more susceptible to having severe complications if they contract the virus.

21 World Health Organisation. (March 2020). [Rational use of personal protective equipment \(PPE\) for coronavirus disease \(COVID-19\)](#)

22 These needs could be due to age, disability, trauma, grief, a chronic condition, behaviour management issues or other concerns.



Individual Child Level Response

Scenario	Key actions for practitioners
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Child currently in kinship care</p> <p>The child and or caregiver has significant needs</p>	<ul style="list-style-type: none"> • Work with family and share information on cleaning surfaces, assistive devices and how to maintain transmission protocols when providing personal care and assistance. • Where possible, local authorities can use technology (i.e. WeChat, WhatsApp, Skype, Google Meet, or Zoom) to convene virtual family group conferences and agree on interim plans and arrangements. For more information on family group conferencing see: Family Group Conference: A Manual for Trainers and Practitioners <ul style="list-style-type: none"> - Where these services are not available, discuss with community leaders and groups about how to provide basic support to children and families, such as regularly checking in with the family using physical distancing measures. • Ensure family and caregivers have access to phone credit and/or devices connected to the internet so that remote support can be provided during lockdown and social distancing. • Frequently follow up with the family to ensure child is well cared for and work with the family to identify and address challenges including by providing information, mentoring, support services. • Together with the family create a plan if the child and or caregiver should become ill or need immediate emergency support.
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Child in need of kinship care</p> <p>For a child needing interim care and a kinship family is willing and able to care for child</p>	<ul style="list-style-type: none"> • In partnership with the child and family, identify who is best placed among the relatives to care for the child (based on relationship with the child, any pre-existing health conditions making him/her more vulnerable, capacity to care for child etc) • Plan with the caregivers how the child's basic needs (like health care or the provision of remote education) will be met • Assess the appropriateness of the placement to ensure any concerns of the child or family have been addressed.



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Individual Child Level Response

Scenario	Key actions for practitioners
<p style="writing-mode: vertical-rl; transform: rotate(180deg);">Child in need of kinship care</p>	<ul style="list-style-type: none"> Place child in family with the understanding that if a child has been in contact with someone who has been exposed to COVID-19, either the child (depending on the age and capacity of the child as well as the physical space in the home) may need to isolate of the rest of the family or the family may need to quarantine from others in accordance with public health advice (14 days²³) Determine how the child can be safely transferred to the relative's home and provide support to enable this, if needed. Plan follow up mechanisms, including support, during and after quarantine period. Work with the child and family to determine how (if there are no safety risks in doing so) the child will remain in contact with his/her parents while in kinship care.
	<p>Placing a child in need of care who is either suspected or confirmed positive for COVID-19</p> <ul style="list-style-type: none"> Determine if testing is available prior to placement. If it is unknown whether the child has been exposed to the virus, arrange for medical screening and testing where indicated, if possible. Otherwise, the family should have the means to self-quarantine within their home for a period of 14 days. Follow health advice or a community health worker's assessment as to whether the child can be placed directly in the kinship family or should to go into either foster care or a quarantine centre for 14 days prior to placement based on the best interests of the child which includes the individual circumstances of the child and kinship family. The assessment should consider: <ul style="list-style-type: none"> If there is high-risk person within the household and are there means to ensure appropriate quarantine (living space, care arrangements, access to basic supplies including PPE, medical, etc.) If the child is old enough to understand and follow the requirements to self-isolate within a bedroom or a with a specific caregiver that is not high-risk. If the child is a young infant or baby, the developmental and care needs of a child of that age, including for individualised care with a designated caregiver, if at all possible, known to the child.
<p>Identified kinship family is unwilling to care for child due to stigma, concern of infection, etc.</p>	<ul style="list-style-type: none"> If a kinship caregiver initially refuses to take a child into their home, every effort should be made to share factual information with the caregivers' help dispel any rumours and work to address their concerns. In cases where caregivers have primary responsibility by law or custom to care for the child, the child should be placed in alternative care on a temporary basis while work is undertaken with the family to support their placement wherever possible and in the best interests of the child. In cases where the child was previously cared for by someone else or by the biological or adoptive family, an alternative placement should be identified either during the period of quarantine or longer term if reintegration with the kinship carer is not in the best interests of the child. It is crucial to address the concerns of the primary caregivers and ensure they consent freely and have the necessary capacity to support and care for the child.



23 World Health Organisation. [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\): Interim guidance](#)



©Hope and Homes for Children 2020
Hope and Homes for Children Ukraine support vulnerable families in Dnipropetrovsk region *Note that the family pictured is not the family depicted in the case study

Ukraine Case Study²⁴

Ukraine has one of the largest proportions of children in institutions in the region. In 2018, 99,917 children were confined to 718 institutions, which corresponds to 1.4% of all children in the country.

A high percentage are children under the age of three and children with disabilities. Over the last five years, Ukraine has demonstrated national commitment to deinstitutionalisation by undertaking significant legislative reform, including the 2017 “National Strategy of Ukraine on Reforming the System of Institutional Care for Children (2017-2026)”, and an action plan for its realization in the first stage (2017-2018). 2019 saw further positive developments, such as the adoption of a range of policy and legislative initiatives on the provision of inclusive education and social services in the community, combined with a renewed national health care model.

Recently in 2020, an action plan for the second stage of the Reform was approved by the Cabinet of Ministers. Faced with COVID-19 restrictive quarantine measures were taken by the Government of Ukraine to contain the pandemic. Around 42,000 children were sent back home from institutions in a sudden and unprepared move. This included children with disabilities and entailed significant risks for those affected. Vulnerable families are facing increasing challenges (e.g. loss of income, unemployment, pressure on food supplies and other necessities), and the situation is expected to get worse for children in the long-term. This makes investment in children’s services and provision of community support for vulnerable families ever more needed.

24 Case study and summary provided by Hope and Homes for Children





Ukraine Case Study Continued

In Ukraine, family-based alternative care is regulated in two particular forms:

- **Temporary emergency placement of a child into a family with relatives or an acquaintance of the child** which can be provided when relatives or someone known to the child applies for such placement and where their living conditions are safe for the child and the child agrees to such placement. If a child has been permanently orphaned, financial support is provided, but not for short-term emergency placement.
- **Short-term fostering (called “patronage” care)** for a child placed into a family which is previously unknown to the child in which the patronage caregiver and family have undergone training, been approved, and signed agreement with a custody and guardianship authority to provide such services. These families are then provided with child support payments directed at the caregiver.

Ukraine currently has 132 patronage families, with a population of 42 million people. Under the global COVID-19 pandemic, all Patronage families are being fully utilised. Recruiting, training and assessing new Patronage families has been challenging under the Government’s restrictions and quarantine measures, particularly in light of the importance of contact and home-based visits for safely approving and supporting Patronage families. In practice, interim emergency care by relatives is more widespread than Patronage in Ukraine.

Therefore, social work specialists are intensifying their efforts to support children within families during the pandemic and remove them only in critical situations threatening the life and health of a child, and local communities are critical to enabling this in Ukraine. Given the low capacity of social work specialists at local level, collaboration, referrals and sharing resources between government, civil society organisations and NGOs, and local communities are essential.



To see an example of how the local community worked together with social workers and the government to place a child in a temporary emergency placement, please see the case example below.





Hope and Homes for Children Ukraine support vulnerable families in Dnipropetrovsk region ©Hope and Homes for Children 2020.

Igor's Story

Prior to the Pandemic, Igor²⁵, a 9-year-old boy, had been living with his grandmother, because his mother had been at a pre-trial detention centre and his father had been working in the temporary occupied territory of Ukraine (called "DPR"). The father left the child with his mother (the child's grandmother) temporarily so that the child could go to school and not have to travel long distances.

Unfortunately, the boy's grandmother became ill due to a stroke. By the end of April, she could no longer take care of her grandson's basic needs. Her neighbours started feeding the boy. A social worker learned about the difficult situation and visited the grandmother and boy. During home visits, the social worker wore personal protective equipment (mask, gloves, and boot covers) provided by HHC Ukraine with support from UNICEF as well as undertaking regular handwashing using hand sanitizer and complying with social distancing rules.

While this work was being undertaken, the issue of the child's care needed to be handled immediately. The social worker discovered the boy had been eating at the neighbour's house for several days and she met with the neighbour to see how long the neighbour could continue to care for the child temporarily. The neighbour knew the boy as her children were in the boy's class and they often played together, and was more than willing to care for him while the social worker continued to make

contact with the father and other relatives. With the permission from the grandmother, the boy began to stay with the neighbour while the grandmother visited during the day.

In the meantime, the social worker was able to contact the child's father and other relatives, but unfortunately given where he was living and due to the quarantine, none of relatives could travel to the village to collect the boy, especially the father who was beyond the "line of demarcation". The social worker then advised the father to reach an agreement with the neighbour about the child's temporary care and arranged for the neighbour and father to speak. The neighbour agreed to temporarily care for the child until the father could return. The social worker continued to follow up with the family and helped to connect the neighbour to a local farmer who agreed to provide food to the neighbour and her family.

The boy's grandmother died a few weeks later. The child's father was able to come back the day after the grandmother died. The boy continued to live with the neighbour until the funeral was arranged and their home was cleaned. Now the boy is living with his father and the social worker has supported the father to find a job in a neighbouring village as well as helping him to collect the inheritance from his mother. The boy continues to play with the neighbour's children, and often visit, but continues to live with his father.



25 Names have been changed to protect identities.



Resources

[Prioritising Support to Kinship Care in Response to COVID-19](#). Family for Every Child. May 2020.

[A Critical Resource at Risk: Supporting Kinship Care during the COVID-19 Pandemic and Beyond](#). Center for the Study of Social Policy. May 2020.

[COVID-19 Fact Sheet for Grandfamilies and Multigenerational Families](#) – developed for grandparents living with families in the United States. Contains links to CDC resources. Generations United

[Social Service Workforce Safety and Wellbeing during the COVID-19 response- Recommended Actions](#). UNICEF, IFSW, ACPHA, GSSWA.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



For more information on isolation and quarantine measures please see:

[Clinical Management of COVID-19](#). World Health Organisation

[Children, Isolation and Quarantine – Preventing Family separation and other Child Protection Considerations during COVID-10](#), UNICEF.





2. Considerations for Foster Care

In many countries foster care is a well-established way for children who cannot stay with their biological family to be cared for in a family environment. While foster care is understood differently in different settings, for the purposes of this document we refer to foster care as care provided to a child by someone outside of the extended family (for a focus on care provided by relatives please see the previous section). Foster care is generally for short-term placements whilst family reunification or longer-term care options are supported. Some countries that had functioning foster care systems before the pandemic are utilising these services during COVID-19 to reduce the number of children in residential care facilities.

As with kinship carers, foster carers tend to be older and some may have underlying health conditions making them more at risk of contracting severe illness from COVID-19 and are often caring for more than one child. In addition, COVID-19 containment measures may interfere with the direct contact children were having with parents or other previous caregivers and family members. Family connections and communication are an important part of foster care placements unless determined not to be in the best of the individual child.

System Level Response



Foster Care : System Level Response


Topic	Key actions for child protection practitioners and welfare authorities
Supportive services available for foster care families	<ul style="list-style-type: none"> • Work together with the foster carers and foster care agencies to determine what kind of support they need and how best to provide it either directly or through the community. • Review social protection systems and other methods of cash support to identify and eliminate any barriers for families to access payment recognising that foster carers may incur additional expenses and challenges of caring for a child during the crisis. • Ensure children and foster carers receive age-appropriate information about COVID-19, how to prevent transmission, and the basic signs and symptoms. • Identify a way for foster carers to communicate with one another in the community (mobile phone, adding data to phone, WhatsApp groups) for peer support. • Make sure that foster carers and children have an effective and reliable way to contact the supporting case worker or social service agency. For foster carers with no reliable phone or internet connect, case workers with the appropriate protective measures should continue to visit the family following agreed public health guidance. Please see: Ethical Decision-Making in the Face of COVID 19 (IFSW) • Review referral pathways and ensure the foster carers know which services used by the child may be disrupted during lockdown measures and how support can be accessed during this time. • Create clear messages targeting the community to address any potential stigma and discrimination based on a child having been exposed to the virus. • Support foster carer’s needs related to COVID-19, including PPE²⁶, supplies and material/ financial support to address both containment related challenges and the additional costs of caregiving for a child.

26 World Health Organisation. (March 2020). [Rational use of personal protective equipment \(PPE\) for coronavirus disease \(COVID-19\)](#)





System Level Response


Topic	Key actions for child protection practitioners and welfare authorities
	<ul style="list-style-type: none"> • Ensure foster carers have the means (phone credit, mobile phone) to facilitate foster children’s contact with their biological family when in the child’s best interest (i.e. no concerns of safety). • Adapt and share resources on self-care and how to provide remote support in your context. <div style="border: 1px dashed #ccc; padding: 10px; margin-top: 10px;">  <p>Links to resources on self-care: Self-Care for Foster Parents, Center for the Study of Social Policy; Self-Care during the COVID-19 Pandemic, the Mayo Clinic COVID-19 Wellbeing and Self-Care Resources for Carers and Practitioners, Martin James Foundation; Strengths-Based Practice in Troubled Times, the Center for the Study of Social Policy; Stressbusters, Save the Children; Parenting without Violence Key messages (see caregiver and family wellbeing sections for messages on self-care), Save the Children; Mental Health and Psychosocial Considerations during the COVID-19 Outbreak, WHO.</p> </div>
<p>Availability of medical screening and testing</p>	<ul style="list-style-type: none"> • Children who have been exposed to COVID-19 or their exposure status is unknown should undergo medical screening for COVID-19 and testing for the virus where indicated prior to placement in a foster family. • If testing is currently unavailable, advocate to health actors for free and immediate testing for children who have been exposed to COVID-19 or their exposure status is unknown prior to being placed in foster care.
<p>Recruiting Emergency Foster Carers</p>	<ul style="list-style-type: none"> • Reach out to existing foster families or those that have previously fostered to determine if they would be willing to care for another child, with appropriate support if needed. • Experienced foster families should be identified for the placement of children who face particular risks, such as babies and infants, children and teens who have experienced violence, children with disabilities who have particular medical or other care needs, migrant and refugee children who cannot be placed with relatives, among others. • Where new foster carers are recruited, it is essential that vetting²⁷ should be conducted prior to placement. • Babies and young infants must be placed in family care as they require individualised care by secure caregivers in a nurturing and stable environment which residential care cannot provide. Specialised foster care placements for these children should be established as a priority with experienced foster carers. • Identify experienced foster carers who are not at high-risk and are willing to care for babies and young infants, in line with evolving public health evidence and guidance. • Consult existing foster carers to determine who is willing and able to care for additional children and/or a child who has been exposed to COVID-19 and in need of care. • Determine the most likely places to recruit potential foster carers in your community (e.g. community groups, mosques, churches). • Gather information on the specific needs, characteristics and support routines of children who may need foster care (e.g. those exposed to someone with symptoms of COVID-19, babies and infants, adolescents, children with disabilities, children who have experienced trauma or neglect, migrant or refugee children). This could include care routines and any personal assistance they may need after placement.



27 For example, through background checks and/or references from the community.



System Level Response

Topic	Key actions for child protection practitioners and welfare authorities
<p>Recruiting Emergency Foster Carers</p>	<ul style="list-style-type: none"> • If children that may have been exposed to COVID-19 are going to be placed in foster care, ensure that the selection process includes minimising risks to caregivers (e.g. arrange for medical screening, and testing of the child for COVID-19 where indicated); recruiting foster carers that are not a high risk for contracting severe illness due to COVID-19²⁸; discussing how to minimise risk to others in the household, especially those at high-risk for severe forms of the illness. • Providing all foster carers with soap, PPE and supplies to protect against infection. • Be clear, accurate and transparent on what will be provided and for how long, including any PPE, and support available (material, financial, psychosocial). • In developing communication materials to recruit foster carers, it is important to be accurate as well as inspirational. In many countries peer-to-peer recruiting is widely considered the most effective way of recruiting new foster carers. Use existing foster carers to promote the need and benefits to their family and friends. • Involve existing foster carers in the development of materials, and make sure you know your target group. Test the materials with community members and potential foster carers to get their reactions and adapt accordingly. <div style="border: 1px dashed #ccc; padding: 10px; margin: 10px 0;"> <p> See Annex III on how to develop a simple social behaviour change (SBC) Strategy and Content Brief</p> <p>For more information on SBC communication development please see materials from: FHI 360</p> </div> <ul style="list-style-type: none"> • If new foster carers are recruited quickly, ensure that there is increased monitoring and support when a child is placed with them.




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28 World Health Organisation. [COVID-19 Vulnerable and High Risks Groups](#); Center for Disease Control. [People who are at Increased Risk for Severe Illness.](#)



System Level Response


Topic	Key actions for child protection practitioners and welfare authorities
<p>Foster care training needs</p>	<ul style="list-style-type: none"> • If in-person training for emergency foster carers is impossible, consider remote sessions either via the internet or telephone. Where a full assessment cannot be completed, pre-existing foster carers that have already been vetted should be used. • Foster carers should be provided with information on stress-management, self-care, and understanding up to date referral mechanisms. • Ensure that all foster carers receive up to date information about COVID-19 and work to dispel any rumours or factually incorrect information about the virus. This training should include information about the disease, how to prevention transmission, and what to do if anyone in the family exhibits signs or symptoms. • Foster carers should have access to materials that explain the virus in a child friendly way. <div data-bbox="359 757 1300 1182" style="border: 1px dashed #ccc; padding: 10px; margin: 10px 0;"> <p> Please see the following resources, although there may be many available within a specific country or context that are more appropriate: How to talk to your child about the coronavirus, UNICEF; My Hero is You, Storybook for Children on COVID-19, Interagency Standing Committee; Coronavirus Story, Elsa Support; Hello! I am a Virus, cousins with the flu and common cold. I am Coronavirus, Mind Heart; Resources to help families during COVID-19, PBS Kids</p> <p><i>*Note that social distancing guidance in these materials varies and national standards should be referenced to avoid causing confusion.</i></p> </div>
<p>Considering longer term solutions for those currently in placement</p>	<ul style="list-style-type: none"> • Given the changing context of COVID-19, plans should be made to reunify children with their biological family as soon as it is safe to do so. • Foster care providers should review all cases where the reintegration of the child with his/ or her family is pending. A determination should be made as to whether it is still feasible and safe for reintegration to proceed and, if it is in the child's best interests, whether it can be brought forward. The support needs of the family should be identified and met to enable them to care appropriately for the child. • Follow up for newly reintegrated children should continue. • Where a child's family are living on the other side of an international border, coordination with social service workers on either side of the border is essential for the reintegration of a child with his/her family and the follow-up process. Use existing cross-border coordination mechanisms, where they exist, and refer to ICRC where appropriate. Please see Specific Challenges for Alternative Care Across Borders for additional considerations.





Foster Care: Individual Child Level Response

Child currently in foster care

Scenario	Key actions for practitioners
<p>For children currently living in foster care and no one in the foster family is considered high-risk²⁹</p>	<ul style="list-style-type: none"> • Support and follow up with family to determine if they have any specific needs and or any high-risk family members (including children). • Contact with the biological family should be facilitated remotely, including seeking involvement of primary caregivers in key decisions about the child. Every effort needs to be made to ensure modes of communication are accessible to children and caregivers with disabilities. • Determine appropriate ways of follow up (either remotely or if needed following physical distancing) and either formal or informal support mechanisms. • Ensure family is still able and willing to continue fostering a child. • Determine if family is able and willing to take any additional children into their home. • Support family to create a plan should a family member become sick. • Ensure family is aware of existing services and how to access those services. • Identify any need for support and/or any additional concerns. • Determine if there is any need for follow up and or the urgency/frequency of follow up. <div style="border: 1px dashed #ccc; padding: 5px; margin-top: 10px;">  Please see the COVID-19 Case Management Guidance to review how to prioritise cases. </div>
<p>The primary caregiver in existing kinship care arrangement is considered high risk</p>	<ul style="list-style-type: none"> • Prioritise placement into foster care with no high-risk family members. • If the caregiver is currently caring for a child, determine if they have any concerns about being able to continue to do so. • Discuss ways to protect all family members from the virus. • If there is a high-rate of infection in the community and/or country, high-risk foster carers without children should not have additional children placed with them unless it has been confirmed that that child does not have the virus (either through testing or quarantine prior to placement).
<p>Foster carer becomes too ill to care for the child and no other family member is able to care for them</p>	<ul style="list-style-type: none"> • Should the foster carer show symptoms of COVID-19, plans should be made for another placement through discussions with the child and foster carer. • The case worker, family, and child should consider whether anyone in the current family can continue to care for the child while the foster carer recovers to minimise disruption. • Should the foster carer become too ill to care for a child and no other responsible adult in the foster family can care for the child, a new placement for the child should be made based on a need's assessment in partnership with the health care provider and a holistic determination of the child's best interests. • Planning for the placement should also include screening and testing the child where indicated prior to placement as well as safe ways to transfer the child to the next placement.



29 When referring to high-risk, we are referring to children and adults with pre-existing medical conditions such as respiratory issues, autoimmune diseases, diabetes and those over the age of 60 which make them more susceptible to having severe complications if they contract COVID-19.



Individual Child Level Response

Child in need of foster care placement

Scenario	Key actions for practitioners
<p>Placing an unaccompanied or separated child</p>	<ul style="list-style-type: none"> Initiate Family Tracing and Reunification (FTR) where feasible and try to find and document basic information on where the child may have come from, circumstances of separation, identification of parents/primary caregivers and their whereabouts, other key relatives or friends of the family who may be able to provide information. Ascertain wishes of the child. <div style="border: 1px dashed #ccc; padding: 10px; margin: 10px 0;">  <p>For examples, see Toolkit on Unaccompanied and Separated Children and A Practice Handbook for Family Tracing and Reunification in Emergencies.</p> </div> <ul style="list-style-type: none"> If it is unknown whether the child has been exposed to the virus, the family should have the means to self-quarantine within their home for a period of 14 days.
<p>Placing a child with either suspected or confirmed COVID-19 who is in need of care</p>	<ul style="list-style-type: none"> If it is unknown whether the child has been exposed to the virus, arrange for medical screening and, where indicated testing prior to placement, if possible. Otherwise, the family should have the means to self-quarantine within their home for a period of 14 days. Follow health advice or a community health worker's assessment as to whether the child can be placed directly in the foster family or should go into either family-based or centre quarantine for 14 days prior to placement based on the best interests of the child which includes the individual circumstances of the child and foster family. The assessment should consider: <ul style="list-style-type: none"> If there is a high-risk person within the household and if there are means to ensure appropriate quarantine (living space, care arrangements, access to basic supplies including PPE, medical, etc.) If the child is old enough to understand and follow the requirements self-isolate within a bedroom or a with a specific low-risk caregiver. If the child is very young, whether the child can self-isolate in a bedroom with one primary low-risk caregiver. The community health worker should provide support to the caregiver on how to do this safety. The family should be provided with basic hygiene materials and instructions on how to use it.³⁰ Coordinate with community health workers for additional support. The family should receive regular follow up and know how to access both medical and psychosocial support. Work with the family to determine how they are going to access basic needs while quarantining from the rest of the community and provide support if needed.



30 See: [WHO Home Care for Patients with Suspected Novel Coronavirus \(COVID-19\) infection presenting with mild symptoms: Guidance on Home Care](#)



Individual Child Level Response

Child in need of foster care placement	Scenario	Key actions for practitioners
	Foster carer unwilling to take a child into placement	<ul style="list-style-type: none"> • Assess the safety and capacity of the proposed foster care arrangement. • Advocate for medical screening and testing for the child, where indicated, prior to placement if the foster carers have any concerns about whether the child has been exposed to COVID-19. • If a foster carer refuses to take a child into their home, every effort should be made to share factual information with the caregivers' help to dispel any rumours and work to address their concerns. It is crucial to address any concerns that they have with factual information and the necessary capacity to support and care for the child. • Consider whether there is a safe and appropriate space for the child to quarantine prior to placement. • Foster carers should never be forced to care for a child as this is potentially dangerous for the child's safety.



Resources

FOR POLICY MAKERS:

[The Place of Foster Care in the Continuum of Care Choices: Family for Every Child.](#) 2015.

[Foster Care Scheme- Vatsalya.](#) The Department of Women and Child Development, Government of Goa (India): 2013.

[User Guide on Foster Care:](#) National Commission for Protection of Child Rights (NCPCR) & Centre of Excellence in Alternative Care (India). 2018.

FOR PRACTITIONERS:

[Strategies for Developing Safe and Effective Foster Care:](#) Family for Every Child. 2012

[Process for Foster Care Placements during the COVID-19 Pandemic:](#) The Guatemala Secretariat for Social Welfare (SBS), Attorney General (PGN), UNICEF, and Changing the Way We Care. 2020.

In humanitarian contexts: Chapter 8 of the [ACE Toolkit](#)



*A child receiving physiotherapy session at her foster home in Cambodia
©Children in Families – Family Care First | REACT*

Cambodia **Case Study**³¹

The Royal Government of Cambodia (RGC) worked closely with the Ministry of Health to detect and respond to cases. As of the 12th of May, Cambodia had 122 cases with 85 of which being contracted overseas.

The Government, in consultation with UNICEF and civil society actors, created instructions on preventative measures to national and international associations and NGOs operating residential and community-based care for Cambodia and instructions on how to prevent infection for children with no family members, relatives or guardians. The Ministry of Social Affairs, Veterans, and Youth Rehabilitation (MoSVY) sent guidance to the Ministry's District office (DoSVY) on the Roles and Responsibilities of prevention and response and a letter on screening and quarantine measures for returning migrants from Thailand.

MoSVY created and trained DoSVY on updated case management guidelines during COVID-19 as well as recruiting and training new social workers. UNICEF and MoSVY assessed the needs of all registered Residential Care Institutions (RCIs) and worked to assess the situation of children that had been returned to family care. MoSVY led the mapping of alternative care placements and provided a basic service package for all families with ID poor cards, including kinship carers.

UNICEF and civil society organisations participated in the development of revised case management guidelines considering COVID-19 which was then issued by the government, as well as mapping all alternative care placements available. The majority of households had phone access.

All cases were prioritised either through phone calls or home visits and hygiene kits were provided to all families as well as additional food support and additional emergency cash support to address the immediate income challenges families were facing due to COVID-19. Visits to high risk families continued following public health advice with social workers and physiotherapists equipped with the PPE. An additional cash support and livelihoods component was added to existing child protection programming.

Local community members were mobilised through small groups, loudspeakers, posters, and tuk tuk drivers.

31 Case study prepared by Save the Children on behalf of Family Care First | REACT





CIF staff providing client education to a family regarding COVID-19 prevention
(Note: photo is illustrative only and does not depict the family from this case study)
©Children in Families – Family Care First | REACT

Srey Oun's Story³²

Srey Oun was abandoned at a hospital shortly after her birth because of her severe disabilities. She was born with a brain anomaly, blind, and having significant facial deformities. Srey Oun was referred by the Department of Social Affairs, Veterans and Youth Rehabilitation (DoSVY) to Children In Families (CIF).

After attempts to trace her family were unsuccessful, Srey Oun was placed in a foster family who had prior experience in caring for children with disabilities. With the support from Family Care First | REACT, Srey Oun has been receiving excellent care from her foster care family. A CIF social worker checks in with her regularly, and staff from the ABLE Project also make frequent visits to do therapy for her and to provide additional training and support to the family. The ABLE Project helps to make family-based alternative care inclusive for all children by providing in-home therapy, family training on disability care, medical accompaniment, and disability-specific case management for children with disabilities and/or chronic health problems.

Srey Oun had already been with her foster family for nearly one and a half years when the global COVID-19 pandemic hit. With guidance from Save the Children through Family Care First | REACT, CIF began to plan how to protect their staff and their clients from the virus, while at the same time making sure that vulnerable children and families continued to receive the support they needed. CIF staff participated in Zoom meetings with other FCF | REACT partners to discuss the government's updated instructions and new procedures which needed to be followed. The CIF staff also met together regularly to discuss the particular needs of their own clients. Some of the needs identified were for families to receive clear information about how to protect themselves and

their communities from the virus and for additional financial support as many families' livelihoods were affected by the pandemic.

CIF staff distributed posters with COVID-19 prevention information. They trained families in handwashing techniques, social distancing and other behavioral strategies to prevent transmission of the virus, including through demonstration. Hygiene supplies (masks, hand sanitizer, alcohol) have also been provided to families when they needed to take their children to a hospital for medical checkup or treatment.

During staff meetings, the staff determined which children and families needed direct visits and to what extent children and families could be supported and monitored through virtual visits via cell phones. During this time period Srey Oun had begun to have some health challenges, including seizures, so the ABLE staff supported her in getting to the hospital where the medical doctor could assess her and prescribe medication to control her seizures. Her foster care social worker and ABLE staff have followed up by means of both video calls and home visits to make sure the medicine was effectively controlling her seizures, check on her general well-being, and to review the instructions on COVID-19 protection. ABLE staff also continued to provide physical therapy with family instruction regarding exercises for Srey Oun as they had prior to the onset of COVID-19, though with a decreased frequency and the use of gloves, hand sanitizer and masks for protection in addition to regular hygiene. Srey Oun's seizures have been controlled reasonably well with her current medication and her foster family has continued to provide her with the love and care she needs, including the extra precautions needed to protect against COVID-19.

32 Case study provided by Children In Families (CIF). All Names have been changed to protect identities.





B. RESIDENTIAL CARE

Residential care refers to any group living arrangement where children are looked after by paid or volunteer staff in a specially designated facility.³³

As highlighted above, international standards based on decades of evidence clearly prioritise keeping children in the care of their families and relatives, and if that is not in their best interests, placing them in alternative family-based care.³⁴ As a general rule, residential care should only be used to provide temporary care and its objective should be to contribute actively to family reintegration or to identify family-based care options for children.³⁵ In the context of emergencies, the use of residential care should be restricted “to those situations where it is absolutely necessary” with strict limits on the development of new residential facilities.³⁶

There are **significant additional risks associated with children being in residential care during this pandemic**, as group care arrangements are more prone to cluster infections and children within them at higher risk for abuse, neglect and exploitation. Risks are particularly high for children with disabilities, who are more likely to be in residential care settings in many contexts and, in some cases (due to specific pre-existing conditions or impairments) are also more likely to be at higher risk for contracting COVID-19 and for being more severely affected by it.

The term *residential care* covers all care provided in any non-family-based group setting, such as places of safety for emergency care, transit centres in emergency situations, and all other short- and long-term residential care facilities, including group homes.

In some contexts, these facilities may have dual functions, for example combining a focus on education as well as care, and be known as boarding schools. Or they may be focused on particular ‘categories’ of children, for example children with disabilities, or children deemed ‘in need of protection’.

Regardless of whether they are State run or privately run, registered or unregistered, faith based or secular, house children only or adults and children together, all of these facilities come under formal alternative care regulations and the children in them are under the direct responsibility of the State or mandated agency (for example in refugee contexts). In the context of COVID-19, it is important to remember that quarantine facilities, for example converted boarding schools or other group living arrangements, are forms of residential care.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



33 See [Guidelines for the Alternative Care of Children](#) Para 29 c.iv and [NGO Working Group on Children without Parental Care Discussion Paper](#) (2013)

34 Goldman, P. van Ijzendoorn, M. and Sonuga-Barke, on behalf of the Lancet Institutional Care Reform Commission Group. [The implications of COVID-19 for the care of children living in residential institutions.](#)

35 [Guidelines for the Alternative Care of Children](#), Para.123.

36 [Guidelines for the Alternative Care of Children](#), Paras. 153-156.



©Rik Goverde, Save the Children

Alternative care providers and staff overseeing care placements are also being affected by COVID-19, some being exposed to the virus or falling ill, others unable to come to work as a result of containment measures or because of their impacts on the institutions' ability to operate. Many residential care institutions, particularly privately-run ones in low-and-middle income countries, are relying heavily on funding from international donors and the orphanage voluntourism industry.³⁷ With containment measures affecting both directly, there are reports of facilities unable to operate effectively. **The quality of care in these institutions** is likely to be affected significantly by this, creating additional risk factors for children in them. New strategies need to be urgently put in place to address this.

Some governments and local authorities have acted in response to the pandemic by **ordering the closure of residential care facilities** and sending children back to their families. Evidence shows that in many contexts children in residential care have parents and families who are willing to care for them but face significant challenges in their ability to do so due to poverty, discrimination, and lack of access to social services and support. Where children can go home safely, and it is in their best interest, this should be encouraged to reduce the risks associated with congregate care and ensure they receive the social and emotional support of their families and communities that is critical to their well-being, all the more so in the context of a major emergency.

On the other hand, **rapid closures of institutions** can lead to children returning to families and communities without adequate preparation and support, putting them at risk of experiencing stigmatisation, violence, abuse, neglect and exploitation. It could lead to abandonment or children turning to the streets, unless appropriate measures are taken to facilitate the reintegration and ensure it is a positive option for the child and the family, and caregivers are properly supported.

37 ReThink Orphanages. [Orphanage Volunteering: Can I Volunteer at an Orphanage Abroad?](#)





The challenges faced by these families that led to their children being placed into these residential care facilities in the first place are likely to be amplified in the context of the pandemic. Reintegration of children from residential care to family-based care should be linked to assessment of safety, support needs with clear service plans, short and long term, to enable these families to care appropriately.

In some areas, **residential care facilities are going into lockdown** (with staff and children remaining in the facility), restricting not only access but also communications between children and their families, as well to the agencies responsible for monitoring the quality of care provided. Concerns about children's safety and well-being are particularly acute in such cases, and steps must be taken by government authorities and child protection agencies to ensure children's rights and access to essential services are respected during these containment periods. There are additional concerns about the safety and wellbeing of the staff locked in and consideration needs to be given to their own care responsibilities and wellbeing.

For children who remain in residential care during this pandemic, emergency planning is critical to ensure they are safe, that the facility is in a position to deliver quality care, including abiding by public health restrictions, that there are clear individual care plans in place, and ongoing access and supervision by the authorities for monitoring and to prevent any deterioration of the situation and address potential emergencies.





1. Considerations for Residential Care

The following section is not exhaustive but highlights some of the key actions child protection practitioners and other relevant stakeholders should consider regarding residential care in the context of this pandemic, at system level and individual case level.

Placement decisions and the care of children in residential care are regulated by formal alternative care standards and fall directly under the responsibility of the government or a mandated agency. As a result, system level responses are essential to ensure child, family and service provider interventions are appropriate in the context of the pandemic. Child protection practitioners working in civil society organisations and UN agencies should collaborate with local authorities at all levels, where feasible, to establish a clear operational framework in relation to the use of residential care in the COVID-19 context.

System Level Response

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



Residential Care : System Level Response

Topic	Key actions for child protection practitioners and welfare authorities
Emergency preparedness and residential care	<ul style="list-style-type: none"> • Emergency plans covering residential care services should be developed by the child welfare authorities in partnership with service providers. Planning should consider the fluidity and likely duration and phases of the emergency (at least 18 months from the beginning of the pandemic) and include: <ul style="list-style-type: none"> - Rapid mapping³⁸ and categorisation of all residential care facilities by districts based on standards of care, where this has not been previously done. Community outreach and snowballing research technique³⁹ should be used to identify facilities that are not yet registered with the local social authorities.⁴⁰ - Establishment of a temporary register to assist with the identification and inclusion of unregistered facilities, including location, management and particular characteristics. - Assessment and identification of residential care facilities not equipped to provide adequate care in an emergency setting, taking into account necessary hygiene, social distancing, isolation and quarantine measures, and targeting such facilities for closure and for alternate suitable provisions to be made for children's care. - Assessment and identification of existing temporary shelters with the capacity to serve as interim care centres to facilitate isolation, tracing, rapid assessment and reunification and incorporating these facilities into the child protection response framework for emergency cases. - Clear directives by mandated agencies with oversight of child welfare services should be issued, including detailed steps to be taken by the local authorities and management of residential care facilities for the orderly and safe return of children who can be reintegrated into their families. Formal notification should be made for all children exiting care services to the relevant authorities including in the child's community/district of return.

38 Government at this district level and sub-levels may be able to play a significant role in identifying facilities.

39 Snowball research technique is where facilities help to identify other facilities. It's called snowball because (in theory) once you have the ball rolling, it picks up more "snow" along the way and becomes larger and larger

40 See for examples: [A Rapid Assessment of Children's Homes in Post-Tsunami Aceh](#) and [A Rapid Assessment of Islamic Boarding Schools in Post Tsunami Aceh](#)



System Level Response

Topic	Key actions for child protection practitioners and welfare authorities
Emergency preparedness and residential care	<ul style="list-style-type: none"> - Agreements secured with the public health and education ministries/sectors to ensure oversight over provision of education, nutrition and health services, including health education on COVID-19 to children in residential care settings and remote education in the event of school closures or quarantine events. This should take into account disability and age-appropriate communication and education modalities for children with disabilities. - Governments or mandated bodies, in partnership with relevant child protection actors, should secure/guarantee the supply chains of essential goods (food, hygiene products and essential/basic medicine) and critical services (including those specifically needed for children with disabilities) to alternative care service providers in the event purchasing and travel restrictions are imposed, or goods become scarce and difficult to source through ordinary means. - Identification and securing of qualified staffing and essential resources needed for the period of the emergency and the post-emergency phase, including temporary replacement staff for those who need to self-quarantine, with additional flexible funds for child protection authorities to enable rapid adaptation of systems and services in response to the crisis.⁴¹ - Staff of residential care services and those with oversight over the provision and quality of care in those facilities should be classified for the period of the emergency as 'essential workers' within government management frameworks with authorization specifically to enable movement to conduct necessary assessments and monitoring visits, and to procure food and essential supplies, including PPE if recommended. - Identification and securing of sources of additional support in conjunction with relevant health authorities to ensure facilities are able to meet the support needs of children with disabilities, and/or those with underlying health issues who may be disproportionately affected by COVID-19, including in the event hospitalisation is required. - Authorities and child protection actors should avoid measures that could create hidden incentives for child-family separation or abandonment in the context of this crisis by prioritising access to social services or support through residential care facilities instead of children in families. Securing appropriate care for children in residential care during this pandemic should be clearly framed within broader policies that prioritise access to services for children in their families and should not be provided at a higher level per child than support to children in families. - An assessment of gender, life cycle, and disability dimensions should be undertaken to ensure emergency plans are inclusive.⁴² • Standard Operating Procedures (SOPs) should be in place covering the following at a minimum: <ul style="list-style-type: none"> - Revised gatekeeping procedures to include online and telephone screening of referrals, assessment of necessity and suitability of care placement, authorization of placement, and monitoring by child welfare authorities. - Orderly family reunification of children in residential care settings who can be cared for by their families and whose reintegration should be prioritised. This must include a case-managed process and documentation of where the child returned to, identification of primary caregiver(s), and contact information.



41 Identification of staffing needs take into account child to carers ratios as well other critical qualifications and skills required for to ensure quality alternative care. See [Alternative Care in Emergencies Toolkit](#) for guidance on child to caregiver ratio.

42 [Towards a Disability Inclusive COVID-19 Response Including Children with Disabilities in Humanitarian Action](#), International Disability Alliance; [Disability and emergency risk management for health](#), WHO & partners; [Person centered emergency preparedness planning for COVID19](#), Queenslanders with Disability; [Global Rapid Gender Analysis for COVID-19](#), CARE and International Rescue Committee.



System Level Response

Topic	Key actions for child protection practitioners and welfare authorities
<p>Emergency preparedness and residential care</p>	<ul style="list-style-type: none"> - Provision of financial and material support to caregivers and families whenever needed, including transport, to ensure safe reunification. - Whenever possible, a social or case worker should accompany the child to ensure safe reunification or the caregiver should be provided with safe travel to come to the facility prior to reunification. - Monitoring of reunited children taking into account the articulation of new modalities and approaches to case management necessary in light of restrictions placed on travel and social contact. - Monitoring of residential care facilities' adherence to minimum standards (including child to carer ratios) and any newly imposed safety requirements throughout the duration of the emergency. - Formal registration of every child and adult residing or working in the residential care facilities and mandatory maintenance of an updated and detailed register of any child entering or leaving the institution (including as a result of child running away), any case of illness, hospitalisation, or death, complete with full identification of the individual, dates and times, and procedures followed to notify the authorities. - Establishing a child-friendly, safe, and independent complaints and feedback mechanism and responding to critical incidents in residential care facilities, including reports of abuse or child protection concerns. - Mandatory closure of residential care services due to serious and systemic failure or inability to provide care and protection during the emergency. - Procedures to secure access by the local authorities and mandated agencies to facilities that have gone into lockdown for oversight and to ensure the safety and well-being of children in the facility.
<p>Regulating the use of residential care</p>	<ul style="list-style-type: none"> • Child welfare authorities should issue a moratorium on the establishment of new residential care facilities to be widely communicated along with directives and messages that reinforce existing or modified gatekeeping mechanisms for new referrals to existing facilities. • Restrictions or prohibitions should be placed upon the irregular admission of children into residential care facilities during the emergency. Service providers should be required to immediately notify authorities if a child is brought to their facility and not through formal gatekeeping mechanisms. • Infants and young children should not be placed in residential care in response to the emergency or during the emergency period and family-based care should be secured as a priority. In the event of exceptional circumstances, infants and small children should not remain in residential care for longer than 72 hours/ 3 days and individualised care should be provided by assigned and experienced caregivers for the duration of admission, with no more than 2-3 babies/young child per caregiver. • Particular attention should be paid to prevent placement of children with disabilities in residential care as a response to COVID-19. No child, including children with disabilities, should be placed in residential facilities as a consequence of quarantine procedures beyond the minimum necessary to overcome the period of being contagious or ill.⁴³





System Level Response

Topic	Key actions for child protection practitioners and welfare authorities
<p>Ensuring appropriate and safe care in residential facilities</p>	<ul style="list-style-type: none"> • Residential care facilities caring for children should be assessed to ensure they are in a position to provide an age appropriate, safe, and caring environment which is small and organised around the rights and needs of the child, in a setting as close as possible to a family or small group situation. Minimum standards relating to caregiver to child ratios as well as qualifications of staff are key requirements in that context.⁴⁵ • Appropriate and child-friendly hygiene, social distancing, self-isolation and quarantine measures for sick children should be rigorously implemented and monitored in all residential care settings.⁴⁶ • Ensure that staff of residential care facilities, social service workers and inspectors have access to adequate personal protective equipment (PPE) and testing to prevent transmission. • Ensure staff of residential care facilities receive training on infection prevention and control (IPC), on recognising signs and symptoms of COVID-19, and are provided with necessary supplies to carry out key prevention measures. • Daily monitoring for signs and symptoms of COVID-19 in staff and children should be conducted. Move symptomatic children into a single room, and follow established protocols for IPC and medical referral. Follow advice from local health authorities for quarantining and management of contacts. • Guidance should be provided to ensure staff who are in high risk categories for contracting COVID-19 and those who live with someone in a high risk category or who has been infected are not working directly with children until they are no longer at risk. Paid sick leave schemes and a standby roster of staff should be implemented to ensure staff are not forced to take unnecessary risks. • Only essential personnel should be permitted entry into the facility and all staff who have recently travelled, have been in contact with a known case of COVID-19 or present with symptoms, should be required to self-isolate for 14 days prior to returning to work in line with public health guidelines. Volunteers should not be permitted to enter the facilities. Inspectorate personnel are essential and should always be provided with access to the facility at any time. • Inspectorate personnel should maintain contact with service providers throughout the emergency period to ensure adherence to emergency directives, existing minimum standards and to facilitate rapid response to critical issues. • Clear and tested referral pathways should be agreed and documented with health authorities and providers to support referrals of children who become symptomatic or who require other medical assistance during the pandemic. • All personnel with responsibilities for inspection, monitoring, or provision of services to children in residential care facilities should be made aware of the heightened risk of violence and exploitation in emergencies. • Formal procedures should be strengthened or established to enable safe and confidential identification and reporting of physical, sexual, psychological abuse and exploitation with responsibility assigned to trained child protection personnel to respond to these.



44 [Guidelines for the Alternative Care of Children](#), Para 123.

45 [Alternative Care in Emergencies Toolkit](#)

46 [Cleaning and Disinfection for Community Facilities](#), CDC; [WHO Guidelines on Cleaning and disinfection of environmental surfaces in the context of COVID-19](#), WHO.



Residential Care: Individual Child Level Response

Scenario	Key actions for practitioners
<p>A child needs alternative care- residential care placement considered</p>	<ul style="list-style-type: none"> • Make sure all the options for family-based care have been explored before considering placement in residential care. • No child, including children with disabilities, should be placed in residential facilities as a consequence of quarantine procedures beyond the minimum time necessary to overcome the period of being contagious or ill. • A child with a disability should not be considered for placement in a residential facility based solely on their disability. • Do not create a one-size-fits-all policy to have children enter residential care. Each child should be assessed individually⁴⁷ answering the following questions: <ul style="list-style-type: none"> - Who typically cares for this child? - Is it possible and safe to reunite this child with their caregiver? - Is there an alternative family member over the age of 18 that can care for the child? - Is there an alternative family-based placement option in the child's community? - What is the child's preference? - What risks are present in each care arrangement and how will they be mitigated? - Have you followed established gatekeeping procedures and involved the relevant authorities and individuals in the assessments and decision-making process? - Is there a concrete plan to ensure the child's placement in residential care is only temporary and family reintegration or placement in family-based care enabled? • Placement should follow standard procedures based on case management guidelines adapted to the COVID-19 context. Where the caregiver is known, every effort should be undertaken to ensure they are able to play an active role in the decision-making process, unless it is deemed not in the best interests of the child for safety reasons. This should include providing the caregiver with the resources needed to be involved remotely if travel or contact are deemed not possible. • The child's own opinion and preferences should be heard and taken into account as a critical part of the wider best interest determination.⁴⁸ That includes the review of placement process by the gatekeeping authority, and the child or young person's participation in this process should be supported, including remotely. • The COVID-19 situation is fast evolving and review of the appropriateness of the placement and of steps taken towards family reintegration or placement in alternative family should be an active and central part of the placement process and care planning. A written care plan with clear goals for the placement and a set timeframe, including regular reviews, should be agreed and recorded with the authorities.



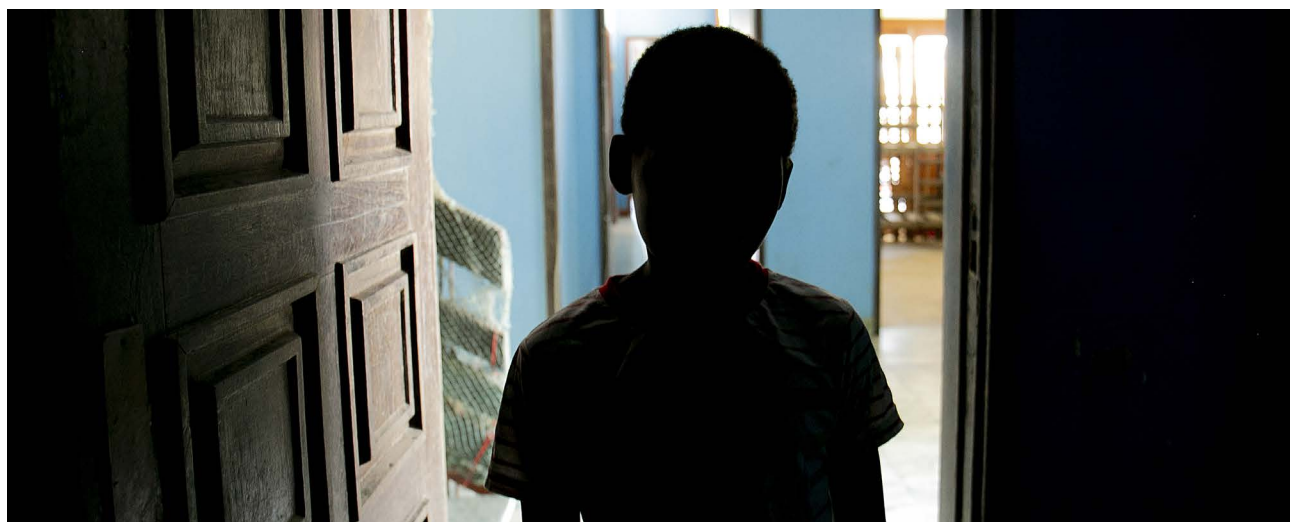
47 For guidance on how to assess the child's current care status, see 5.1 in the [Alternative Care in Emergencies Toolkit](#).

48 [Technical Note: Adaptation of Child Protection Case Management to the COVID-19 Pandemic](#).



Individual Child Level Response

Scenario	Key actions for practitioners
A child is in residential care	<ul style="list-style-type: none"> Children who can safely return to their families during the emergency should be identified and prioritised for reunification. This may include the return of children who are in residential care for education purposes as well as children placed in care as a result of poverty who can be returned to family care with monitoring and support to the family.
A child is in residential care	<ul style="list-style-type: none"> Review each child's case individually and determine if the child can return home. Key considerations need to be given to the suitability and safety of the home care arrangement including what reunification and reintegration support will be needed for the child and caregiver. Children currently in care who can return home or be placed in family based alternative care should be encouraged to do so only when: <ul style="list-style-type: none"> Contact has been made by phone/email with the child and primary caregiver to explore and confirm the suitability of the reintegration and discuss the respective wishes and concerns, as well as reintegration plan. A competent/qualified staff member has determined that the home environment and caregiving arrangements are adequate to ensure the child's safety and well-being. A support/case plan has been put in place and agreed. The child is able to travel home safely accompanied by a competent staff member or identified member of the child's family. A qualified case worker or social worker is able to regularly follow up with the child and the family – preferably face to face, but if this is not possible, by phone. Children have access to safe reporting mechanisms (whether by phone, a community member, etc.) Consider the psychological impact and adapt psychosocial support activities to be conducted with children who remain in the facilities to reduce as much as possible the impact of lockdown and possible quarantine measures. Maintain a positive environment including activities organised for and by children, provide individual and group psychosocial support and peer support networks. Ensure family connections and contact is maintained regularly with family members, including siblings, as this is likely to be a distressing time for both child and family members.





Individual Child Level Response

Scenario	Key actions for practitioners
<p>A child is in residential care</p>	<ul style="list-style-type: none"> • Facilitate communications remotely, including seeking involvement of primary caregivers in key decisions about the child. Every effort needs to be made to ensure modes of communication are accessible to children and caregivers with disabilities. • Adapt care plans for all children who will remain in residential care for part or the whole duration of the emergency period. These should be adapted in consultation with children, their families and other services providers and take into account: <ul style="list-style-type: none"> - Provision of individually- assessed arrangements for children who may be at particular risk of complications from COVID-19 infection, including children with disabilities and underlying health issues, in partnership with health authorities. - Other safety-related risks, such as prior or potential exposure to violence or exploitation. - New modes of engaging in education, recreational activities, maintaining health and fitness, achieving life skills and vocational goals, and receiving services in the event of restrictions or lockdowns. - Revised reintegration plans, ensuring where possible, reunification planning and preparation continues, and children are not kept in residential care for longer than what is strictly necessary. • Ensure residential care facility is equipped to provide appropriate recreational and educational activities to children during periods of self-isolation/lock down, including through partnership with community organisations and other service providers during progressive relaxation of lockdown measures. • Work with care personnel to ensure full documentation of changes in each child’s situation, with records regularly updated, and accessible to the local child welfare authorities and mandated agencies (as specified in context-specific information sharing protocols) upon request to enable their effective oversight. This should include full information on children’s reunification with their families or placement in other forms of alternative care, care plans, communications with family, physical and mental health services, education, and well-being issues.
<p>A child is in residential care facility that goes into lockdown</p>	<ul style="list-style-type: none"> • The considerations listed above are critical for children who are in residential care that goes into lockdown. • Provide child-friendly information on why the facility is locking down, what it means for children and how they can continue to be in contact with their family. • Make sure families are informed and have the means to be in contact with their child, and with designated staffs in the facility to receive regular updates on their child; that they are informed of any changes in the situation of the institution, and are able to be involved in decisions relating to their child’s health, well-being and education during the lockdown period. • Work with the management of the facility to provide staffs with support to ensure their safety and well-being, including through the provision of PPE and putting in place staffing arrangements that minimise risks for staff who have care responsibilities at home or are at high-risk of contracting the virus.





Individual Child Level Response

Scenario	Key actions for practitioners
<p>A child is in residential care facility that goes into lockdown</p>	<ul style="list-style-type: none"> Review plans with management, staffs and local authorities to ensure access to supplies and medical care is secured for the entire duration of the lockdown period, and make sure priority referrals of children and staff who are symptomatic or have been exposed to the virus or have other health needs are operational, and health inspections scheduled in partnership with the health authorities. Ensure children have unfettered access to safe, confidential and independent reporting mechanisms and that they have been provided with all the information and means of using them, with particular attention to securing effective access for children with disabilities. Establish a system for virtual monitoring and conduct a lesson- learned exercise following the lockdown.⁴⁹
<p>A child is leaving residential care</p> <ul style="list-style-type: none"> Facility is closing following order issued by government or as a result of impact of COVID-19 on ability to operate. Facility is not closing but child has been assessed for reunification or placement in family based alternative care 	<ul style="list-style-type: none"> Train teams on rapid Family Tracing and Reunification (FTR) and ensure they have the resources needed to safely and effectively implement this, including communication and transport. <ul style="list-style-type: none"> For examples, see Toolkit on Unaccompanied and Separated Children and A Practice Handbook for Family Tracing and Reunification in Emergencies Provide social/case workers conducting visits (where feasible) with adequate PPE and testing. Closing of the centre should be a managed process, enabling each child’s case to be reviewed and a best interests determination carried out. A prioritization approach should be used to identify children who can rapidly be reunified with their families (for example: families and child have maintained contact and relationships; placement was not due to significant safety concerns; child has expressed clear wish to go home; caregivers have asked for child to come home or expressed readiness to receive child; significant individuals in the child’s community or local service providers are able to conduct follow up and/or provide support etc.) Infants and young children and children who are at a higher risk of contracting COVID-19 and being more severely affected by it, including children with disabilities (due to specific pre-existing conditions or impairments, including immune deficiencies) should also be prioritised for reunification with their families, or if that is not feasible or desirable, be prioritised for foster care. For children whose home is at significant distance from the facility, accompanied transportation back home with a primary caregiver or relative known to the child, or a staff member/case worker should be conducted in partnership with the health authorities and costs met by the facilities or mandated agencies. Document where the child was returned to and contact information; consider provision of financial and material support to families where needed; and how the monitoring of reunified children will take place given the restrictions on travel and physical contact. A full list of children who have been sent home with identification information and contact details should be provided by the facility to the child welfare authorities and mandated agencies, in line with information sharing protocols, to ensure appropriate follow up.



49 See for example: [Virtual Monitoring of Children in Residential Care during COVID-19: Changing the Way We Care.](#)



Individual Child Level Response

Scenario	Key actions for practitioners
<p>A child is leaving residential care</p>	<ul style="list-style-type: none"> • If facilities close rapidly and children are sent home without proper support, tracing should be conducted for all children within the first week of leaving to confirm their whereabouts, followed by a visit or phone call to ensure they are safe and cared for. • Ensure local authorities/communities are informed of the child’s return and a reintegration plan for each child is shared with them and continues to be implemented. • Keep cases open until a period of monitoring suitable to the child’s safety and it has been determined that the child has successfully and safely reintegrated into their family.
<p>Young person is transitioning/ placement ended</p>	<ul style="list-style-type: none"> • Young people who are “aging out”⁵⁰ of residential care settings during the pandemic are likely to face significant challenges with limited social and financial support. They should be referred for priority access to relevant local services/grants/schemes to prevent placement breakdown and support transition. Consider extending age brackets for people “aging out” to continue to access services and support during the pandemic. • Contact all care leavers who may have left a care setting in the last six months and conduct preliminary enquiries to check on their wellbeing and living situations, assessing their support needs and ensure that they fully understand key measures to protect themselves and others from COVID-19. • If they have not secured independent living accommodation and livelihood options, targeted emergency support should be provided, including financial and material resources to meet their short-term needs. • This should include temporary arrangements such as cash or vouchers to pay accommodation, purchase groceries and necessary medication, cleaning and hygiene supplies, and a phone, with sufficient data on their phone to keep in contact with others. • If they live alone, are pregnant and/or have young children, develop a schedule for weekly check-in call and offer specific support for their physical and mental well-being, including access to health services and testing. • Identify care leavers groups or associations that can carry out outreach, provide practical support, guidance and mentorship to young people who have transitioned from care. Partner with them and provide them with funding to enable them to develop online and phone support and expand their reach and advocacy role.



50 The term “aging out” refers to a person who has reached an age where he or she no longer eligible to stay in a residential care facility usually this is around the age of 18.



2. Considerations for Quarantine Centres and Isolation Treatment Centres (ITCs)

The public health response to COVID-19 may, in some cases, mean that children and their caregivers need to be in quarantine or isolated. This section is complementary to and builds on the WHO's [Considerations for quarantine of individuals in the context of containment for coronavirus disease \(COVID-19\)](#) which serves as the overarching guidance.

The following section covers key recommendations and considerations for child protection sectors/actors working in partnership with health workers and authorities in relation to children placed in Quarantine Centres and Isolation Treatment Centres. They are not exhaustive and should be considered in addition to other relevant considerations identified in the section on residential care and framed by public health regulations issued by national and international health bodies in relation to COVID-19.

- **Quarantine** - Separation of healthy persons who have been in contact with a COVID-19 suspect or confirmed case, for the purposes of early identification and treatment can be at home or at a community facility.
- **Isolation Treatment Centres** – A health facility that isolates symptomatic or ill patients. These facilities may have different names in different contexts or locations. Isolation refers to the separation of ill persons who are suspected or confirmed cases of COVID-19, for the purpose of treatment and / or to decrease the risk of infection transmission.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES





Quarantine Centres	
Scenarios	Key actions
<p>Unaccompanied child placed in centre</p> <p><i>Child has been exposed to COVID-19 and cannot be quarantined within his/her family or alternative family-based care placement</i></p>	<ul style="list-style-type: none"> • Placement should be strictly limited to required quarantine period as per public health guidance (typically 14 days). If testing is available, and the child is negative, he/she should not stay in the quarantine centre. • Children should not be placed with other unknown adults and where possible place siblings together. • Children should be cared for by dedicated and trained staff. • Children should be provided with information to understand why they are in the centre (including information about the disease), for what length of time, what steps are being taken to reunite them with their family or relatives, or to place them in an alternative family, and how they can participate in decisions that affect them. • Services should be child-friendly in a language they understand and staff members working in the centre should have experience in working with children and/ or receive training on child friendly communication, child safeguarding, PSS, etc. • FTR and/or placement options should be planned with a case worker ideally following a Best Interests Assessment/ Determination process while the child is in the centre. • Public health guidelines should be followed at all times to reduce contact with people within the quarantine centre. • Specific accommodations should be made to meet the needs of the individual child, including children with disabilities. • Where possible, children should be placed in a quarantine centre with their caregiver or a known relative. • Infants and small children should not be placed in quarantine centres without their caregiver or a relative known to them. In exceptional circumstances where such a placement cannot be avoided, it should be for shortest period of time (as per health guidance on quarantine) and individualised care should be provided by assigned and experienced caregivers for the duration of admission, with no more than 2-3 babies/young child per caregiver.
<p>Family placed in quarantine centre together</p>	<ul style="list-style-type: none"> • Follow up through remote case management support to families in a facility that may need support upon discharge. • If the primary caregiver requests another family member to accompany their child in the quarantine centre, ensure that the relative is over the age of 18 and understands the requirements of being in the quarantine centre. Record contact information for the primary caregiver.
<p>Member of the family placed in quarantine centre</p>	<ul style="list-style-type: none"> • Quarantine centre staff should ask and document caregiving responsibilities of family members prior to admission into the centres to determine if there is any need for follow up support to children who they were caring for prior to being admitted. • Referral mechanisms should be utilised to contact social service workers for any children at home that may need more support while a family member is in quarantine.



Isolation Centres

Scenarios	Key actions
<p>Unaccompanied child enters the health facility</p> <p><i>The child is symptomatic and needs treatment and/or tested positive of COVID-19</i></p>	<ul style="list-style-type: none"> • Ensure linkages with health staff to inform the relevant child protection authority/actors as soon as an unaccompanied child enters the centre. • Immediately start family tracing and reunification as well as identification of longer term care options for when the child is released. • If the child is brought to the centre by an adult, train health workers to record relevant FTR information from the caregiver on a form designed for that purpose: See Annex II for an example and Annex III for an example form. • Keep all belongings that come with the child (clothes, toys, documents etc.) • Do not discharge an unaccompanied child without the relevant authority or child protection actors present. Verify the identity of the adult and their relationship to the child.
<p>A caregiver brings the child to the health facility</p>	<ul style="list-style-type: none"> • Discuss with the caregiver and child options for care in the health facility. This may include the caregiver entering the facility with the child, the caregiver identifying an adult relative to isolate with the child or having the child enter on their own and be cared for by health/child protection staff. Explore benefits and risks of each option, discussing who will care for other children not in the health facility (but likely in quarantine). (See Annex IV)
<p>A child's primary caregiver dies in a health facility</p>	<ul style="list-style-type: none"> • Contact the alternative caregiver whose name and contact information should have been included on the intake record at the time of admission. • Verify the relationship of the potential caregiver to the child and assess the caregiver's ability and willingness to provide ongoing care for the child. • Use child-friendly and age appropriate language to explain to the child that their caregiver has died. If possible, do this with a supportive adult or the alternative caregiver present. • If an alternative caregiver cannot be identified, contact the relevant child protection authority/actors to identify alternative care and do family tracing.





©Mark Wahwai, Save the Children

Kenya Case Study⁵¹

Kenya confirmed its first COVID-19 case on 13th March 2020. In response to the gradually increasing numbers of confirmed cases, the Government of Kenya took proactive action and ordered the closure of Kenya's international airports, introduced a nightly curfew, closed schools and recommended that those who can work from home do so to observe principles of physical distancing.

In support of containment measures, Kenya's National Council for Children's Services (NCCS) and the Department of Children's Services (DCS) took several immediate actions aimed at preventing and responding to the unique needs of children in residential care. On March 17, 2020, the Government issued a directive instructing all residential care facilities for children, including boarding schools and childcare facilities, to release children from care immediately.⁵² In response to this, NCCS, with support from UNICEF and other partners, convened a working group whose primary objective was to design guidance and key messages about COVID-19.

The first product was a set of key messages targeting children, parents/caregivers, residential care facilities and community members focused on how to prevent the spread of COVID-19, truths versus falsehoods, treatment of those who have COVID-19 and information about key services and hotlines to report abuse or get up to date health information.⁵³ Following this, a second Government Directive was issued which required Children's Officers and Social Services to submit a report detailing the number of children released to families and challenges associated with the process.

51 Case study prepared by Changing the Way We Care

52 Ministry of Labour and Social Protection. State Department for Social Protection. Office of the Principle Secretary. MEAC L&SP/1/32. Presidential Directive on Containment of the Coronavirus. March 17, 2020.

53 Ministry of Labour and Social Protection, Office of the Principal Secretary. [Preventing and Responding to COVID-19: Key messages to support those working with vulnerable children and families.](#)



To support the implementation of the directive, DCS, with support from civil society members of the working group, conducted a rapid mapping to determine the number of children returned home and the number remaining in residential care facilities. This information was presented and used to inform appropriate responses.⁵⁴

At the same time, NCCS, DCS and Changing the Way We Care (CTWWC) worked closely together to develop guidance related to the case management process with specific issues to consider for children remaining in residential care and those who have been reunified as a result of COVID-19.⁵⁵

This guidance was shared with government and non-governmental actors responsible for case management of children's cases. UNICEF also worked with DCS to address the capacity needs of Children's Officers regarding skills and knowledge needed to address child protection during the pandemic. Efforts were also focused on providing support, albeit virtually, for children who had been rapidly reunified, including not only the gathering of data on whereabouts but also collection of critical information to ensure that children were safe, and needs were being met post-reunification. The data collected showed that a significant number of children returning to family-based care were to kinship families.⁵⁶

A virtual monitoring tool was being utilised by several of the working group members to ensure that key areas of wellbeing of the child and his or her family were being monitored via phone.⁵⁷ Children's Officers will also be trained in the virtual monitoring tool to use for following up children's cases for which they are responsible. The same process and tools are also being used by several civil society organisations to monitor young people who have moved to independent living situations.

Together with Maestral International, a series of twelve webinars were designed and conducted to cover thematic areas of child protection impacted by COVID-19. One such webinar was designed to address residential care, and directors of private and statutory institutions were invited to attend. More than 70 CCI directors attended the webinar together with over 400 Children's Officers.

As containment measures remain in place and number of cases are still on the rise in Kenya, government and non-governmental actors will continue to have a coordinated response to ensure that children in residential care and those who have left are receiving information related to COVID-19, that practices and procedures appropriately adapt to the new and emerging scenarios, and that responses are quickly designed and disseminated to best address the needs of children in residential care.



Case conferencing being conducted. © CTWWC

54 Ministry of Labour and Social Protection. State Department for Social Protection. Office of the Principle Secretary. MEAC L&SP/5/1. Presidential Directive on Containment of the Coronavirus. March 31, 2020; Better Care Network and Alliance for Child Protection in Humanitarian Action. Webinar on Alternative Care. [Presentation by NCCS.](#)

55 Changing the Way We Care, May 2020. Case management considerations for children in residential care during COVID-19 pandemic; [Changing the Way We Care, May 2020. Gatekeeping considerations during COVID-19 pandemic.](#)

56 [Better Care Network and the Alliance for Child Protection in Humanitarian Action.](#) Op cit.

57 Changing the Way We Care (2020). [Virtual Monitoring Tool.](#)





©Sarah A.Fajardo,CRS

Mary's Story⁵⁸

Mary is a 12-year-old girl who came from a family of five children. She lost both of her parents and was then placed in the care of another family. This family had many children of their own and struggled to meet the needs of all of them. As a result, Mary was placed in a Charitable Children's Institution (CCI as it is known in Kenya i.e., a residential care facility) when she was seven. In 2015, she was transferred to another residential facility where it was hoped she would be able to access better nutrition and education for her to finish her studies.

In late March as a result of COVID-19, Mary was one of thousands of children in CCIs immediately released from the facility and sent back to their family. In the case of Mary, this was her maternal grandparents.

As part of a structured monitoring process aimed at checking on Mary's wellbeing and ensuring that the placement was safe and appropriate for her, a local organisation supported by Changing the Way We Care, had their social worker conduct a child, family and community assessment. This was to identify the strengths of the family and community as well as potential risks and services needed. As a result of the assessment and home visit, Mary's family was provided a cash transfer to support critical household needs and livelihood training to facilitate an income generating activity.

The family used it to build a chicken coop which provided eggs to sell as well as store firewood that they also sell for income. Mary was signed up to the National Health Insurance Fund (NHIF) to provide medical support for herself, other children in the household and the elderly caregivers.

During a recent home visit, the grandparents confirmed with the social worker that they had received the cash transfer and used it to purchase food, sanitary towels, shoes and underwear for Mary. With the remainder of the money they bought firewood to sell to help boost the household income.

When Mary first returned home, the grandparents and the social worker noted she seemed distressed. She often mentioned how she missed the CCI. She stayed by herself and did not engage with other children in the household. However, little by little, the social worker began to engage her and supported the grandparents in how to best communicate with Mary, her attitude and demeanour started to improve. The last time the social worker visited, Mary was very positive, playing with other children and actively engaged with her grandparents and classmates. With small steps and a clear path forward based on findings from the assessment, Mary and her family are taking positive steps towards a successful reintegration.

58 All Names have been changed to protect identities.





Isolation Treatment Centre – Cox's Bazar
©Catherine McGowan Save the Children

Bangladesh Case Study - Cox's Bazar⁵⁹

Approximately one million Rohingya refugees reside in the densely populated and overcrowded camps of Cox's Bazar in Bangladesh. Having fled Myanmar in 2017, refugees live in makeshift shelters with limited access to clean water and sanitation facilities. Where social distancing and simple hygiene practices are near impossible, the impact of COVID-19 is expected to be dire.

On the 24th of March, the Government of Bangladesh closed both non-formal and formal schools and educational institutions across the country, and imposed limitations on movement within the Rohingya camps. In Cox's Bazar district, the Office of the Refugee Relief & Repatriation Commissioner provided guidance for essential and critical services that may continue in the camps, including a limited number of child protection case workers. On 16th April, the Office of the Director General, Directorate General of Health Services of Bangladesh declared the 'whole of Bangladesh, as per the section 11(1) of Infectious Disease (Prevention, Control and Elimination) Act, 2018, (no 61 law of 2018) as 'infection risk area'. The COVID-19 pandemic has heightened protection risks for children while creating new separation concerns.

In Cox's Bazar, the Child Protection Sub-Sector established COVID-19 specific guidance on Alternative Care and Case Management to be used at the interagency level. Case management actors were rapidly trained and case workers followed up

with foster families and at-risk caregivers to ensure placements were secured and where needed, identify alternative caregivers. In preparation for the upward trajectory of cases of transmission, and subsequent risks this poses to family unity, the Health and Child Protection Sectors worked together to create SOPs ([Care for Children in Health Facilities during COVID-19](#)) and provide guidance and training to health and child protection staff to respond to various scenarios in Quarantine Centres, Isolation Centres and Isolation Treatment Centres.

In each health facility, several health staff were identified as "child carers" and trained to talk through care options with caregivers, provide care to unaccompanied children in health facilities, run psychosocial support activities, and utilise child-friendly language to orient children to the facility. Ongoing mentoring sessions are provided by child protection actors to child carers to discuss challenging areas and explore additional child protection topics.

⁵⁹ Case study prepared by Save the Children. All Names have been changed to protect identities.





Story of Ajmeri and Hasan⁶⁰

A child protection facilitator follows up with the family daily in the quarantine centre © Ummay Habiba/Save the Children

Ajmeri and Hasan along with their father, Nur Alam, who has a disability, stayed in the quarantine centre for 14 days as their mother, Rashida Khatun, and their youngest sibling Tarik (8 months old), were suspected of having COVID-19 and were quarantined in an isolation centre in another camp. Save the Children (SC), in collaboration with other organisations, provided care for the children and their father in the quarantine centre.

Rashida Khatun and her youngest child Tarik were suffering from a throat sore, fever and diarrhoea. They went to a hospital in the camp and received primary treatment. The hospital also took their blood sample as the symptoms were similar to those of COVID-19. The Camp in Charge (CiC) and the designated UNHCR official took the other family members to an isolation centre in Teknaf. Their father, Nur Alam's recalls, "We became separated all of a sudden and Rashida had no idea where we were, neither did I. They told me that Rashida and the child will be taken to an isolation centre in Teknaf, but as I was also quarantined and physically challenged. I became afraid with the thought that they could harm my wife and child."⁶¹

"Ajmeri and Hasan were crying and asking for their mother. At that time, the child protection worker, came to us and asked if we were facing problems. Later he

and another sister [another female child protection worker] brought some toys for my children and they became busy playing and stopped crying. It was a great relief for me. However, with the help of the quarantine centre authority, I was able to talk with my wife after four days".

"We didn't take any clothes with us to the quarantine centre and couldn't take a bath for few days. The child protection workers kept following up every day about our conditions and needs, so I explained the issues to them, and they provided clothes for me and my children. They also provided hair oil and a comb for my children".

"Afterwards we were allowed to bring all the utensils, clothes and toys that were given in the quarantine centre to our shelter".

Rashida and Tarik were admitted in the isolation centre and received care from the ITC. They were provided a hygiene kit and being observed by the health professionals in a female ward. Rashida said, "I was shifted to a female ward with my baby and stayed there for eight days. They gave me three meals a day and doctor used to come four times every day for routine check-up. We both became better and they discharged me after eight days. Now the family is reunited and happy again."

60 All Names have been changed to protect identities.

61 There had been rumours circulating in the camp that people infected with COVID-19 would be killed or sent away and never returned.





Resources

Interagency Technical Note on the Protection of Children During the COVID-19 Pandemic: [Children and Alternative Care - Immediate Response Measures](#).

[Case management considerations for children in residential care during COVID-19 pandemic](#), Changing the Way We Care.

[Guidelines for virtual monitoring of children, their families and residential care facilities during the COVID-19 pandemic](#), Changing the Way we Care.

[Case management considerations for children at risk of separation, including recently reunified children, during COVID-19 pandemic](#), Changing the Way we Care

[Guidelines for Residential Institutions: Keeping Children Nourished During the COVID-19 Pandemic](#), Spoon Foundation.

[Care for Children in Health Facilities during COVID-19](#) (Standard Operating Procedures for Isolation Treatment Centres), Save the Children.

[COVID-19 - Information and guidance for social or community care and residential settings](#) (Scotland), Health Protection Scotland.

[Alternative Care in Emergencies Toolkit](#) provides tools and guidance to facilitate the process of planning and implementing interim care and related services for children separated from or unable to live with their families during an emergency.

[COVID-19 Guidance for Interim Care Centres](#) provides practical guidance is for staff and partners already running Interim Care Centres (ICCs) during the Covid-19 pandemic. Interim care is defined as care arranged for a child on a temporary basis of up to 12 weeks, Save the Children.

[Child Safe Programming and Safeguarding in Interim Care Centres](#) outlines some of the potential risks children face in Interim Care Centres and suggests how to manage them to ensure that children are as safe as possible, Save the Children.



For more information on isolation and quarantine measures please see:

[Clinical Management of COVID-19](#). World Health Organisation

[Children, Isolation and Quarantine – Preventing Family separation and other Child Protection Considerations during COVID-10](#), UNICEF.





SPECIFIC CHALLENGES FOR ALTERNATIVE CARE ACROSS BORDERS

As international borders close or become restricted, it has been increasingly difficult to facilitate alternative care for children across borders resulting in children being detained, institutionalised, or simply left in limbo. While some Governments worked to decrease the numbers of people in immigration detention, others cited numerous challenges, including restrictions in cross-border case management.⁶²

Although all previous sections in this Guidance is applicable to children crossing borders, additional considerations need to be taken into account for their care:

- Governments should ensure that emergency measures to contain the virus do not result in the forced separation, detention or institutionalisation of children.
- Children should not be detained on either side of the border and priority should be given to the immediate release of children in immigration detention, as children should never be detained based on their immigration status or that of their parents. This is especially true given the heightened risk of the spread of COVID-19 in congregate care.
- Governments should adopt clear policies at global, regional and national levels, to ensure cross-border case management, family tracing, and appropriate care placements are able to take place during the pandemic. This should include updated procedures for when and how children and families are tested prior to placement or reunification, what happens if a child or caregiver tests positive, and where and how children and families safely quarantine or self-isolate if required.
- Remote and emergency measures should be put in place to facilitate access to consular and asylum procedures during lockdown and other measures that result in scaled down service provision at the national level.



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⁶² All alternative care decisions should be framed by international human rights and refugee law, including respect for the principle of non-refoulement, the right to seek asylum, the principle of non-discrimination, the best interests of the child, the right to family unity, the right to leave one's country and return taking into consideration data protection standards and principles.





- Governments should have clear procedures in place for children who are identified at border points to enable comprehensive assessments to be conducted as part of the case management process, and to ensure family tracing and reunification or alternative care placements are explored in a timely manner.
- Standard Operating Procedures, if in place, should be updated to include measures in place to prevent the spread of the virus in line with existing public health protocols. Where there are concerns about the spread of the virus prior to placement in alternative care, children should be screened for COVID-19 and tested where indicated.
- Contact between families on either side of the border should be encouraged and actively facilitated, including for families where one or more members have tested positive for coronavirus.
- Child welfare and social protection authorities across borders should cooperate to facilitate family tracing and reunification in line with the child's best interests through the establishment or strengthening of central authorities at the national level. Children reunified with families or placed in alternative families across borders need to be followed up after placement with the appropriate safeguarding provisions in place.



Resources

[Technical Note: COVID-19 and Children Deprived of Liberty](#), The Alliance for Child Protection in Humanitarian Action & UNICEF.

UN Network on Migration. [COVID-19 and Immigration Detention: What can Governments and other stakeholders do?](#)

[On the Move Alone \(OMA\): A Practical Tool for Case Management of Unaccompanied](#)





SPECIFIC CHALLENGES FOR ALTERNATIVE CARE FOR STREET CONNECTED CHILDREN

Children in street situations are being severely affected by the containment measures taken to restrict transmission of the virus and the closure of social services and shelters. The majority of these children have no safe home to go to and are living alone or with peers; others are with their families on the street in highly precarious situations.

These children often have poor health status and underlying health conditions – particularly respiratory – that may make them more vulnerable to COVID-19. Most public health measures being recommended during this pandemic, such as social distancing, self-isolation, frequent hand washing and wearing of mask are simply not an option for them.

In addition, many of these children earn their own living or work to earn a living to support their families and face a dramatic loss of income due to containment measures and as a result need immediate support to survive and protect themselves and their families. Most of these children are not included in any government programmes or initiatives as they are not registered and have no legal identification documents. Instead they rely on services offered through drop-in centres to meet their basic needs, but many such facilities have been closed as a response to the pandemic or due to loss of funding. Further, these children are particularly vulnerable to sexual abuse and violence if they are living alone on the streets, especially

under circumstances where other children/adults with whom they live may have left the urban areas in response to containment measures. Widespread discrimination and policing to round them up and remove them from the street result in high levels of stigmatization and violence against them, detention in dangerous conditions, and often cause these children to go into hiding, rendering them even more vulnerable and out of the reach of services.

While the alternative care guidance provided in this document is applicable to these children, additional considerations apply as well:

- Governments should prioritise children in street situations in the provision of emergency services and funding, including by extending existing social support and protection schemes to specifically target these children, as well as by removing potential barriers to accessing basic services, such as requirements for documentation or the authorization or presence of an adult in order to receive them.



- Governments and civil society organisations should ensure that drop-in centres and similar such facilities, as well as outreach services to street-connected children, are designated as essential services, and that they are resourced, provided with information [on how to prevent the spread of COVID-19](#), and able to facilitate access to key services such as health, hygiene, protection, education, and nutrition.
- Governments should consider street-connected children when designing information sharing and communications on how to stay safe, with particular emphasis on child-friendly information that can be understood by children who are unable to read.
- Police should be directed to ensure that children in street situations are not arrested and instead are supported with access to shelters or other adequate alternative housing, and connected to health, child protection and other support services, including through child helplines.
- Outreach services to children on the street should be prioritised and resourced, including the provision of hand washing stations on the streets, food outreach programs, and by designating street outreach by social workers as essential services, providing them with the authorization and adequate protective equipment and transport needed to carry out this work effectively during lockdown periods or other restrictions.
- Governments should work with local organisations and NGOs with existing relationships with street-connected children to map and identify vulnerable children and their needs.
- Drop-in centres and shelters should include experienced, dedicated case workers to work with each child and young person on a comprehensive assessment of care options, including family reunification or placement in alternative care, ensuring that decisions are fully informed by the child's views and wishes and recognising that these children have often exercised high level of autonomy and also experienced significant adversities in their relationships and lives.
- Where there are concerns about the spread of the disease, children should be screened for COVID-19 and tested where indicated prior to reunification or placement. Staff in shelters and drop-in centres should follow preventive measures to reduce the risk of spreading the virus.
- Whilst family reunification may be feasible and in children's best interests in many circumstances, the drivers that have led them to live and work

on the streets must be addressed through comprehensive individual safety assessments as well as direct and concrete support to the children and their caregivers, with frequent follow up monitoring provided. During the pandemic, families may require additional support, and where appropriate, remote monitoring mechanisms should be put in place when in person monitoring is not possible.

- Case workers should work with relatives and prospective foster parents to identify support needs to address potential discrimination based on personal or social beliefs about children who are street-connected, as well as to support these caregivers and children to address positively potential conflict and behaviour issues that may arise during the placement.
- The provision of supervised independent living arrangements should be considered for older adolescents who have been autonomous for prolonged periods of time and who do not wish to be reunified or placed in alternative family care.



Resources

[COVID-19 and street connected children's rights: Public spaces and orders to self-isolate \(CSC\)](#)

[COVID-19 and street-connected children's rights: The right to the highest attainable standard of health \(CSC\)](#)

[COVID-19 and street-connected children's rights: The right to access to information \(CSC\)](#)

[COVID-19 and street-connected children's rights: The right to adequate food \(CSC\)](#)

[Technical Note: COVID-19 and Children Deprived of Liberty](#)

[Guidance for Street Workers during the pandemic \(StreetInvest\)](#)

[Social Service Workforce Safety and Wellbeing during the COVID-19 response- Recommended Actions](#)

[UNICEF Transformative Action to Accelerate Results for Children in Street Situations in the Decade of Action \(2020–2030\): Technical Guidance](#)






ANNEXES

ANNEX I: EXAMPLE SBCC STRATEGY FOR RECRUITING FOSTER CARERS⁶³

Social Behaviour Change Communication

 For more information about creating a comprehensive SBCC strategy, please review the [FHI 360 C-Modules](#) on how to go through the steps towards effective behaviour change.

In recruiting foster carers and developing an appropriate programme or advocacy strategy on alternative care, it is important to: 1) Understand and analyse the situation, identifying gaps in knowledge; 2) Focus and design your communication strategy based on the analysis, 3) Create your strategy for the intended audiences, 4) Implement and monitor (including getting feedback from your audience and the community, 5) Evaluate your results and adjust as necessary.

As with any programme, it is important to first understand the situation. This includes a better understanding of what the need for alternative care and foster care will be (both due to COVID 19 as well as other emergency placements due families coming under increasing strain due to the crisis). In developing an SBCC Strategy, consider the following:

Consider creating a simple context analysis including:⁶⁴

Community & Services: What foster services currently exists? Who is responsible for these services (both oversight as well as running services)	
Enabling environment: What are the laws and policies related to foster care placement?	
Information: What information is available? Consider information about COVID-19 as well as foster care	
Motivation: What currently motivates people to foster? Who would be best placed? (and how safeguards would be applied)	
Ability to act: What support or additional support would foster carers need to care effectively for children during this time?	
Norms: What are pre-existing norms related to fostering children? How has this been done traditionally prior to COVID-19?	

- CONTENTS 
- INTRODUCTION 
- CONTEXT 
- APPROPRIATE CARE 
- KEY PRINCIPLES 
- CONSIDERATION FOR PLACEMENT 
- FAMILY BASED CARE 
- RESIDENTIAL CARE 
- CARE ACROSS BORDERS 
- STREET CONNECTED 
- ANNEXES 

63 Adapted from: FHI360 C-Modules: <https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication>

64 This is very simplified so for more information on a context analysis and research please refer to: <https://www.fhi360.org/sites/default/files/media/documents/Module1-Practitioner.pdf>



- Consider how best to target people who are at lower risk for having severe illness when contracting COVID-19 while also where possible using existing experienced foster carers.
- Consider in messaging what you want people to do differently (i.e. – help their neighbours, sign up to be foster carers, encourage existing foster carers to agree to be emergency foster carers for children exposed to the virus etc).
- Consider how to use broader SBCC as well as Risk Communication and Community Engagement strategies (RCCE) to address rumours and misinformation about the spread of the virus and any stigma or discrimination associated with those who have contracted the virus.

Analyse your assessment to determine:

- Target audience (primary, secondary, tertiary)
- Enablers and barriers for them to act

Example Content Brief for Developing a Foster Care Recruitment Strategy

Audience	What do we want them to do?	Why are they not doing it?	How do we motivate them?	Where do they get information, they trust
Widows	Provide emergency or longer-term foster care	Fear of what others will think Concern about cost of caring for a child	Link to existing social protection schemes/ cash support Provide remote training and support groups	Marketplace Other women
Social workers, case workers, health workers or care workers, including day care	Provide emergency or longer-term foster care	Not sure it is available Existing family obligations	Appeal to greater good Address other responsibilities Appeal to short term nature of need Provide remote accredited training	Other social workers/ health workers





In developing your message content, consider the following:

DO for establishing message content	Do NOT
<p>Use evidence-based data to inform messages alignment with PwV factsheet.</p> <p>Develop concise messaging using simple language and easy-to-do actions with one main idea at a time (what people need to know and do, why they should do it (benefits and risks), and how to do it)</p> <p>Instil confidence with positive messages that reinforces the specific behaviour</p> <p>Dispel rumours, myths, and misinformation with a response that is proportionate to the incorrect information.</p> <p>Appeal to people’s sense of individual and collective responsibility</p> <p>Consider communication channels from rapid assessment data).</p> <p>Repeat the message across multiple channels frequently to increase reach and dose of the message</p> <p>Link messages to available services and resources</p>	<p>Provide background information, as this may distract audiences from the key messages.</p> <p>Develop long messages that address more than one issue at once.</p> <p>Provide information that is dishonest, unproven or factually incorrect.</p> <p>Blame individuals, organisations or institutions for the emergency.</p> <p>Fuel fear and anxiety, they are likely already elevated.</p> <p>Use language that can be interpreted as judgmental or discriminatory.</p> <p>Use technical jargon and complex, technical words.</p> <p>Use humour (this can often be misunderstood)</p> <p>Reference or link to unconfirmed, unreliable, or out-of-date sources for information on the outbreak.</p>

Do not forget the importance of pre-testing your message and getting feedback from the audience. Messages will need to continue to evolve as the situation progresses.





ANNEX II: EXAMPLE INFORMATION FOR NON-CP ACTORS TO ASSIST IN FAMILY TRACING

Example from the Syria Response:

FOR NON-CP ACTORS (MEDICAL, PROTECTION, MILITARY, SECURITY)

Preserving Critical Tracing Information for young/ injured/disabled UNACCOMPANIED CHILDREN

When **very young children or children who cannot communicate due to disability** or injury are separated from their families, the risk is high that they will lose their identity and the chance of ever finding their families. If information can be collected about the child at/from the location of separation, or at the point of first contact, the chances of finding their families can be good.

Speed is essential: *collecting and documenting information must begin immediately and as close to the location where the child was found/separated as possible.*

Who is the best source of information about the child? Community members who were with the child when s/he got separated and **first responders** (e.g. medical, military, protection actors).

What can you do when you have first contact with a young/non-communicative child?

- 1) Unless the child is in immediate danger **do not move them from the location where they are first identified before:**
 - Talking to people (including other children) who are/were close to where the child was found: does anyone have information about the child or his/her family (i.e. names, addresses, places of origin, etc). If the situation does not permit you to immediately collect this information please try to get names/contact information from these people, for later follow-up by Save the Children.
 - If nobody knows the child but he/she came with a group of people try to get information about the group e.g. the community where they are from, ethnicity, etc
- 2) If the child is brought to you by someone who found them, **ask this person everything they know about the child/family**, and the precise location where the child was found (i.e. neighbourhood, village). If possible, get this person's name/contact information for follow-up by Save the Children. Ask also if they know whether the child is still wearing the same clothes they were found in, and make note of this.

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES





- 3) **Do not throw anything away** (child's clothes, bracelets, hair ties, necklaces, photos, papers – anything at all that is found on or near the child). These are all valuable for family tracing purposes. Preserve everything in a plastic bag, labelled with child's case #; and transfer bag with the child, when child's location changes.
- 4) If possible **take a photo of the belongings** before bagging them, to have as a back-up in case the bag or some of the items go missing. A photo of the child will be taken by Save the Children when the case is referred but if you have an opportunity to do so as well, please do.
- 5) Complete whatever information you have collected, on the **Rapid Registration Form for Non-CP actors**. No detail is too small. Use the back of the page if necessary. Phone or email the information to Save the Children and/or send the form with the child and his/her belongings when the child is transferred.
- 6) **Medical staff – when a seriously injured adult patient/parent arrives at the hospital alone with a young or non-communicative child:** if possible, collect basic family information from the parent while they are still conscious on the Form as above. If parent dies before this can be done, look for possessions on the patient that could be transferred with the child to Save the Children, for potential future family tracing/verification (jewellery, photos, cell phone, distinguishing birth marks or physical features on the deceased person, etc.). Take a photo of the deceased parent if ethically appropriate, to link to the child. Take the same steps as above in relation to the child him/herself (take photos, preserve all belongings, etc).





ANNEX III: Example Form for Health Workers to Document FTR Information

The following form is to be used by Health Workers who have received an unaccompanied child. Please fill out the information below. Note that no detail is too small. Please contact the Child Protection/Child Welfare focal point to begin family tracing and reunification.

Basic Information	
Name of Health Worker:	
Name and Location of Medical Facility:	
Contact Information of Health Worker:	
Date and Time Child Arrived at the Health Centre:	
Child's Information	
Name of Child (please list birth name and nicknames and mark them each accordingly)	
Age of Child (can be approximation)	
Sex of Child	
Did someone accompany or bring the child to the centre?	If yes, please answer the following questions:
Name	
Age	
Contact info	
Permission to contact	
Relationship to the child	
Precise location (enough detail to go to the exact point)	
Date & Time the child was found	
Other community members/authorities present in the location the child was found:	
Information known about the child (name, age, gender, ethnicity, community where they are from, cause of separation, etc.):	
Is the child wearing the same clothes now as when you found them?	
Is there anything else you know about the child?	
Further Information	
Please list all items the child came with (clothing, jewelry, papers, photos, etc.) Please preserve everything in a plastic bag, labelled with child's case #; and transfer bag with the child, when child's location changes.	

CONTENTS



INTRODUCTION



CONTEXT



APPROPRIATE CARE



KEY PRINCIPLES



CONSIDERATION FOR PLACEMENT



FAMILY BASED CARE



RESIDENTIAL CARE



CARE ACROSS BORDERS



STREET CONNECTED



ANNEXES



ANNEX IV: Example Informed Consent Script for entering an Isolation Treatment Centre

Informed Consent Script for Health Workers

Cox's Bazar, Bangladesh

Informed Consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age.

To ensure consent is "informed", health worker must provide the following information: 1) Giving the client all the possible information and options available to him/her so he/she can make choices. 2) Informing the client that he/she may need to share his/her information with others who can provide additional services. 3) Explaining to a client what is going to happen to him/her. 4) Explaining the benefits and risks of the service to the client. 5) Explaining to the client that he/she has the right to decline or refuse any part of services. 6) Explaining limits to confidentiality.



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1) Parent/Caregiver needs to determine whether they will enter the Isolation Centre or ITC with their child

Caregiver: Asymptomatic

Child: Symptomatic and requires care in the Isolation Centre or ITC

Hi, I am [insert name] and I work for [insert organisation]. I would like to share some information with you so you can decide next steps for you and your child.

Your child needs to go into the [Isolation or ITC] until they recover. While they are in the centre, there are three options available:

- 1) You can accompany your child
- 2) Another family member over the age of 18 can accompany your child
- 3) Your child can go in under the care of our staff/volunteers

There is no right or wrong answer. I am going to run through a few things to consider, you can stop and ask me questions at any time:

- Although we put in all safety measures we can, the centre has patients with Covid-19 and therefore we can't guarantee that you won't contract it.
- If you decide to enter with your child, we will provide you with a mask and hand washing facilities and training on how to use it.
- You will need to stay in the "red zone" of the ITC for the duration of your stay. If you leave the red zone of the ITC, you will need to quarantine for 14 days. This means you will need to stay at home for 14 days and monitor if you have any symptoms.
- You won't be able to leave and come back to the centre.
- Consider who will care for any other children who are not in the centre, they should be cared for by someone over the age of 18.
- If you decide to admit the child alone, Save the Children has staff in the centre who will care for your child. We ask that you still maintain contact with your child, you can do this by visiting or dropping off notes.
- If you would like another family member to accompany your child, please put down their full name, and relationship to the child. They must be over 18 years old.

Do you have any questions? [Allow them to ask any questions and process the information]. Then ask, what would you like to do?

Ensure you document the decision of the caregiver on the child's file.

If the caregiver decides to go with the child, explain the rules of the centre, how to use PPE and where to ask questions or make complaints.

If the caregiver decides that the child will enter alone. Explain who will care for the child (where possible introduce them to the staff/volunteer) and how the parent can visit the child and stay in communication.





2) Parent/Caregiver needs to determine whether a child will enter isolation with them.

Caregiver: Symptomatic and requires care in the Isolation Centre or ITC

Child: Asymptomatic

Hi, I am [insert name] and I work for [insert organisation]. I would like to share some information with you so you can decide next steps for you and your child.

You need to go into the [Isolation or ITC] until you recover. For the safety of your child(ren), we recommend that they stay with another relative or trusted community member who are over the age of 18. Where possible, we will assist you to be in contact with your child while you are in the centre. Do you have someone that you think could care for the children while you recover?

If the parent agrees, verify the identity of the caregiver. This may be 1) the parent visually confirms the caregiver who they hand their child over to or 2) the health worker accompanies the child to the designated caregiver. Prior to handing the child over, they must verify the identity of the caregiver. This can be done by having the caregiver and parent speak over the phone and taking a picture of the caregiver and showing it to the parent to verify it is the right person. **Ensure that this information is documented in the parent's file.**

If the caregiver wants to keep their child with them, this may be an option in the Isolation Centre but not the ITC.

I would like to share some information if you want to consider keeping the child with you. You can stop and ask me questions at anytime:

- Although we put in all safety measures we can, the centre has patients with Covid-19 and therefore we can't guarantee that your child won't contract it.
- If you decide to have your child accompany you, we will provide your child with a mask and hand washing facilities and train both of you on how to use it.
- You and your child won't be able to leave and come back to the centre.
- When you and you child leave, you will need to quarantine for 14 days. This means you will need to stay at home for 14 days and monitor if you have any symptoms.

Ensure you document the decision of the caregiver on the child's file.



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