

[Template] Inter-agency Child Protection Case Management Standard Operating Procedures

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| [Insert logos of agencies participating in the process] | |
| Country | Example Text |
| Location | [Geographical area covered by the SOPs] |
| Collaborating parties | 1.  2.  3.  4.  5. |
| Approved | [dd/mm/yyyy] |
| Revisions |  |

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# INTRODUCTION TO THE TEMPLATE STANDARD OPERATING PROCEDURES

The [Global Case Management Task Force](https://alliancecpha.org/task-forces) under the Alliance for Child Protection in Humanitarian Action produced this template for Child Protection Case Management Standard Operating Procedures (SOPs). It has been developed in association with and should be used together with the Five-Step Guide to Developing Inter-Agency Standard Operating Procedures for Child Protection Case Management in Humanitarian Settings.

As with the guide, the template SOPs have been developed to support those involved in or intending to develop inter-agency SOPs for child protection case management in humanitarian settings. As such, they may be used by government authorities in coordination with other child protection actors, as well as by country-level Child Protection Coordination Groups. The template SOPs could also be adapted for contexts where single actors are providing CPCM to complement or support the work of the functioning national authorities.

The aim of the template SOPs is to promote and standardise an inter-agency approach to developing SOPs for child protection case management in humanitarian settings. Whilst they have been developed for use in humanitarian settings (including protracted crises), they can also be adapted for use in development settings.

# INSTRUCTIONS FOR USE

The template SOPs are structured as follows:

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* *The* ***Content Guide*** *is italicised text and can be found between dashed lines. The content guide is intended to help users understand what should be included in each section.*

**---------------------------------------------------------------------------------------------------------------------------**

* Content in black text is **Standard Text** applicable for all child protection case management SOPs and may be copied directly from the template. Please note that content aims to be as simple and light as possible to facilitate the rapid development of SOPs in humanitarian contexts. It may be built upon and expanded according to requirements.

Examples of text are provided in boxes and may be adjusted or removed.

* Text in blue refers to context-level information which should be inserted or adapted according to context.
* Additional template / examples of tools and guidance are included as an annex to the SOPs and are referred to in the text.

# SECTION 1: BACKGROUND AND INTRODUCTION

## Case Management

*---------------------------------------------------------------------------------------------------------------------------*

*The definition should include the standard inter-agency definition of case management and may include national definitions of case management and information about how humanitarian case management supplements national case management systems.*

*---------------------------------------------------------------------------------------------------------------------------*

Case management is a way of organizing and carrying out work to address an individual child’s (and their family’s) needs in an appropriate, systematic and timely manner, through direct support and/or referrals, and in accordance with a project or programme’s objectives.[[1]](#footnote-1)

Supplement according to context.

## Objective and Scope of the SOPs

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*****Objective:***** *The Objective should be discussed and agreed upon during the planning workshop (see the Five-Step Guide, under Step 2: Plan, page 10), building on a discussion on the rationale for developing the SOPs.*

**Examples of Objective:**

“To provide a common strategy for addressing cases of children who are harmed or at risk of harm and ensuring quality, consistency, coordination in services and adherence to the internationally agreed upon standards on case management.”

“These SOPs describe guiding principles, procedures, roles and responsibilities in the prevention of and response to child protection concerns affecting children [clarify if it applies to all children or a specific group] and where they are (camp/urban, etc.). The SOPs detail the minimum procedural standards within the case management process.”

*****Scope:***** *Under the Scope, the following information could be captured:*

* *Geographical scope: the geographical area where the SOPs apply.*
* *Programmatic scope: the specific issues focused on (but not limited to) based on an overall risk analysis of the wider population in need.*
* *Participating actors: an overview of the participating authorities and agencies that will be working with the SOPs.*

**Examples of Scope:**

Refugee Context:

“These Child Protection Standard Operating Procedures (SOPs) concern [number] refugees, including [number or percentage] of children, and asylum seekers from [country/countries]. Asylum seekers [or prima facie refugees depending on the context] are arriving at a rate of [number] per [week/month] and are currently located in [name of camps/areas].

Conflict / Natural Disaster Context:

“Protection concerns covered by these SOPs include issues such as [e.g. child survivors of sexual abuse, children associated with armed forces and armed groups, unaccompanied and separated children, children involved in hazardous child labour, etc.].

These SOPs were developed in consultation with [actors]. This document is designed to be used in coordination with [existing national and international resources, policies and standards].”

## Context Analysis

*---------------------------------------------------------------------------------------------------------------------------*

*This section should outline:*

1. *Profile of humanitarian impact:*

* *Overall numbers of people affected broken down by men, women, girls and boys;*
* *Locations of affected population including names of camps / settlements / urban areas.*

1. *The nature and scale of specific child protection threats, violations and vulnerabilities in your context that require a response. Where possible, this should include analysis of the social, economic, political and other causes of those risks and should ensure that diversity, disability and other issues of concern are reflected where appropriate.*
2. *The nature and scale of existing resources, capacities, positive coping strategies, strengths and resilience in your context to build on in the response.*
3. *International legal framework related to child protection that the country is signatory to and/or that the humanitarian child protection community abides by. Specify those legal frameworks relevant to the issues in-context (e.g. refugee protection, conflict, child labour). Examples of relevant legal frameworks are included below.*
4. *National legal frameworks related to child protection.*
5. *The national or local child protection case management system including:*

* *Mandated authority for child protection case management and capacity to respond to humanitarian crisis;*
* *Community-level mechanisms to respond to individual needs of the child and links between formal and informal child protection systems;*
* *Mapping of key stakeholders including coordination mechanisms and links between formal and informal child protection systems, as well as other non-traditional child protection stakeholders that play a role in addressing the needs of children and promoting their wellbeing (e.g. healthcare providers, police, judicial officials, NGOs from other sectors such as MHPSS or education). This should also include information on existing capacities and human and financial resources;*
* *Relevant SOPs already existing in the country (including the date of signature);*
* *Key gaps or weaknesses in any current case management systems and processes including the extent to which children who are discriminated against (and as a consequence, marginalised) are able to access services, any access and security constraints etc.;*
* *Mapping of prevailing views, beliefs and attitudes related to child protection and case management.*

*Analysis of the context should continue on an on-going basis as the context changes, populations move, and capacity to prevent and respond to child protection concerns evolves.*

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**International Legal Framework**

* United Nations Convention on the Rights of the Child (1989);
* United Nations Convention on the Elimination of Discrimination against Women (CEDAW) (1982);
* Universal Declaration of Human Rights (UDHR) (1948);
* United Nations Convention on Rights of Persons with Disabilities (CRPD) (2006);

***Refugee Protection***

* The 1951 Convention Relating to the Status of Refugees and it's 1967 Protocol;

*****Migration*****

* International Convention on the Protection of the Rights of Migrant Workers and Members of their Families 1990 (Resolution 45/158);

*****Statelessness*****

* The 1954 Convention Relating to the Status of Stateless Persons;
* The 1961 Convention on the Reduction of Statelessness;

*****Conflict*****

* The Geneva Conventions (1949) and their Additional Protocols (1977);
* UN Security Council, Resolution 1612 (on Children in Armed Conflict) (2005);
* The UN Security Council Resolution, No. 1325 (on Women, Peace and Security) (2000)

*****Trafficking*****

* UN Convention against Transnational Organised Crime (2000);
* Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children (2000);

*****Child Labour*****

* ILO Convention No 138 on the minimum age for admission to employment and work;
* ILO Convention No 182 on the Elimination of the Worst Forms of Child Labour;

*****Juvenile Justice*****

* UN Standard Minimum Rules for the Administration of Juvenile Justice (Beijing Rules, 1985);
* UN Rules for the Protection of Juveniles Deprived of their Liberty (Havana Rules, 1990);
* UN Guidelines for the Prevention of Juvenile Delinquency (Riyadh Rules, 1990);

*****Children Associated with Armed Forces or Armed Groups*****

* Principles and Guidelines on Children Associated With Armed Forces Or Armed Groups (Paris Principles) (2007).

Add information according to context.

## Dissemination, Review and Revision

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*****Dissemination:*** *Outline how the SOPs will be disseminated amongst case management actors (e.g. relevant government bodies, community structures, service providers, national/local NGOs, CBOs, international agencies, service providers and community structures,) at both national and sub-national levels (as needed).***

*****Review and Revision:***** *Indicate under what circumstances, how and with what frequency the SOPs will be reviewed and revised and how communication on the review and revision process between national and relevant sub-national groups will be organized.*

*(see the Five-Step Guide, under Step 4: Disseminate & Build Capacity, page 11/12 and Step 5: Review & Revise, page 12)*

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In terms of revising the SOPs, [the SOP Focal Point] should call a review meeting with the focal points in participating authorities and agencies every [length of time] or if the answer to any of these questions is ‘yes’:

* Is the SOP not achieving its stated objectives?
* Since the last review, have there been any changes to the operational environment or significant new information about child protection threats, violations and vulnerabilities that may impact on eligibility and prioritization of cases?
* Have any of the procedures proven unworkable or not appropriate in the current context?

The review will include updates at all [national and sub-national] levels and will take into account changes in context, impact on risk, vulnerability and eligibility for case management, updates in service mapping and referral pathways, and developments in the case management process and information management system.

Other case management tools, protocols and guidance that may be annexed to the SOPs should be revised as and when necessary without waiting for a formal review process. For example, services available in humanitarian crises change rapidly and it is critical that the service mapping is a living document, continually updated across all sectors, in order to remain relevant and effective as a case management tool. Referral pathways should also be updated to reflect available services.

Supplement according to context.

# SECTION 2: DEFINITIONS AND GUIDING PRINCIPLES

## 2.1 Definitions of Key Terms

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*The SOPs should list and define key terms used throughout the document. These may also be annexed to the SOPs. The key terms and definitions below are generic examples that can be copied into SOPs. A more comprehensive list of key terms and definitions can be found in the Standard Child Protection Case Management Forms in Humanitarian Settings:*

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**Core Definitions:***[[2]](#footnote-2)*

* **Assent:** The expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child’s “informed assent” is sought.
* **Caregiver:** A caregiver is someone who provides daily care, protection and supervision of a child. This does not necessarily imply legal responsibility. A customary caregiver is someone that the community has accepted, either by tradition or common practice, to provide the daily care, protection and supervision of a child.
* **Case:** The individual at the centre of the case plan. In different settings people may use different terms such as “client” or “case” to refer to the individual at the centre of a case plan. As the forms relate specifically to case management, the term “case” is generally used.
* **Caseworker:** The key worker in a case who maintains responsibility for the child’s care from identification to case closure. In different settings people may use different terms such as “social worker” or “case manager”.
* **Child Protection:** the prevention of and response to abuse, neglect, exploitation, and violence against children.
* **Child Protection System**:**** The set of laws, policies, regulations and services needed across all social sectors – especially social welfare, education, health, security and justice – to support prevention and protective responses for children inclusive of family strengthening.[[3]](#footnote-3)
* **Confidentiality:** The obligation that information about an individual disclosed in a relationship of trust will not be disclosed or made available to unauthorized persons that are inconsistent with the understanding of the original disclosure or without prior permission.
* **Consent**: Informed, free and voluntary agreement of an individual who has the legal capacity to give consent.
* **Documentation:** The process of collecting and storing information specific to individual children and their families, both information that the child and family provide directly as well as any information collected indirectly, this also includes the use of case management forms, notes taken, and gathering these in case files.
* **Psychosocial Support:** Refers to any type of local or outside support that aims to protect or promote psychosocial wellbeing and prevent or treat mental disorders.
* **Referral:** The process of formally requesting services for a child or their family from another agency through an established procedure and/or form; caseworkers maintain overall responsibility for the case regardless of referrals.
* **Resilience:** The ability of children and their families to deal with, and recover from, adversity and crisis, influenced by individual characteristics and external factors like: diversity of livelihoods, coping mechanisms, life skills such as problem-solving, the ability to seek support, motivation, optimism, faith, perseverance and resourcefulness.
* **Supervision**: A relationship that supports the caseworker’s technical competence and practice, promotes well-being and enables effective and supportive monitoring of casework.
* **Vulnerability:** Physical, social, economic and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering and death.

Add key terms according to context

## 2.2 Guiding Principles for Case Management[[4]](#footnote-4)

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*The following guiding principles are taken from the* [*Inter-agency Guidelines on Case Management and Child Protection (2014)*](http://cpaor.net/resources/inter-agency-case-management-guidelines-and-training-manuals-2014-available-arabic-english)*. Key stakeholders engaged in child protection case management should comply with these principles to guide their behaviour and interaction with children and their families / caregivers. This also provides a foundation of care and responsibility for decisions and actions taken. See additional guidance and minimum standards below in Section 8: References and Annexes.*

*Fundamental principles that guide case management should be discussed and agreed during the planning workshop (see the Five-Step Guide, under Step 2: Plan, page 8).*

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**Guiding Principles:**

**Do No Harm**

This means ensuring that actions and interventions designed to support the child (and their family) do not expose them to further harm. At each step of the case management process, care must be taken to ensure that no harm comes to children or their families as a result of caseworker conduct, decisions made, or actions taken on behalf of the child or family.

Caution should also be taken to ensure that no harm comes to children or families as a result of collecting, storing or sharing their information. For example, care should be taken to avoid creating conflict between individuals, families or communities, and collecting unnecessary information that, if in the wrong hands, could put the child or family at risk of violence. Unless care is taken, this may expose a child and his/her family to further harm such as revenge acts or violence.

**Prioritise the Best Interest of the Child**

The “best interests of the child” encompass a child’s physical and emotional safety (their well-being) as well as their right to positive development. In line with Article 3 of the United Nations Convention on the Rights of the Child (UNCRC), the best interests of the child should provide the basis for all decisions and actions taken, and for the way in which service providers interact with children and their families. Caseworkers and their supervisors must constantly evaluate the risks and resources of the child and his environment as well as positive and negative consequences of actions and discuss these with the child and their caregivers when taking decisions. The least harmful course of action is the preferred one.

All actions should ensure that the child’s rights to safety and on-going development are never compromised. The Best Interests Principle must guide all decisions made during the case management process. Often in child protection there is no one “ideal” solution possible, but rather a series of more or less acceptable choices that must be balanced with a child’s best interests.

**Non-discrimination**

Adhering to the non-discrimination principle means ensuring that children are not discriminated against (treated poorly or denied services) because of their individual characteristics or a group they belong to (e.g. gender, age, socio-economic background, race, religion, ethnicity, disability, sexual orientation or gender identity).

Children in need of protective services should receive assistance from agencies and caseworkers that are trained and skilled to form respectful, non-discriminatory relationships with them, treating them with compassion, empathy and care. Case management staff must actively work to be non-judgmental and avoid negative/ judgmental language in their work. Whether engaged in awareness raising, prevention or response activities agencies and caseworkers should challenge discrimination, including policies and practices that reinforce discrimination.

**Adhere to Ethical Standards**

For agencies and staff working with children, professional ethical standards and practices should be developed and applied; these may be professional codes of conduct and child protection policies. National laws and policies may exist in addition to international norms and standards to protect children that are relevant and have to be respected. Adhering to ethical standards includes following the guidelines presented in this document. These guidelines are fundamental to the delivery of professional and quality care and protection for children.

**Involve the Child in Decision-making**

Children have the right to participate in decisions that affect in accordance with their evolving capacity related to their age and level of maturity. Listening to children’s ideas and opinions should not interfere with caregivers’ rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child’s wishes (based on considerations of their best interest), they should always empower and support children and deal with them in a transparent and respectful manner. In cases where a child’s wishes cannot be prioritized, the reasons should be explained to the child.

**Seek Informed Consent and/or Informed Assent**

Informed consent is the voluntary agreement of an individual who has the capacity to give consent, and who exercises free and informed choice. In all circumstances, consent should be sought from children and their families or caregivers prior to providing services.

To ensure *informed consent*, caseworkers must ensure that children and their families fully understand: the services and options available (i.e. the case management process), potential risks and benefits to receiving services, information that will be collected and how it will be used, and confidentiality and its limits. Caseworkers are responsible for communicating in a child-friendly manner and should encourage the child and their family to ask questions that will help them to make a decision regarding their own situation. (See appendix 13 of the [Inter-agency Guidelines for Case Management and Child Protection](https://resourcecentre.savethechildren.net/node/10255/pdf/cm_guidelines_eng_.pdf) for a sample of guidance note for informed consent).

Informed assent is the expressed willingness to participate in services. It requires the same child-friendly communication of information outlined above. However, for younger children who are by nature or law too young to give informed consent, but old enough to understand and agree to participate in services, the child’s “informed assent” is sought. Even for very young children (those under 5 years old) efforts should be made to explain in language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.

In some situations, informed consent may not be possible or may be refused, and yet intervention may still be necessary to protect the child. For example, if a 12-year-old girl is being sexually abused by her father, she may feel loyalty to him and her family and not want to take any action. That does not mean that agencies can ignore what is happening. Where consent is not given, and where the agencies involved have a legal mandate to take actions to protect a child, the reasons for this should be explained and the participation of children and non-offending family members continually encouraged.

**Respect Confidentiality**

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

Respecting confidentiality requires service providers to protect information gathered about clients and to ensure it is accessible only with a client’s explicit permission. For agencies and caseworkers involved in case management, it means collecting, keeping, sharing and storing information on individual cases in a safe way and according to agreed-upon data protection policies. Workers should not reveal children’s names or any identifying information to anyone not directly involved in the care of the child. This means taking special care in securing case files and documents and avoiding informal conversations with colleagues who may be naturally curious and interested in the work.

Importantly, confidentiality is limited when caseworkers identify safety concerns and need to reach out to other service providers for assistance (e.g. health care workers), or where they are required by law to report crimes. These limits must be explained to children and parents during the informed consent or assent processes. Supervisors and caseworkers should work together closely to take decisions in such cases where confidentiality needs to be broken.

**Ensure Accountability**

Accountability refers to being held responsible for one’s actions and for the results of those actions. Agencies and staff involved in case management are accountable to the child, the family, and the community.

Agencies and individuals providing case management must comply with the national legal and policy framework and international standards around [Protection from Sexual Exploitation and   
Abuse (PSEA](http://www.pseataskforce.org/)) and [accountability to affected populations](https://interagencystandingcommittee.org/system/files/legacy_files/TOOLS%20to%20assist%20in%20implementing%20the%20IASC%20AAP%20Commitments.pdf). They will also have to comply with professional codes of conduct where these exist. In the absence of a legal framework, the guiding principles and the good practice standards outlined in the Minimum Standard for Child Protection in Humanitarian Action (2012) provide a foundation for practice.

Agencies introducing or supporting case management services must take responsibility for the initial training, on-going capacity building and regular supervision of staff to ensure appropriate quality of care. This must also provide children and their families with routine opportunities to give feedback on the support and services they have received.

**Case Management Services Should Be:**

Child Friendly:entails providing services in ways that are appropriate and accessible for children. For example, by providing information in formats / language that can be understood by children of different ages.

Child Centered:entails organizing and delivering services, and making decisions in a way that centers on children’s needs and best interests. For example, you should consider holding reviews and meetings at times that are convenient for children and their families, rather than those which fit in with the working hours of staff.

**Empower Children and Families to build upon their Strengths**

All children, and their families, possess resources and skills to help themselves and contribute positively towards finding solutions to their own problems. Caseworkers and supervisors must work to engage children and families to play an active role in the case management process.

Throughout the case management process (including during assessment, case planning, and reviews) caseworkers should focus on empowering children and their families to recognize, prevent and respond to child protection concerns themselves. In practice, this means that, in addition to identifying problems and providing services, caseworkers must consider the child and family’s strengths and resources and how to build their capacity to care for themselves.

While caseworkers are providing an important service, it is ultimately the child and their family’s lives that are affected; they must always be active participants in the decisions made for their care. Furthermore, helping children to participate in decision-making is an important part of the recovery process that builds their sense of control over their lives and helps them to develop natural resilience.

**Base all Actions on Sound Knowledge of Child Development, Child Rights and Child Protection**

Assessments and interventions must be made on the basis of knowledge about child development, child rights and child protection (such as understanding vulnerabilities and risk factors, and family dynamics). *Child development* knowledge helps caseworkers to determine how to involve and communicate with children depending on the age and evolving capacities. As standards for the treatment of children vary across cultures and regions, *child rights* knowledge is essential to ensure international norms and standards are respected and incorporated into case decisions. Finally, staff working with children who are affected by humanitarian crises, sexually exploited or unaccompanied or separated should also receive specialized training in handling such sensitive cases. Without such knowledge, case plansmay not adequately address children’s needs and uphold their rights, and could even be harmful to the child.

**Facilitate Meaningful Participation of Children**

Children have a right to express opinions about their experiences and to participate in decisions that affect their lives. Agencies and caseworkers are responsible for communicating with children their right to participate – including the right not to answer questions that make them uncomfortable – and supporting them to claim this right throughout the casemanagement process. Children’s participation helps to prevent a caseworker from coming to a decision that is in their best interests but against their wishes (e.g. removing them from an abusive home), and caseworkers should explain such decisions with care and empathy to the child involved.Involving children, and their families, in planning and decision-making regarding their own care is critical to ensure services provided are appropriate and effective; furthermore itcontributes to children’s natural resilience and their ability to be agents for their own protection.

It is important to remember that a child’s ability to make decisions is related to their age, maturity, and evolving capacities. Even very young children are able to participate in decisions, although this may take more time and skills from the caseworker to be able to support the child to voice their views. Children have the right to receive information in an appropriate format so that the child understands what is happening throughout the case management process.

In contexts where children’s status is weak (e.g. due to gender, ethnicity, or disability) or where it is not culturally or socially acceptable for them to participate, children may be less at ease or feel less confident in participating and in making decisions. Caseworkers have a role to play in encouraging children to voice their concerns and in reassuring them about their ability to take decisions. Particularly in contexts where it may be not safe for children to speak out publicly, caseworkers have a responsibility to create a safe and confidential space for children to participate in their own case. Upholding confidentiality and considering safety in the development of case plans are essential to ensure children are not placed at risk.

**Provide Culturally Appropriate Processes and Services**

Caseworkers and agencies should recognize and respect diversity in the communities where they work and be aware of individual, family, group and community differences. This is important to be able to make an informed and holistic assessment of a child’s situation.

Cultural sensitivity also improves caseworkers’ capacity to work effectively with children, families and communities and to identify solutions that leverage local methods of care and protection and are in line with the children and families’ values and beliefs. Without consideration of the cultural context, the quality of case management services can be hindered, leading to the development of case plans that do not fit the realities of people’s lives and beliefs and that may not be acceptable and therefore difficult to implement.

When what is in the best interest of the child conflicts with cultural values or practices, managers and caseworkers must continue to prioritize the child’s best interests and take decisions that do not place them in additional risk (do no harm). It may be difficult to identify solutions that are seen as acceptable to the family or community, but managers and caseworkers must make every effort to work with children and families to identify culturally acceptable solutions that at the same time uphold the rights of children. With difficult issues like female genital mutilation, non-education of girls or child laborers, caseworkers should develop harm reduction strategies and seek to address the underlying causes of social conditions. For example, families who send girls to school might be given priority access to cash transfer programs or livelihood projects.

In some contexts, confronting these protection issues and cultural practices can lead to conflict and may create additional risks for children, families and communities as well as for caseworkers. Decisions made around these issues must include a careful assessment of risk and always respect the principles of do no harm and the best interests of the child.

**Coordinate and Collaborate**

Child protection programs are more effective when agencies work together, and involve communities , families and children in their efforts. Case management can provide a process for improving coordination and collaboration among all actors with a mandate to protect children including community leaders, government departments, service providers, CBOs, local NGOs and international agencies.

Agreed protocols on information sharing and referrals contribute to quality case management and ensure confidentiality and the best interests of the child are upheld. International organizations, in particular, have a responsibility to coordinate their activities and efforts with national governments and non-government agencies to ensure that existing systems are strengthened and not duplicated.

**Maintain Professional Boundaries & Addressing Conflicts of Interests**

Caseworkers and agencies should act with integrity by not abusing the power or the trust of the child or their family. Caseworkers must not ask for or accept favors, payments or gifts in exchange for services or support.

Personal and professional limitations and boundaries must be recognized and respected. Steps should be taken to address conflicts of interest where these arise. An example of a conflict of interest might be where the caseworker and child are in some way related or from the same social network, or where the caseworker working with the child is also the caseworker for the perpetrator of the abuse.

Caseworkers and agencies should take action to resolve these issues in a way that is positive for the child so that children are neither negatively affected nor given an unfair benefit as a result.

**Observe Mandatory Reporting Laws and Policies**

Many countries have mandatory reporting requirements, which oblige certain actors (such as child protection agencies and staff, teachers, nurses and doctors) to report cases of child abuse to relevant government authorities. However, these requirements can be challenging for caseworkers when the information is of such a sensitive nature that it cannot be shared with other actors without placing the child at risk of further harm.

This is of particular concern when data protection protocols are not in place or are not strictly followed. In humanitarian settings, where there is concern about the safety and security of those involved, it is good practice to deal with reporting decisions on a case by case basis, informed by the local standards and practices applicable in the country of operation, and always guided by the best interests of the child.

Agencies working with children should have their own internal child protection / safeguarding policies that should be complied with at all times (See Reference Section for further information). Often these set higher standards regarding the responsibilities of staff and expected behavior than that sanctioned in law.

# Section 3: Roles and Responsibilities

## 3.1 Roles and Responsibilities of Key Stakeholders

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*Case management roles and responsibilities should be defined during the planning workshop (see the Five-Step Guide, under Step 2: Plan, page 8/9) for the actors involved in the case management system outlined below. A Template Terms of Reference (ToR) for the Country-level Child Protection Case Management Task Force can be found in Annex C.*

*---------------------------------------------------------------------------------------------------------------------------*

This section outlines the roles and responsibilities of actors involved in child protection case management, as follows:

1. Relevant government bodies at different levels;
2. CP Coordination Group and/or Case Management Task Force under the CP Coordination Group at national and sub-national levels;
3. Child Protection Case Management Agencies;
4. Case Management Supervisors;
5. Caseworkers;
6. Service providers identified through the related mapping (see 3.3);
7. Relevant community structures including local leadership;
8. Children and their families / caregivers.

Add information according to context

## 3.2 Caseworker and Case Management Supervisor Roles and Responsibilities, Staff Ratios, Core Competencies and Capacity Building

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***Caseworker and Case Management Supervisor Roles and Responsibilities:*** *Caseworker and case management supervisor roles and responsibilities should be aligned and agreed between case management actors and core elements of job descriptions should be developed and annexed to the SOPs.*

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It is essential that staff working in case management have clear roles and responsibilities and a management and supervision structure in place. Sample job descriptions for caseworkers and case management supervisors can be found in Annex X and can be adapted for use by each case management actor.

Add information according to context

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***Staff Ratios:*** *The caseworker to cases ratio, case management supervisor to caseworkers ratio, and (where applicable) data entry staff to cases ratio should be agreed upon between case management actors and included in the SOPs. It is encouraged that caseworkers conduct their own data entry. However, if not possible, the standard text below provides a suggested ratio for data entry staff.*

*---------------------------------------------------------------------------------------------------------------------------*

Good case management practice is underpinned by well supervised, experienced, trained, and where possible, certified staff who have the time and resources to carry out their work. In order to ensure this, caseworkers must have a reasonable caseload, reflecting their skills, competencies and experience.

The minimum standard is that the number of cases allocated to each caseworker should not be more than 25. This is the maximum caseload for a caseworker and the actual caseload is dependent on factors like the distance to follow-up on cases, the distance between cases, the number of high risk cases in a caseload, and the capacity of the caseworker. The case management supervisor should review the caseload of individual caseworkers to ensure it is manageable at least once every 2 weeks. Each supervisor should not oversee more than 5-6 caseworkers.

The need for data entry staff depends on the capacity of caseworkers to use computers and technology. Where needed, data entry staff with strong IT skills should be responsible for approx. 100 cases.

*---------------------------------------------------------------------------------------------------------------------------*

***Core Competencies and Capacity-building:*** *Core competencies for caseworkers and supervisors should be outlined and specific to case management (see appendix 1 from* [*the Inter-Agency Guidelines for Case Management and Child Protection (2014)*](http://cpaor.net/resources/inter-agency-case-management-guidelines-and-training-manuals-2014-available-arabic-english)*.*

*Capacity building plans for case management actors should be based on capacity assessments. Caseworker and case management supervisor capacity assessment tools can be adapted from the* [*Inter-agency Child Protection Case Management Supervision and Coaching Package (2018)*](https://alliancecpha.org/en/child-protection-online-library/case-management-supervision-and-coaching-package)*.*

*The SOPs may reference global inter-agency training packages that link to the competencies and capacity-building plans. Where these have been adapted at the national level, the national training package should be included instead.*

*Inter-agency Trainings relevant for child protection case management include:*

* [*Inter-agency Case Management Training Package*](https://alliancecpha.org/case-management/)
* [*Case Management Supervision and Coaching Training Package*](http://cpie.info/CMsupervisiontraining)
* *Caring for Child Survivors of Sexual Abuse in Humanitarian Settings Training Package*
* *UNHCR Best Interests Procedures Training Package*

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Caseworkers and Case Supervisors should have their capacity assessed and receive on-going capacity building through training, supervision and coaching.

Add information according to context

## 3.3 Service Mapping

*---------------------------------------------------------------------------------------------------------------------------*

*Multi-sector service mapping is an essential element of case management as it helps the different actors involved in the case management process as well as beneficiaries to know which services they can access and how. Map the service providers available in each geographical area related to these SOPs, enabling children at risk to violence, exploitation, abuse and neglect to have access to assistance and appropriate support.*

*The visual below[[5]](#footnote-5) shows examples of the various types of support and direct services that may be required to respond to the child protection needs identified in the assessment stage. This can be used to think through the different types of supports and services that should be mapped according to context.*



*Ensure coordination with the Gender-based Violence (GBV) Coordination Mechanism to determine who will be providing specialized support to child survivors of sexual and gender-based violence (S/GBV) – including child, early and forced marriage, intimate partner violence (for girls who are married), rape and sexual violence, female genital mutilation, honour-based violence, etc. – per location and to outline referrals between Child Protection and GBV actors.*

*Supports and services should then be listed with details of specific contacts for referrals and information about who can access the service and how. These can be organised by type of service and by sub-national location.*

*---------------------------------------------------------------------------------------------------------------------------*

Service mapping, referral pathways on specific issues (Section 3.4) and Information Sharing Protocols (Section 6.1) are core components of referral mechanisms. The following multi-sector service mapping identifies who is providing what service to which children, where.

|  |  |  |  |
| --- | --- | --- | --- |
| **Example of template listing relevant service providers**  Location: <insert location for service directory>  The following actors are providing services to children and their families / caregivers in the area covered by these SOPs. These services have direct and indirect impact on the lives of children and their families / caregivers. | | | |
| **Name of Actor/Organization** | Service(s) Provided | Location, Name and Contact Details of Focal-Point *Specify physical address, focal point, email / telephone* | Notes (e.g. associated costs, hours of operation, eligibility criteria, emergency contact, time of intake etc.) |
|  |  |  |  |
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Supplement according to context.

## 3.4 Referral Pathways and Mechanisms

*---------------------------------------------------------------------------------------------------------------------------*

*This section should outline the referral mechanisms. Specific referral pathways developed for the context should also be listed here and annexed to the SOPs. A Referral Pathways Template can be found in Annex D for contextualisation.*

*---------------------------------------------------------------------------------------------------------------------------*

Referral mechanisms are the means by which referrals are made and feedback provided between caseworkers and service providers following agreed information sharing protocols (see Section 6.1) and defined referral pathways.

Referral pathways map the process of referral to supports and services for specific types of child protection threats, violations and vulnerabilities. These may include [e.g. child survivors of sexual abuse, children associated with armed forces and armed groups, children in need of MHPSS, unaccompanied and separated children, children involved in hazardous child labour, etc.].

When community members or service providers identify children who may need case management, they should take the following initial steps:

* Provide a safe and caring response;
* Respect the confidentiality and wishes of the child/caregiver – as long as this does not put the child at further risk.
* Provide information about available case management services and seek consent/assent from child and family;
* Facilitate referral to relevant case management services as per the referral pathways in Annex X when child/caregiver consent;
* For child survivors of sexual violence promote immediate (within 72 hrs) access to medical care, mental health and psychosocial support;
* No referral (including for child survivors of sexual violence) should be made without explicit consent/permission, except in case of an immediate safety or security risk to the child (consult child protection focal point to determine the child’s best interest);

Community members and other service providers who often come in contract with children should be trained on how to identify children at risk and how to conduct safe referrals.

Supplement according to context.

# SECTION 4: OVERALL RiSK ANALYSIS, ELIGIBILITY AND PRIORITISATION OF CASES

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***Overall Risk Analysis:*** *This section should outline the overall child protection risk analysis conducted in-context which identifies the key threats and violations affecting children and which children are most vulnerable to them (by taking into account individual, family and social factors). It should outline how to differentiate and identify those children among the large numbers of children in need of support that are at significant risk of harm. This will subsequently feed into the eligibility criteria (see below). Analysis may be drawn from secondary data that pre-exists the humanitarian crisis, from child protection and multi-sector assessments, from case or incident data analysis, and by involving the community in determining which children are at significant risk of harm.*

*---------------------------------------------------------------------------------------------------------------------------*

In [humanitarian context], not all children require individually targeted child protection interventions. A nuanced analysis of which children should receive what type of intervention, such as case management support, is needed. Among the large numbers of children in need of support in [humanitarian context], child protection professionals should differentiate and identify those cases that are at significant risk of harm. In doing so, child protection professionals should focus on children who’s rights to [violence, abuse, exploitation, and neglect, family reunification, identity, and life] are threatened and/or violated and/or children who are vulnerable due to [separation, their status as a refugee, social isolation of the family, being part of a minority/indigenous group, racism and discrimination in their community and their ability to access services as a consequence of this].

**Distinguishing between Vulnerability and Risk**

The terms **RISK** and **VULNERABILITY** are different things although strongly related. They are sometimes used interchangeably which can cause confusion. In order to understand risk and vulnerability, it is also helpful to understand the terms threats and violations.

**Threats and violations** refer to threats (something that may happen) and violations (something that has happened or is happening) of children’s rights based on the United Nations Convention on the Rights of the Child. In child protection case management, this particularly focuses on the violations of and threats to children’s rights to protection from violence, abuse, exploitation and neglect (but may also include violations of and threats to children’s rights to survival and development).

**Vulnerability** refers to individual, family, community and society characteristics that reduce children’s ability to withstand adverse impact from violations of and threats to their rights. Examples include a child’s separation status, a child’s age and gender, the attachment relationship between child and caregivers, the socioeconomic status of the family, the access to services in the community, culture and traditional practices in the community, and the national child protection case management system. Vulnerability is therefore the opposite of resilience and draws from the same balance between risk and protective factors within the different protection layers of the ecological framework.

**Risk** refers to the likelihood that violations of and threats to children’s rights will manifest and cause harm to children. It takes into account the type of violations and threats, as well as children’s vulnerability and resilience.

The relationship between risk and vulnerability can therefore be described as:

**Risk = threats and violations x vulnerability/resilience**

*For example:*

*A child with disabilities may be very vulnerable to abuse, but if they have a loving family and a good support network, they may be at low risk.*

*A child who lives with their family and goes to school may be considered not so vulnerable, but if their father drinks and is violent then the child may be at high risk of abuse and negligence.*

Supplement according to context.

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***Eligibility****: Eligibility defines those children who require an individual case management response as opposed to linking them to other services or community-based support. Not having appropriate gatekeeping processes in place to establish eligibility for case management may lead to high caseloads which can overwhelm the limits of the response. This may have as a consequence that the specific needs of individual children cannot be responded to in a timely and appropriate manner (sometimes even causing non-intervention), and can additionally cause confusion with the community as expectations are raised for the child and family but not met. This section should outline the eligibility criteria adopted in country (which should build from the overall risk analysis conducted in-context). An eligibility flow chart can also be added. A sample eligibility flow chart for caseworkers to use as soon as a child at risk is identified can be found in Annex D for contextualisation..*

*---------------------------------------------------------------------------------------------------------------------------*

The following section outlines the process of determining which children should receive case management in [humanitarian context] based upon eligibility criteria and the eligibility flow chart included in Annex X. This flow chart is to be used by caseworkers in determining eligibility for case management for individual children as soon as a child at risk is identified.

**Example Eligibility Criteria**

* *The person is a child.*
* *The child is harmed or at risk of harm based on [outcome of overall risk analysis].*
* *The child requires an individual, systematic and coordinated response in accessing services through the support of an individual caseworker.*

Apart from criteria defined to determine which children would be eligible to receive case management, the agency providing child protection case management should, as a minimum, have sufficient human and financial resources, staff capacities and competencies, information management systems and safe working practices in place to safely and appropriately provide case management to children.

Supplement according to context.

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***Prioritisation****: It is necessary to prioritise cases within the caseload in order to ensure that children most in need of urgent attention receive case management support in a timely manner. The case prioritisation guide in Annex E can be adapted and contextualised and used to differentiate between cases that are high, medium, low or no risk within those cases that are eligible for case management. The risk level of a case will determine the timelines for action, response and follow-up throughout the case management process. Although the standard text below and case prioritisation guide in Annex E provide suggested timelines for action, response and follow-up, these need to be contextualised in-context. An Urgent Action Referral Card (for immediate concerns that need to be addressed at-once before proceeding with any of the next steps in the case management process) is also included for adaptation and contextualisation in Annex F.*

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Prioritizationis used to determine the timelines with which to respond to a child’s needs throughout the case management process. The case prioritization guide in Annex X should be used to differentiate the urgency for action, response and follow-up between those cases that have been found to be eligible for case management.

Cases can be prioritized as high, medium, low or no risk. No risk can occur when cases were initially found to be eligible for case management at the identification stage, but where new information found at the registration and initial assessment and/or comprehensive assessment stages shed a new perspective on the case that decreased the risk level. Cases may also be re-categorised to no risk as the case plan is implemented and risks are reduced and/or vulnerabilities addressed.

* **High risk:** Child is significantly harmed or at risk of significant harm or death if left in her/his present circumstances without protective intervention;
* **Medium risk:** Child is harmed to some degree if left in her/his present circumstances without protective intervention. However, there is no evidence that the child is at risk of significant harm or death;
* **Low risk:** Child is at risk of harm if left in her/his present circumstances without protective intervention;
* **No risk:** Child found to be not at risk of harm or is no longer at risk of harm.

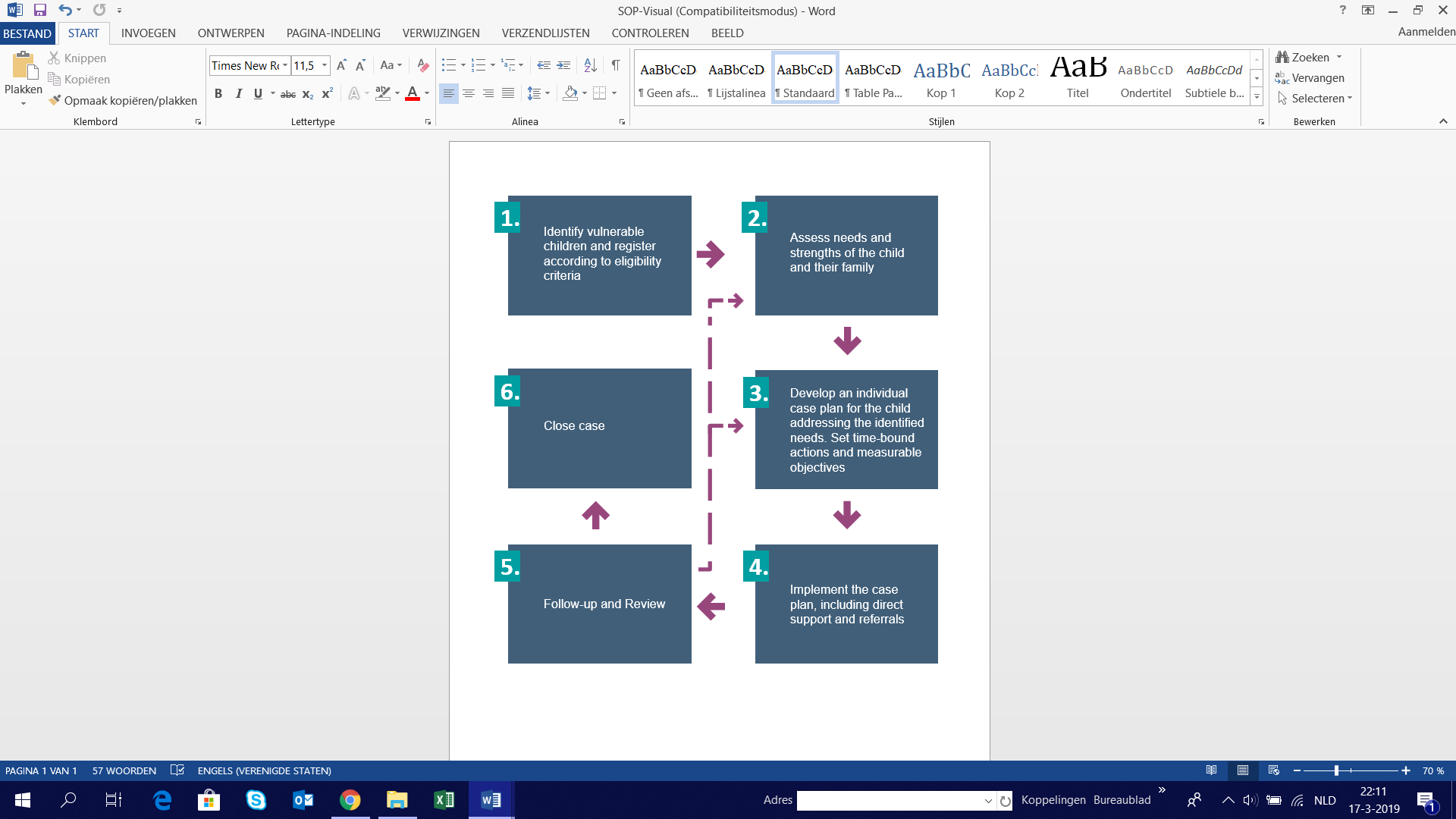
|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Example of timelines for action, response and follow-up throughout the case management process by risk level.** | | | | |
|  | HIGH RISK | MEDIUM RISK | LOW RISK | NO RISK |
| **Comprehensive Assessment** | Immediately after registration and initial assessment, before leaving the child. | Within 3 days after registration and initial assessment. | Within one week after registration and initial assessment. | No action required or case closure recommended. Potential monitoring by community-based mechanisms. |
| **Case plan** | Within 3 days after the assessment. | Within one week after the assessment. | Within two weeks after assessment. |
| **Follow-up** | At least twice a week as soon as case plan implementation started. | At least once a week as soon as case plan implementation has started. | At least once every two weeks as soon as case plan implementation has started. |
| **Case review** | At least every month. | At least every two months . | At least every three months. |

When working with affected communities, caseworkers should know what to do if they come across a child, family or community member who needs immediate, on-the-ground support due to threats to life, safety or dignity. This includes unaccompanied children without safe interim care options. Concerns such as these need to be addressed immediately (while respecting the confidentiality and wishes of the child/caregiver – as long as this does not put the child at further risk) before proceeding with any of the next steps in the case management process. An Urgent Action Referral Card is included as Annex X and should be completed with the contact details of the relevant service providers in the [sub-national area]. This card should be carried with caseworkers at all times. The same information should be made available to communities in an accessible and child-friendly format.

# Section 5: Case Management Process

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*Describe the process involved in each of the following steps, detailing roles and responsibilities, coordination with other actors, timeframes for action and response based on the prioritisation guide, and required documentation. Also include considerations for children affected by specific child protection concerns (e.g. child survivors of sexual violence), when and how to conduct safety planning, when and how to conduct case transfers, and when and how to conduct case conferences. Consult existing case management protocols for specific guidance on all these issues, in line with your context.*

*---------------------------------------------------------------------------------------------------------------------------*

## Identify Vulnerable Children and Register[[6]](#footnote-6)

Determine if the case meets the eligibility criteria for case management before registering the case for case management. Obtain informed consent/assent from the child and family (where possible and if appropriate) by the caseworker to carry out and document the interview, for information about the case to be shared with other service providers and for aggregate-level reporting, and to accept services. Screen for any child protection concerns that need to be addressed immediately and ensure that the child’s immediate needs (e.g. health care, safety, overnight/interim care) are covered before proceeding with the next steps – this may also include developing and putting in place a safety plan before leaving the child. Take into account the child’s preference regarding the profile of caseworker (i.e. male/female, ethnicity, culture, language). Make an initial assessment of the protection concerns and risk level of the case to determine the timeframe for action and response throughout the next steps of the case management process.

Supplement according to context.

## 5.2 Assessment

Ensure an assessment of the child’s situation is carried out [within one week] of registration (this may need to be conducted earlier depending on the risk level of the case), taking into consideration the risks and protective factors of the child, family and social environment. Factors may include age, gender and capacity of child, caregiver capacity, education and risks/safety concerns.

Ensure families and children have a clear understanding of the case management process, how to raise concerns/complaints and why certain decisions are being made, particularly if they go against the views/wishes of the child. Caseworkers should build relationships with the child and family where they feel respected, heard and safe, and where decisions are taken together with the child and family (and where decision that are taken in the best interest of the child are explained).

Supplement according to context.

## Develop Case Plan

Develop case plans together with the child and family (where possible and if appropriate) [within two weeks] of the assessment (this may need to be conducted earlier depending on the risk level of the case). Other significant people in the child’s life as well as other service providers and relevant authorities may partake in the development of the case plan if they have a role to play in it *and* if informed consent/assent has been given for this by the child/family.

Supplement according to context.

## 5.4 Implement the Case Plan

Ensure actions are taken in order to realize the plan – including direct support and services and referral to service providers. The caseworker is responsible for coordinating and advocating for services, arranging case conferences, documenting progress and ensuring objectives are met.

Supplement according to context.

## 5.5 Follow up and Review

Ensure follow-up occurs at least [once in every two weeks] (this may need to be conducted more often depending on the risk level of the case) as soon as case plan implementation has started and throughout the rest of the case management process. This involves confirming that the child and family are receiving appropriate services and support, monitoring the child’s situation and identifying changes. Follow up should also help to identify and address any barriers a child and his/her family may face in accessing services and support.

Conduct reviews at least [once every 3 months] (this may need to be conducted more often depending on the risk level of the case) as soon as case plan implementation has started. Review are conducted with the child and family (where possible and if appropriate) to discuss whether the objectives outlined in the case plan are being met, if the plan remains relevant and how to adjust.

Supplement according to context.

## 5.6 Case Closure

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*Agree criteria and guidelines for case closure that are specific to the caseload and context and in line with legal requirements, if these apply.*

*---------------------------------------------------------------------------------------------------------------------------*

It is important to formally close cases which are not active so that efforts can be concentrated on proactively following up with children and families who do need case management support. A decision to close a case should be made with the involvement of the child and family (where possible and if appropriate). Cases should not be closed immediately after the plan has been concluded, but after a set period of time during which several follow-up visits and at least one case review meeting have taken place to ensure the child’s sustained well-being. The child and family (where possible and if appropriate) should be made aware that they can contact the case management agency should needs arise again.

Supplement according to context.

**Example Case Closure Criteria, Egypt**

***Objective:***

To ensure that cases are closed only when appropriate and that those cases which remain open are being actively offered a service.

***Timeline:***

Cases should be closed only in agreement with the members of the case conference, except in low risk level cases where they should be closed by the case manager with the agreement of the case management supervisor, children and their families should also be involved in the decision to close a case.

***Action Points:***

The decision to close a case, and the reasons for it should be recorded and the decision communicated to all those working with the child.

Circumstances when it is appropriate to close the case include:

* Overall goal of the case plan has been met, child is safer from harm, child’s care and wellbeing is supported and there are no additional concerns;
* Child has turned 18 years-old (ensure a transition plan is in place and the case knows where and how to access support);
* Child/caregiver(s) no longer want support and there are no grounds to go against their wishes;
* Relocation of child to an area where there is no agency to transfer the case to;
* Child departed for a durable solution where there is no agency to transfer the case to;
* Child no longer contactable (wait at least three months before closing the case);
* Death of child

At least two monitoring visits / follow ups should be conducted before closing a case to ensure that the situation is stable for the child.

Where cases are transferred the child /family must be consulted before the transfer and the case must not be closed until the transfer has been agreed by the other organization.

Case transfers differ from case closures. Case transfers can happen at any stage of the case management process. During a case transfer, the full responsibility over the case is being handed over to another caseworker/agency. Case transfers should be avoided, unless absolutely necessary with good cause and/or a clear indication that the child will receive better services to meet their needs. This could be when a child moves (but still needs a case plan for protection) and/or when the original caseworker/agency are no longer best placed to lead/manage/coordinate the child’s case.

Supplement according to context.

# Section 6: Information Management

## 6.1 Data Protection / Information Sharing

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*This section should highlight the data protection protocols and information sharing protocols that have been developed in-context and ensure that these are included as annexes to the SOPs. The generic global data protection protocols and information sharing protocols can be adapted and contextualised for content.*

* *Data Protection Protocols should be developed taking in to account legal provisions within the country.*
* *Information sharing protocols need to define how information will be shared, verbally, electronically or through a paper system, as well as the procedures put in place to ensure that the confidentiality of the child is protected and respected at all times. The country-level Child Protection Coordination Group may need to consult the GBV Coordination Group in the development of the information sharing protocols.*

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Data protection protocols (DPPs) guide what information to collect, how the information will be used, and how the information will be stored. The [context] DPP is included as Annex X.

Information sharing protocols (ISPs) define what information about children should be shared, when, for what purpose, by whom and with whom. The [context] ISP is included as Annex X.

Supplement according to context.

## 6.2 Documentation and Record Keeping

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***Documentation****: This section should outline the forms that will be used for documentation and whether these will be paper-based, digital or both. Common forms should be standardised across child protection case management actors as this helps ensure uniformity in documentation across the caseload and facilitates more effective information sharing. The standard child protection case management forms can be adapted and contextualised for content.*

*---------------------------------------------------------------------------------------------------------------------------*

The following standardised case management forms are included in Annex X:

**Core Forms**

* Consent & Assent Form
* Case Registration & Initial Assessment Form
* Assessment Form
* Case Plan
* Referral Form
* Services Provided Form
* Follow Up Form
* Review Form
* Case Closure Form

**Supplementary Forms**

* Additional Registration & Initial Assessment Info for UASC
* Missing Children Form
* UNHCR Best Interests Assessment (BIA) Form
* Case Conference Report
* Tracing Action History Form
* Adult Verification Form
* Child Verification Form
* Reunification Form
* Case Transfer Form
* Child Feedback Form
* Caregiver Feedback Form
* Case File Cover Sheet
* Case Notes
* UNHCR Best Interests Determination (BID) Form
* Case Transfer Form
* Case Re-Opening Form
* Case File Checklist Form

Add information according to context.

*---------------------------------------------------------------------------------------------------------------------------*

***Record Keeping****: Supplement the information below with context-specific information as appropriate. Add details on how long records will be kept for both paper-based and digital systems. In cases that involve adoption or alternative care arrangements, information may need to be stored long after case closure.*

*---------------------------------------------------------------------------------------------------------------------------*

A separate case file should be maintained for every child, with key information presented in a standard, structured way. The Case File Cover Sheet in Annex X outlines the content and order of the case file.

A non-identifiable code should be allocated to each case file and used for documentation, referral and when sharing information relating to the case. A list that links the case file codes with the children’s names should be maintained and stored in a different location.

Case files should be stored in a locked cabinet or password protected computer and managed according to the DPP in Annex X.

Supplement according to context.

## 6.3 Database

*---------------------------------------------------------------------------------------------------------------------------*

*State which database will be used in this context (e.g.* [*CPIMS+*](https://www.cpims.org/)*, ProGres V4) and identify how data will be collected, entered, used, monitored, analysed and, if required, shared. In many circumstances, a simple database that records key information and facilitates case tracking and supervisory oversight is most appropriate when used alongside paper-based files. A case management database is recommended* *to manage information where there is likely to be a high volume of cases (more than 100 cases receiving regular case management services) and the need to share information between case management actors. Where a case management system is more mature and the staff capacity and information technology operating environment enables it, case management documentation and record keeping may be digitalised, reducing the need for a paper-based system.*

*Where appropriate, include details about information sharing between databases.*

*---------------------------------------------------------------------------------------------------------------------------*

Add information according to context.

# Section 7: Signatures

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*Once SOPs are agreed, senior representatives of all participating case management actors including government authorities, UN Agencies, international NGOs, national NGOs and Civil Society Organisations, should sign the SOPs as co-authors, indicating a commitment to adhering to the case management SOPs.*

*---------------------------------------------------------------------------------------------------------------------------*

Signatures of participating authorities and agencies

|  |  |
| --- | --- |
| *(signature and date)*  Name:  Title:  Agency: | *(signature and date)*  Name:  Title:  Agency: |
| *(signature and date)*  Name:  Title:  Agency: | *(signature and date)*  Name:  Title:  Agency: |
| *(signature and date)*  Name:  Title:  Agency: | *(signature and date)*  Name:  Title:  Agency: |

# Section 8: References and Annexes

*---------------------------------------------------------------------------------------------------------------------------*

***References:*** *Specific guidance may be referenced, according to needs in context. These may include the below or others developed in-country or internationally.*

*---------------------------------------------------------------------------------------------------------------------------*

**Guidelines and Minimum Standards**

* [Minimum Standards for Child Protection in Humanitarian Action](https://alliancecpha.org/cpms/) (revised 2019)
* [Alternative Care in Emergencies Toolkit](https://resourcecentre.savethechildren.net/library/interagency-working-group-unaccompanied-and-separated-children-2013-alternative-care) (IAWG UASC 2013)
* [Inter-agency Guidelines on Case Management and Child Protection](http://cpaor.net/resources/inter-agency-case-management-guidelines-and-training-manuals-2014-available-arabic-english) (2014)
* [Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings](http://gbvresponders.org/response/caring-child-survivors/) (2012)
* [IASC Guiding Principles on Unaccompanied and Separated Children](https://resourcecentre.savethechildren.net/library/inter-agency-guiding-principles-unaccompanied-and-separated-children) (2004)
* [Field Handbook on Unaccompanied and Separated Children](https://resourcecentre.savethechildren.net/library/field-handbook-unaccompanied-and-separated-children) (2016)
* [Toolkit on Unaccompanied and Separated Children](https://resourcecentre.savethechildren.net/library/toolkit-unaccompanied-and-separated-children) (2016)
* [Guidelines on Mental Health and Psychosocial Support in Emergencies](https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings) (IASC, 2007)

**Refugee-specific guidelines**

* [A Framework for the Protection of Children](http://www.unhcr.org/uk/protection/children/50f6cf0b9/framework-protection-children.html) (UNHCR, 2012)
* Guidelines on Assessing and Determining the Best Interests of the Child (BID Guidelines), (UNHCR, forthcoming 2018)
* [ExCom Conclusions, No. 107 (LVIII) on Children at Risk](http://www.unhcr.org/uk/excom/exconc/4717625c2/conclusion-children-risk.html) (2007)
* [ExCom Conclusions, No. 105 (LVII) on Women and Girls at Risk](http://www.unhcr.org/uk/excom/exconc/45339d922/conclusion-women-girls-risk.html) (2006)
* [Resettlement Handbook](http://www.unhcr.org/46f7c0ee2.pdf) (UNHCR 2007)
* [Handbook for Registration](http://www.unhcr.org/afr/3f8e93e9a.pdf) (UNHCR 2003)
* [Guidelines on Policies and Procedures in Dealing with Unaccompanied Children Seeking Asylum](http://www.unhcr.org/uk/publications/legal/3d4f91cf4/guidelines-policies-procedures-dealing-unaccompanied-children-seeking-asylum.html) (UNHCR 1997)

*---------------------------------------------------------------------------------------------------------------------------*

***Annexes:*** *Annexes should be inserted once the SOPs are finalized and according to the need of a specific country intervention. These may include:*

*---------------------------------------------------------------------------------------------------------------------------*

* Case Management Forms
* Eligibility Criteria and Flow Chart for CPCM
* Prioritization Matrix for cases deemed eligible for CPCM
* Urgent Action Referral Card
* Service Mapping
* Multi-sector Referral Pathways (including reference to GBV and MHPSS services)
* Data Protection Impact Assessment (DPIA)
* Data Protection Protocols
* Information Sharing Protocols
* Monitoring and Evaluation Tools
* Core Competencies for CPCM
* Sample Job Descriptions
* Capacity Building Plan
* Guidelines for Specific Cases (i.e. unaccompanied and separated children, child survivors of sexual abuse, child labour, child marriage, physical abuse, CAAFAG, etc.)

# Annex A: SAMPLE CASEWORKER JOB DESCRIPTION

|  |  |  |  |
| --- | --- | --- | --- |
| **Position** | Caseworker | **Grade** |  |
| **Department & Location** |  | **Date** |  |
| **Reports to** | Case Management Supervisor | | |
| **Contract period** |  | | |
| **Purpose** | The CP Caseworker will conduct all steps of the case management process for an assigned number of individual children vulnerable to violence, abuse, exploitation, neglect and their families in this process. | | |
| **Objectives** | * To ensure children harmed or at risk of being harmed are identified and receive individual case management support by conducting documentation, assessments, action plans, direct service provision, referrals and follow ups for an assigned case load of children * To provide support to families in the process of case management, including foster and alternative care (if applicable) * To directly work with other caseworkers and service providers on management of caseload and referrals | | |

**Specific Roles and Responsibilities:**

**Case Management for Individual Children and their Families:**

* The caseworker will provide quality case management services to children who have experienced or are at risk of violence, abuse, neglect and exploitation or are otherwise vulnerable in line with the eligibility criteria and case prioritization guide.
* Guide children and their families through the case management process (identification and registration, assessment, case planning, implementation of the case plan, follow-up and review, case closure) as outlined in the Standard Operation Procedures.
* Provide psychosocial support and emotional support to children and families throughout the case management process.
* Conduct safe referrals to essential services as appropriate, and follow-up to ensure services provided were responsive to the needs identified within the assessment.

**Community and Interagency Coordination:**

* Liaise with community members, service providers, NGO partners and government stakeholders to identify and safely refer children at risk.
* Maintain an up-to-date service mapping for your geographical area.
* Participate in inter-agency case conferences (presentation of cases and dissemination of challenges).

**Case Management Teamwork:**

* Actively engage in all capacity building opportunities, including formal trainings, shadowing/observation, capacity assessments, etc.
* Participate in regular case management meetings with the case management team.
* Prepare for and participate in regular structured individual supervision sessions, identifying challenges and areas for development.

**Other Duties:**

* Adhere to the Child Protection Policy, Safeguarding policy and Code of Conduct.
* Provide feedback on written documents and the design of future programming.
* Consistently and proactively monitor/assess the safety and security of field teams; promptly reporting concerns or incidents to management.
* Any other duty delegated by your supervisor.

**Communications and Working Relationships:**

* Case Management Supervisor: Direct report.
* Child Protection Manager: Overall management of activities at the field office level.
* Child Protection Technical Lead: As the lead person for the Child Protection Team at national level.
* Service Providers in geographical area.

**Knowledge, Skills, Experience, Attitudes and Behaviour Required:**

**Knowledge:**

* Minimum of Bachelors in Social work, Counseling Psychology, or relevant discipline.
* Previous work experience in community development or with an NGO (preferably in child protection).
* Minimum 2 years of professional experience working with children.
* Excellent writing, facilitation, and organizational skills.
* Excellent command of the English language and the local language of the affected population.
* Strong drive for results and ensuring timely delivery of quality products.
* Experience managing child protection cases in a sensitive and child friendly manner.

**Skills:**

* Excellent communication and engagement skills with children and their caregivers.
* Able to empathize with children and families that have been impacted by the humanitarian emergency..
* Strong skills in monitoring, evaluation, research and conducting participatory, community-led assessments.
* Experience working with case files and databases and providing regular documentation.
* Excellent community mobilization skills.
* Ability to work individually and within a team.
* Good analytical, problem solving and project planning skills.
* Able to communicate clearly and strategically with internal and external stakeholders as a representative. This includes effective negotiation and representation skills.
* Computer knowledge - Microsoft Word, Excel, Outlook.

**Behaviour:**

* Advocates for children’s rights and child participation in all decisions that affect them.
* Strongly drives performance forward in area of the business for which they are responsible together with the team.
* Demonstrated ability to work in a multi-cultural environment and establish harmonious and effective working relationships.
* Conceptual understanding of and commitment to humanitarian work.
* Sets a strong learning culture in their part of the organisation.
* Remains calm and positive under pressure and in difficult situations.
* Aware of impact on others and adjusting own behaviour accordingly.

# Annex B: SAMPLE CASE MANagement SUPERVISOR JOB DESCRIPTION

|  |  |  |  |
| --- | --- | --- | --- |
| **Position** | Case Management Supervisor | **Grade** |  |
| **Department & Location** |  | **Date** |  |
| **Reports to** |  | | |
| **Contract Period** |  | | |
| **Purpose** | *“Supervision is a relationship that supports the caseworker’s technical competence and practice, promotes wellbeing and enables effective and supportive monitoring of casework.”* (Inter-Agency Guidelines for Case Management and Child Protection, 2014)  The Case Management Supervisor will be responsible to oversee the case management program in [selected region]. The Case Management Supervisor will be responsible for the effective implementation and proper documentation of all CP cases, through supervision and support of [five] caseworkers. The Case Management Supervisor works in close collaboration with [the other members of the CP team] and ensures that trends and challenges are properly are communicated and documented. | | |
| **Objectives** | * To ensure the effective implementation of case management services for children harmed or at risk of being harmed through appropriate assignment of cases, coaching and supervising caseworkers in their casework. * To provide administrative, educational and supportive supervision to the case management team in individual and group settings. * To collaborate with other child protection colleagues and key stakeholders in order to regularly report trends and advocate for vulnerable children. | | |

**Specific Roles and Responsibilities:**

**Administrative Case Management Supervision:** *(Ensure competent, accountable practice)*

* Ensure ethical, timely, effective and quality case management programming for children who have experienced or are at risk of violence, abuse, neglect and exploitation (or are otherwise vulnerable in line with the eligibility criteria and case prioritization guide) by the case management team.
* Ensure case management team successfully implements case management, as per the Standard Operation Procedures.
* Support the design, set-up and monitoring and evaluation of the Case Management Program; including recruitment and performance management of caseworkers.
* Ensure monitoring, evaluation, and accountability tools are utilized and completed accordingly by the case management team.
* Remain abreast of developments in the field of service provisions, this includes maintaining and updating spreadsheet with mapped services and focal points for service provisions.
* Conduct gap analysis and provide recommendations on improvement of the functionality of referral mechanisms and direct service provision.
* Review case files through case file checks on a monthly basis.
* Draft and submit weekly and monthly reports to the Child Protection Manager in a timely manner.

**Developmental Case Management Supervision:** *(Ensure caseworkers are continually updating their knowledge and skills and applying them to their daily work)*

* Conduct a caseworker capacity assessment with each new caseworker within the first month of recruitment.
* Provide ongoing capacity building to caseworkers on the SOPs, case management tools, ISP/DPP, referral pathways, etc.
* Support caseworkers through a coaching approach; including reflective practice, self-awareness, collaborative problem solving and the application of case management guiding principles.
* Facilitate shadowing visits for new caseworkers and conduct observations of caseworkers on a regular basis.

**Supportive Case Management Supervision: *(****Ensuring the emotional and psychological wellbeing of case management team)*

* Ensure the safety of case management team within the communities they are operating.
* Promote self-care and team building of case management team.

**Community and Interagency Coordination:**

* Liaise with service providers, CP partners and government stakeholders to ensure safe identification and referral of children at risk, according to the eligibility criteria.
* Ensure that case management team maintain an up-to-date service mapping for the geographical area.
* Lead inter-agency case conferences (presentation of cases and dissemination of challenges), as per the SOPs.
* Actively participate in all relevant working group meetings as well as bilateral meetings with other agencies on behalf of the Case Management program, in close consultation with the Child Protection Manager.

**Case Management Teamwork:**

* Lead in regular case management meetings with the CM team (one meeting every 1-2 weeks).
* Prepare for and lead in regular structured individual supervision sessions with each caseworker (1 hour per caseworker every 1-2 weeks).

**Other Duties:**

* Adhere to the Child Protection Policy, Safeguarding policy and Code of Conduct.
* Consistently and proactively monitor/assess the safety and security of field teams; promptly reporting concerns or incidents to the Child Protection Manager and liaising with external parties as required to maintain/enhance the security environment for the program.
* Other duties as assigned by the Child Protection Manager to enable and develop the program.

**Communications and Working Relationships:**

* Position Reports to: CP Manager
* Position directly supervises: Caseworkers
* Indirect Reporting: N/A

**Knowledge, Skills, Experience, Attitudes and Behaviour Required:**

**Knowledge:**

* Technical diploma or degree in social work, human rights, or related degree preferred.
* Minimum of 2 years’ experience of implementing case management in humanitarian or development settings.
* Good understanding of the national social welfare systems, alternative care systems, juvenile justice system and child protection mechanisms.
* Experience in capacity building, conducting trainings, on-the-job coaching and technical supervision.
* Experience in community mobilization and conducting outreach activities, including the ability to work on supporting case management work for children at risk.
* Excellent writing, facilitation, and organizational skills.
* Excellent command of the English language and the local language of the affected population.
* Strong drive for results and ensuring timely delivery of quality products.
* Experience managing child protection cases in a sensitive and child friendly manner.

**Skills:**

* Coaching, teambuilding and leadership skills.
* Excellent communication and engagement skills with children and their caregivers.
* Able to empathize with children and families that have been impacted by the humanitarian emergency.
* Strong skills in monitoring, evaluation, research and conducting participatory, community-led assessments.
* Experience working with case files and databases and providing regular documentation.
* Excellent community mobilization skills
* Ability to work individually and within a team.
* Good analytical, problem solving and project planning skills.
* Able to communicate clearly and strategically with internal and external stakeholders as a representative. This includes effective negotiation and representation skills.
* Computer knowledge - Microsoft Word, Excel, Outlook.

**Behaviour:**

* Advocates for children’s rights and child participation in all decisions that affect them.
* Strongly drives performance forward in area of the business for which they are responsible together with the team.
* Demonstrated ability to work in a multi-cultural environment and establish harmonious and effective working relationships.
* Conceptual understanding of and commitment to humanitarian work.
* Sets a strong learning culture in their part of the organisation.
* Remains calm and positive under pressure and in difficult situations.
* Aware of impact on others and adjusting own behaviour accordingly.

# Annex C: TEMPLATE TERMS OF REFERENCE FOR COUNTRY-LEVEL CASE MANAGEMENT TASK FORCE

This document provides an example of a Terms of Reference (ToR) of a country-level Case Management Task Force (CMTF). The template is intended as guidance and so should be adapted by Child Protection and Case Management Coordinators for each context.

Other country-level CMTF examples can be found here:

* <Link to Country sample ToRs – will live in Google Drive>

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# BACKGROUND

*---------------------------------------------------------------------------------------------------------------------------*

*This section will introduce the justification around the need for a CMTF in a particular context. Background information should include:*

* *Country/context situation (statistics)*
* *Justification for establishing a CMTF*
* *Current activities surrounding child protection and case management*
* *Purpose the group sets to achieve through a CMTF.*

*---------------------------------------------------------------------------------------------------------------------------*

# CMTF Composition

* [Insert names of participating organizations/agencies]
* [Insert names of participating organizations/agencies]

# Goal

[Insert goal of CMTF relevant to country and context specific needs].

***Example 1:*** *The goal of the Case Management Task Force is to improve responses on case management as part of child protection systems building in [humanitarian context].*

***Example 2:*** *The goal of the Case Management in Emergencies Task Force is to support the development of a comprehensive child protection Case Management in Emergencies system for refugee and migrant children and their families in [humanitarian context].*

# Functions and OBjectives of the CMTF

* [Indicate specific objectives and functions here to meet the goal of the CMTF]
  + [Identify and list key outputs/deliverables and expected results under each objective]
* *Development of tools and guidance for case management in humanitarian responses and systems building*
* *Develop or promote context-appropriate tools to evaluate CM systems*
* *Develop an app for tablets to support case management and interaction with children*
* *Establish case management coaching tools and guidance materials*

# CMTF Decision-Making Process

*---------------------------------------------------------------------------------------------------------------------------*

*Describing the decision-making process can help CMTF members make more deliberate, thoughtful decisions by organizing relevant information and defining procedures in arriving at alternatives.*

*---------------------------------------------------------------------------------------------------------------------------*

Add information according to context.

# Roles and Responsibilities

*---------------------------------------------------------------------------------------------------------------------------*

*Specific roles responsibilities and main tasks of the CMTF members should be listed here. This may include expectations for members, chair and activity group assignments.*

*---------------------------------------------------------------------------------------------------------------------------*

## Expectations for all CMTF members:

* [List agreed upon expectations]

## Responsibilities of the Chair of the CMTF:

* [List agreed upon expectations for the Chair]

*---------------------------------------------------------------------------------------------------------------------------*

*In order to successfully implement the CMTF workplan, partners should volunteer to contribute to separate activities and outputs. Activity Groups should be formed in order to take responsibility to agree on the deliverables and an achievable timeframe.)*

*---------------------------------------------------------------------------------------------------------------------------*

## Activity Group Lead Agency Expectations:

* [Activity groups will be led by agencies, responsibilities of leading agency will be listed in this section]
* *Guide the Activity Group in the development of clear deliverables and workplan outlining expected progress over [X] year duration.*
* *Provide regular progress reports and presentations from the Activity Group to the CMTF.*

## Activity Group Contributing Agency Expectations:

* [Contributing group responsibilities and expectations will be listed in this section]
* *Contribute to the development of clear deliverables and workplan outlining expected progress over [X] year duration.*
* *When appropriate, suggest pilot countries for products development.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity Group** | **Summary** | **Lead Agency** | **Contributing Agencies** |
| [An objective, task, or activity as agreed upon by the CMTF] | *[List details of the objective/task*  *here]* | *[Lead agency]* | *[Contributing agencies]* |
| EXAMPLE:Technical Assistance, Training and Coaching | *Provide technical assistance to the*  *Ministry of Women, Children and*  *Social Welfare in defining the roles*  *and responsibilities of different case*  *management actors within the CM*  *system (child protection authorities*  *as well as other Government actors,*  *NGOs, CBOs and actors at the*  *community level.* | *IRC*  *Plan* | *TDH*  *CP AOR*  *UNICEF*  *UNHCR* |

# Meetings and Amendments

*---------------------------------------------------------------------------------------------------------------------------*

*Include when and where potential meetings will happen and how meetings will be documented in this section. A clause regarding amendments may also be helpful for creating changes as needs and priorities shift with the field.*

*---------------------------------------------------------------------------------------------------------------------------*

Convening of Meetings

The CMTF meets on a regular basis and will be convened by [insert].

Venue of Meetings

The venue for the meetings will be at [insert venue] or another agreed upon venue.

Documenting the Meetings

A draft agenda will be circulated to members of the CMTF at least [insert amount] days before the meeting, giving the members the opportunity to suggest additional items for discussion. Minutes of the meetings will be taken and draft minutes will be circulated to the CMTC members within [insert timeframe] after the meeting date. The final minutes will be printed and put into the minute book at [insert].

## Amendments

This Terms of Reference is a working document and may be altered to meet the current needs of all members by agreement of the majority of the members. Unless there is a specific request from members to make amendments, the Terms of Reference will be reviewed once a [insert timeframe] to re-affirm responsibilities of the Task Force.

# Annex D: REFERRAL PATHWAYS TEMPLATE

**HOW TO USE**

This template will map the process of referral to supports and services for specific types of child protection threats, violations and vulnerabilities. These may include [e.g. child survivors of sexual abuse, children associated with armed forces and armed groups, unaccompanied and separated children, children involved in hazardous child labour, etc.].

**NOTE**

No referral should be made without providing all information to the child (and family where possible and if appropriate) about referral options, procedures and risks.

**BEST PRACTICES FOR CHILD PROTECTION ACTORS:**

* Informed consent/assent needs to be given by the child/family before being able to make a referral – unless this puts a child at further risk.
* Accompany the child / family to the service.
* Have current information and contact details for the range of services offered and who the staff providing them are.
* Case workers maintain overall responsibility over the case and to follow-up on the referral with the child and service provider to ensure progress updates and needs are met.

##### Child with Protection Threats, Violations and/or Vulnerabilities identified by:

🡪Self/Family 🡪Community/Peers 🡪Cross-Sector Partners 🡪Agency Staff/Volunteers

Does the child have immediate life-threatening protection concerns?

**NO** Then, does the child meet eligibility criteria for case management in this context?

*<Insert Criteria>*

**YES** Then refer immediately to health and child protection partners.

Health Partner:

CP Focal Point Name:

Contact:

Child Protection Partner:

Emergency Focal Point Name:

Contact:

**YES**

**NO** Then, does the child have other needs that require referral to services or other support?

**Refer to CP Partner for case management services.**

Child Protection Partner Agency:

Identification & Registration Focal Point:

Contact Information:

**YES** Then, refer to services as appropriate to (below):

**NO** Then, inform child how to access services in case of future need.

|  |  |  |
| --- | --- | --- |
| Does the child have other needs that require referral to services?Refer as appropriate to *<insert specific location>* (below): | | |
| What services does the child need? | 1. Go through child protection referral pathway prior to referencing this form. 2. Complete standard child protection case management referral form. | |
| HEALTH | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| SAFETY & SECURITY | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| FAMILY TRACING & REUNIFICATION | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| CAMP RELOCATION & REFUGEE RESETTLEMENT | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| MENTAL HEALTH and PSYCHOSOCIAL SUPPORT | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| GENDER-BASED VIOLENCE SUPPORT | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| LEGAL ASSISTANCE | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| SOCIAL INTEGRATION | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| LIVELIHOODS | **[NAME AGENCY 1]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* | **[NAME AGENCY 2]**  Focal Point:  Contact: *(number/email)*  Admission Criteria: *(boys/girls, age group, additional services etc.)* |
| BID PANEL | **UNHCR**  Focal Point:  Contact: *(number/email)* | **Child Helpline**  *(insert number here)* |

# Annex E: SAMPLE ELIBILITY FLOW CHART FOR CHILD PROTECTION CASE MANAGEMENT

**Question 1**: Is the person a child?

**NO**

*Do not intake for case management but refer to humanitarian protection actor for follow-up*

In some cases, the person who is harmed or at risk of harm be an adult with children who are more vulnerable as a result. These cases should be referred to a humanitarian protection agency who should liaise with relevant child protection actors to ensure that the needs of the children are met.

**YES**

*Go to Question 2*

If unsure and the person is claiming to be below the age of 18, assume that they are a child.

**Question 2**: Is the child harmed or at risk of harm based on [outcome of overall risk analysis]?

**NO**

*Do not intake for case management.*

*Go to Question 4*

**YES**

*Go to Question 3*

**Question 3**: In order to meet the child’s needs, ensure her/his protection, and promote her/his wellbeing; does the child require a case management response in accessing services through the support of an individual caseworker?

**Question 4**: Does the child require access to services?

**YES**

*Link to services.*

*Know the other services where the child can be referred to. Acquire informed consent / assent to refer and support them to access these services.*

**NO**

**NO**

*Do not intake for case management.*

**YES**

*Intake for case management*

*Consider what other support the child and family may need, e.g. whether they can be included in community-based programming, or how the key issues may be addressed through advocacy.*

# Annex F: SAMPLE CASE PRIORITISATION GUIDE FOR CASE MANAGEMENT

Due to increasing numbers of children at risk of harm during humanitarian crises, it is necessary to prioritise cases within the caseload in order to ensure that children most in need of urgent attention receive case management support in a timely manner. This case prioritisation guide helps to differentiate the urgency for action, response and follow-up between those cases that have been found to be eligible for case management. Cases can be prioritized as high, medium, low or no risk. The determination of the risk level for each case will determine the timeframes for assessment, case planning, and follow-up and review in the next steps of the case management process.

**Prioritisation** is used to determine the timelines with which to respond to a child’s needs within the case management process.

**SET-UP OF THE CASE PRIORITISATION GUIDE**

The table below presents the definitions of the different risk levels, the corresponding timeframes of response within the case management process, and examples of child protection cases with high, medium, low and no risk. The table also presents examples of immediate concerns due to threats to life, safety or dignity which need to be addressed immediately before proceeding with any next step in the case management process.

**NOTES TO USING THE CASE PRIORITISATION GUIDE**

* **Contextualise:** The timeframes of response within the case management process that corresponds to each risk level should be contextualised in-context. The content of the table should also be adapted and further expanded based upon the issues that are being addressed and the overall risk analysis in-context (including vulnerability dimensions around gender).
* **Assessing the risk level for a protection concern:** In assessing the risk level for a protection concern (e.g. physical violence and abuse, neglect, child labour), the (potential) degree of harm is the main consideration to take into account. In order to determine this, caseworkers should take into consideration factors such as the child’s age and gender, the child’s displacement and separation status, the child’s health and disability status, the frequency and severity of the protection concerns, when an incident happened, the opportunity of potential perpetrators to contact the child, and the protective and risk factors within the family and wider environment of the child. This assessment is based on a ‘snapshot in time’ and caseworkers should take into account that risk level may evolve over time and should be reconsidered throughout the case management process.
* **Assessing the risk level for a case:** Children are often faced with multiple protection concerns (i.e. they can be an unaccompanied child who is engaged in child labour). Each protection concern may be assigned a different risk level (see ‘assessing the risk level for a protection concern’). However, the overall risk level of a case is equal to the highest risk level assigned to the different protection concerns which the child is faced with. Compounding protection concerns therefore often increase the overall risk level of a case. As with assessing the risk level for a protection concern, cases may be re-prioritised as the situation and context changes. This could be as new information becomes available, or because the case plan is being implemented and protection concerns are being addressed (moving the case from the higher risk levels to the lower risk levels, and ultimately to a level of no risk).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Risk level | HIGH | MEDIUM | LOW | NO |
| Definition | **Child significantly harmed or at risk of significant harm or death if left in her/his present circumstances without protective intervention.** | **Child is harmed to some degree if left in her/his present circumstances without protective intervention. However, there is no evidence that the child is at risk of significant harm or death.** | **Child is at risk of harm if left in her/his present circumstances without protective intervention.** | **Child found to be not at risk of harm or is no longer at risk of harm.** |
| Timeframe for response | **Comprehensive assessment Immediately after registration & initial assessment, before leaving the child.**  **Case plan**  **Within 3 days after the assessment.**  **Follow-up**  **At least twice a week as soon as case plan implementation has started.**  **Case review**  **At least every month.** | **Comprehensive assessment**  **Within 3 days after registration & initial assessment.**  **Case plan**  **Within one week after the assessment.**  **Follow-up**  **At least once a week as soon as case plan implementation has started.**  **Case review**  **At least every two months.** | **Comprehensive assessment**  **Within one week after registration & initial assessment.**  **Case plan**  **Within two weeks after assessment.**  **Follow-up**  **At least once every two weeks as soon as case plan implementation has started.**  **Case review**  **At least every three months.** | **No action required or case closure recommended.**  **Potential monitoring by community-based mechanisms.** |
| Immediate concerns which need to be addressed immediately before proceeding with any next step in the case management process. | **HEALTH CARE**  e.g. child is injured or in need of medication/medical attention within a certain timeframe (including if sexual assault has occurred within the past 120 hours).  **SAFETY CONCERNS**  e.g. there are indicators of ongoing abuse of the child occurring within the family.  **OVERNIGHT/INTERIM CARE REQUIRED**  e.g. children without adult care and/or where it is unsure whether the child’s home or current living arrangement is safe enough to stay in until further assessment is made.  ***OTHER DIRECT SUPPORT NEEDED***  *to be contextualised in context.* | | | |
| Physical violence and abuse | * Child experiencing or at risk of serious physical violence or abuse with significant harm or death as a result. * Child with disabilities / under the age of 5 injured in domestic violence incident. * Child at risk of becoming seriously impaired by treatable condition and her/his parents or legal caretakers fail to provide or consent to treatment. | * Child experiencing non-injurious physical violence or abuse and is not at-risk of significant harm or death. * Child witnessing physical violence and abuse. | * Child experienced serious physical violence or abuse with the perpetrator(s) no longer having contact with the child but without the child having adequate support from family, community and service providers. * Child living in household with reported incidents of domestic violence. | * No violence present (factors causing or potentially causing harm have been addressed or removed). * Child experienced prior physical violence or abuse with the perpetrator(s) no longer having contact with the child and with the child having adequate support from family, community and service providers. |
| Emotional violence and abuse | * Child is being persistently belittled, isolated, discriminated, humiliated, threatened and intimidated, or treated in another non-physical but hostile form by a significant caregiver or another person with frequent contact to the child. | * Significant caregiver’s (or another person with frequent contact to the child) approach to the child over the age of 5 is emotionally harmful in a non-physical manner (e.g. occasional belittling, isolation or humiliation). | * Child is at-risk of being negatively treated differently than other siblings/children by a significant caregiver or another person with frequent contact to the child. | * Factors causing or potentially causing the emotional harm have been addressed (caregiver received support or person causing harm no longer has contact with the child). |
|  | * Significant caregiver’s (or another person with frequent contact to the child) approach to the child who is disabled / under the age of 5 is emotionally harmful in a non-physical manner (e.g. occasional belittling, isolation or humiliation). |  |  |  |
| Sexual violence, abuse and exploitation | * Child experiencing or at risk of sexual violence, abuse and/or exploitation where the person causing harm has access to the child. * Child experienced sexual violence, abuse and/or exploitation within the last 120 hours. * Girl mother with a child with disabilities. * Child who is married below age of consent without the child having adequate support from family, community and service providers. * Child who became pregnant as a result of rape (and may be forced to marry). * Child engaged to be married below age of consent regardless of consent; marriage to occur in less than one month. * Child engaged to be married; above age of consent and not consenting to marriage. | * Child experienced sexual violence, abuse and/or exploitation in the past (more than 120 hours ago) with the perpetrator(s) no longer having contact with the child but without the child having adequate support from family, community and service providers. * Child who is married below age of consent with the child having adequate support from family, community and service providers. * Child engaged to be married below age of consent regardless of consent; marriage to occur in more than one month. * Child engaged to be married; above age of consent and consenting to marriage. | * Child experienced sexual violence, abuse and/or exploitation in the past (more than 120 hours ago) with the perpetrator(s) no longer having contact with the child and with the child having adequate support from family, community and service providers. * Child who is married above age of consent. | * No sexual violence, abuse and/or exploitation present (factors causing or potentially causing harm have been addressed or removed). |
| Neglect | * Serious injury or illness due to neglect from caregiver (e.g. malnutrition with no apparent causal factors or failure to seek timely and appropriate medical care for a serious physical or mental health problem). * Child with disabilities / under the age of 5 being neglected by caregiver. | * Caregiver fails to protect a child from non-injurious harm or to fulfil a child’s rights to basic necessities. * Caregiver being emotionally or psychologically unavailable or chronically inattentive to a child; failing to nurture or encourage the child; denying the child warmth and opportunities for developmental enrichment or exposing the child to intimate partner violence and substance abuse. | * Caregiver fails to provide safe and appropriate adult supervision that – in light of the child’s age, development or situation; the duration and frequency of the unsupervised time; and the environment in which a child is left unsupervised – places the child at risk of harm. | * Factors causing or potentially causing the harm have been addressed (caregiver received support and factors causing or potentially causing harm have been addressed or removed). |
| Child labour | * Child involved in or at risk of entering the Worst Forms of Child Labour, including: forced or bonded labour, recruitment into the armed forces or an armed group, trafficking, sexual exploitation, illicit work, or life-threatening hazardous work. | * Children under the age of 14/15 in child labor (including children under the age of 12/13 in light work). * Child above the age of 14/15 in non-life-threatening hazardous work. | * Parents are threatening to send the child under the age of 14/15 in child labor (including children under the age of 12/13 in light work). * Parents are threatening to send the child above the age of 14/15 into non-life-threatening hazardous work. | * The child is no longer in child labor or at-risk of child labor and supports have been put in place to ensure the child does not return to child labor. * Child in productive and stimulating work activities (not affecting their health, development and education). |
| Mental disorders and psychosocial distress | * Child in severe distress to the extent of suicide, self-harm (including risk behavior such as substance abuse), harm to others and/or apathy. * Child with serious mental disorder(s). | * Child is showing signs of distress for 6-8 weeks after signs begun with no change or improvement, while other children are recovering. | * Child is showing signs of normal distress – including physical, cognitive, emotional symptoms and changes in behaviour – for less than 6-8 weeks after signs begun and without the child having adequate support from family, community and service providers. | * Child is showing signs of normal distress – including physical, cognitive, emotional symptoms and changes in behaviour – for less than 6-8 weeks after signs begun, and the child has adequate support from family, community and service providers. * The child’s psychosocial wellbeing is restored; the child is engaged in a range of activities and is not displaying physical, cognitive, emotional symptoms of distress nor behaviors of concern. |
| Unaccompanied and Separated Children | * Unaccompanied child without access to appropriate care and support. * Separated child under the age of 15 in highly vulnerable care arrangement (e.g. more than 8 children in household, caregivers into substance abuse, single vulnerable caregiver - physical/mental illness, disability, elderly). | * Unaccompanied under the age of 15 with access to appropriate care and support. * Separated child at the age of 15 and above in highly vulnerable care arrangement (e.g. more than 8 children in household, caregivers into substance abuse, single vulnerable caregiver - physical/mental illness, disability, elderly). | * Unaccompanied child at the age of 15 and above with access to appropriate (temporary or recently placed long-term) care and support (e.g. supported and monitored independent living arrangement). * Separated child with access to appropriate (temporary or recently placed long-term) care and support. | * Unaccompanied and / or separated child who has been reunified with family or is placed in long-term and durable alternative care where the child is being adequately cared for and the situation has been monitored and follow-up on for at least 6 months with no issues arising. |
| Children Associated with Armed Forces and Armed Groups | * Child associated with armed forces or armed groups. * Child at risk of being recruited into armed forces or armed groups. * Child released from or left armed forces or armed groups and who is at risk of significant harm due to discrimination, violence and/or abuse. | * Child released from or left armed forces or armed groups and who is at risk of harm due to discrimination, violence and/or abuse. * Child released from or left armed forces or armed groups and not receiving support or services as needed. | * Child released from or left armed forces or armed groups in temporary care arrangement or recently reunified/placed in a long-term care arrangement and receiving support and services as needed. | * Child released from or left armed forces or armed groups who has been reunified with family or is placed in long-term and durable alternative care where the child is being adequately cared for, the child has been reintegrated into the community, and the situation has been monitored and follow-up on for at least 6 months with no issues arising. |
| Children in contact with the law | * Child deprived of liberty (arrested or in detention ). * Child in conflict with the law who enters the formal justice system with no possibility for diversion or appropriate child-friendly alternative sentencing and restorative justice measures. | * Child in conflict with the law who enters formal justice system with possibility for diversion or appropriate child-friendly alternative sentencing and restorative justice measures. | * Child in conflict with the law who did not enter formal justice system, but is at risk of doing so if services are not provided. * Child in contact with the law as witness or victim and without adequate family, community and/or juvenile justice system support. | * Children in conflict with the law who have been dealt with through diversion from the justice system or through appropriate child-friendly alternative sentencing and restorative justice measures and the situation has been monitored for at least 3 months with no further risk present. * Child in contact with the law as witness or victim and with adequate family, community and/or juvenile justice system support. |

Urgent concerns that need to be addressed immediately (while respecting the confidentiality and wishes of the child/caregiver – unless this puts the child at further risk) before proceeding with any next steps in the case management process.

**URGENT ACTION REFERRALS**

**AGENCY NAME**

HOURS OF OPERATION: ---------------

NAME OF FOCAL POINT 1 :

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LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

NAME OF FOCAL POINT 2 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

**AGENCY NAME**

HOURS OF OPERATION: ---------------

NAME OF FOCAL POINT 1 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

NAME OF FOCAL POINT 2 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

**AGENCY NAME**

HOURS OF OPERATION: ---------------

NAME OF FOCAL POINT 1 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

NAME OF FOCAL POINT 2 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

**AGENCY NAME**

HOURS OF OPERATION: ---------------

NAME OF FOCAL POINT 1 :

----------------------------------------------

LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

NAME OF FOCAL POINT 2 :

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LOCATION: -------------------------------

EMAIL: ------------------------------------

PHONE #: ---------------------------------

**After Urgent Action, Follow-up and continue with Case Management**

* Registration
* Assessment
* Case Planning
* Case Plan Implementation
* Follow-up and Review
* Case closure

**OTHER DIRECT SUPPORT NEEDED**

to be contextualized in context.

**OVERNIGHT/INTERIM CARE REQUIRED**

e.g. children without adult care and/or where it is unsure whether the child’s home or current living arrangement is safe enough to stay in until further assessment is made.

**SAFETY CONCERNS**

e.g. there are indicators of ongoing abuse of the child occurring within the family.

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**HEALTH CARE**

e.g. child is injured or in need of medication/medical attention within a certain timeframe (including if sexual assault has occurred within the past 120 hours an urgent medical referral is needed since this is within the window of time for the provision of lifesaving treatment – e.g. legal evidence collection within 48 hours, prevention of HIV within 72 hours, emergency contraception within 120 hours).

**BEST PRACTICES FOR REFERRALS**

* Informed consent/assent needs to be given by the child/family before being able to make a referral – unless this puts a child at further risk.
* Accompany the child / family to the service.
* Have current information and contact details for the range of services offered and who the staff providing them are.
* Case workers maintain overall responsibility over the case and to follow-up on the referral with the child and service provider to ensure progress updates and needs are met.

1. Minimum Standards for Child Protection in Humanitarian Action (2012). Standard 15: Case Management. [↑](#footnote-ref-1)
2. CPWG (2014) Inter-agency Guidelines for Case Management and Child Protection, p. 6-7 [↑](#footnote-ref-2)
3. UNICEF Global Strategy, 2008. [↑](#footnote-ref-3)
4. CPWG (2014) Inter-agency Guidelines for Case Management and Child Protection (with the following additions: Involve the Child in Decision-making, Protection from Sexual Exploitation and Abuse and Accountability to Affected Populations). [↑](#footnote-ref-4)
5. CPWG (2014) Inter-agency Guidelines for Case Management and Child Protection [↑](#footnote-ref-5)
6. Text under all the steps of the case management process are taken from the Minimum Standards for Child Protection in Humanitarian Action (forthcoming, 2019) Standard 15: Case Management [↑](#footnote-ref-6)