Decision tree for remote Child Protection Case Management during COVID-19

May 15th, 2020

The purpose of this guidance note is to support Child Protection program teams in deciding if remote case management is the best option to ensure service provision continuity throughout the COVID-19 pandemic. Contextualization and adaptation will be needed to make sure that case management services reflect in-country capacity of staff, access to technology by caseworkers and local populations, and infection control measures.

Case management is a lifesaving, essential service that we must maintain and adapt while keeping both staff and clients safe. During the period of COVID-19, caseworkers and supervisors need to prioritize caseloads to ensure that high risk cases continue to receive adequate support, while medium and low risk cases may need to be deprioritized:

Case Management would classify as a PC1, 2 or 3 where (use/adapt country vulnerability criteria):

- PC1 – are high risk cases: sexual abuse, physical violence and maltreatment, worst forms of child labor, CAAFAG, children orphaned by the death of family members with no or an inappropriate care arrangement, unaccompanied children who have no care arrangement or are in abusive care, separated children in an inappropriate care arrangement, children in abusive or neglectful residential care facilities, child-headed households, early/forced marriage under 12 years of age, children with disabilities experiencing abuse or neglect
- PC2 –are medium risk cases: non-hazardous child labor, early/forced marriage 13 -17, harsh physical punishment, non-life threatening emotional abuse
- PC3 –are low risk cases: separated children who are in appropriate care arrangement, caregivers/children in need of documentation, permissible light work

Limit face to face meetings and/or home visits to only high risk cases and prioritize remote check-in via telephone if possible. When visiting the family/child, stay outside in a well ventilated space, 2 meters away from family members/child, while maintaining confidentiality. This approach may not be appropriate for very sensitive cases. In this situation, try to identify a closed space that is big enough to be at least 2 meters away from each other, with good ventilation. If it is not possible to achieve these standards, prioritize regular remote follow up until the situation changes and a face to face meeting is safe. Ensure that caseworkers wear a mask and use hand sanitizer regularly. If hand sanitizer is not available, use a bottle of water and soap. Strict staff sickness policy implemented – staff must not attend work if sick.

In the event of hibernation or imposed confinement orders, some types of remote service delivery such as virtual case management could increase risk or create harm. Remote case management should ONLY be provided if we can ensure safety, privacy and confidentiality.

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The decision tree below guides decision-making on what modality is best to ensure service provision continuity. Face to face case management should be the first option if the context allows and IRC is able to provide PPE to all of its case workers. Advocacy should be done towards government where case management is not considered as an essential service. Suspension of services should be a last resort option. If suspension is the only option, this decision should be properly communicated to all opened cases, explaining the reason why and the potential timeframe for the reopening of services.

Go here for guidance on information management for case management in COVID 19.

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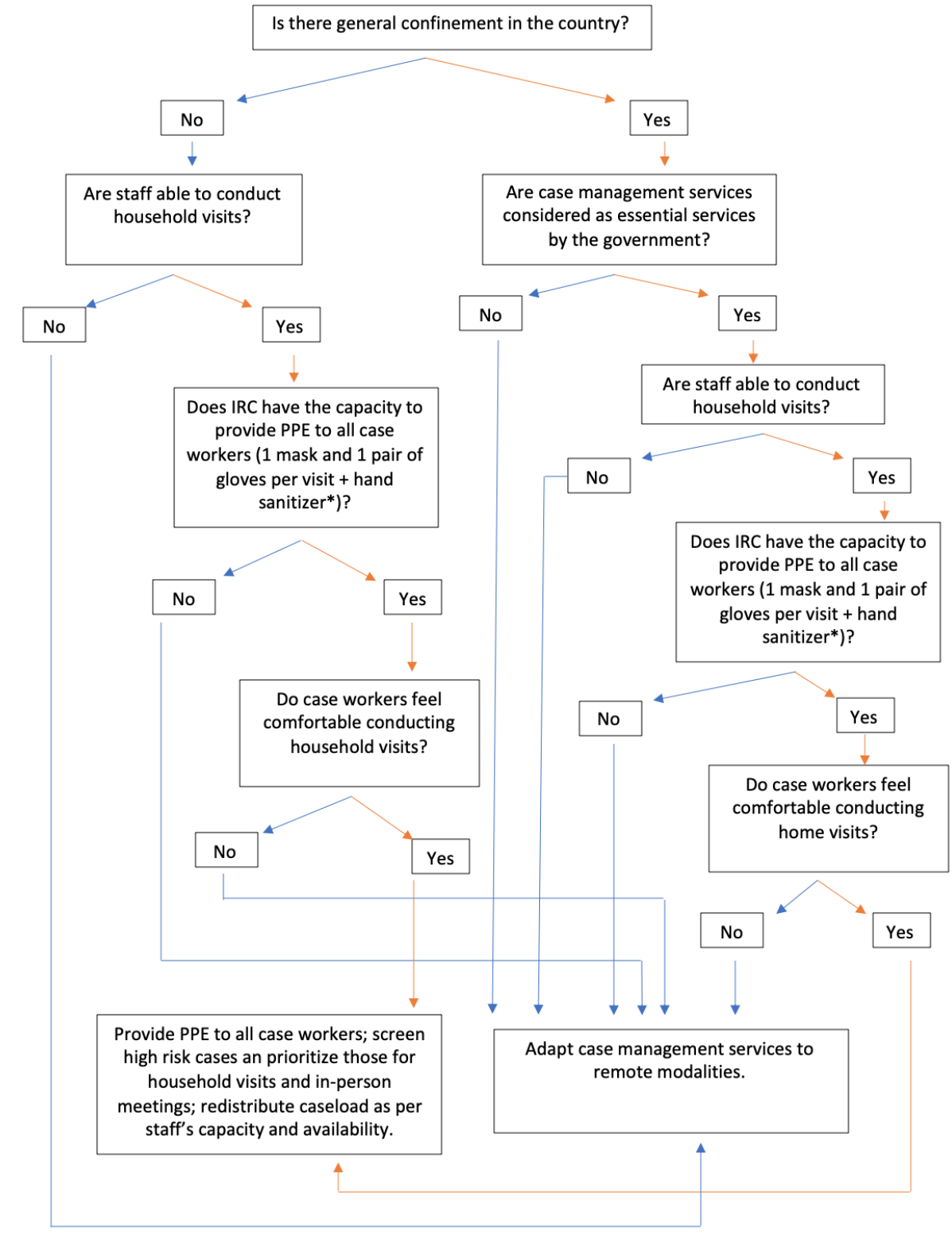

*Please make sure to coordinate with your Health department for further advice on how to safely conduct household visits and in-person meetings during an outbreak.