UAC/Alternative Care Guidance for the COVID-19 Situation – Iraq Child Protection Sub-Cluster

Introduction:

Children are particularly vulnerable during infectious disease outbreaks for three main reasons: 1. Children who have other medical conditions have **specific susceptibilities** to infection during infectious disease outbreaks; 2. Infectious diseases can **disrupt the environments** in which children grow and develop and 3. Measures used to prevent and control the spread of infectious diseases can **expose children to protection risks**[1]. This guidance provides an overview of the risks assosciated with disease outbreak that could **cause children to be left without appropriate parental care,** and provides scenearios for where children may be identified **as unaccompaied and separated in Iraq** due to issues related to COVID-19.

Based on these scenarios, and the **current and potential impacts of the COVID-19 situation** on forms of alternative care in Iraq outlined in the *Guidance Note Alternative Care – CMWG Iraq 2018*, this guidance provides **practical steps and actions** for child protection case management actors to follow in order to **identify and provide safe and appropriate forms of alternative care** for children identified as seperated from their parents/caregivers in and outside of camps as well as at hospitals assigned for referrals of suspected COVID-19 cases[2]. This guideline dose not address the case of long-term family separation when caregivers need to be in prolonged medical care or are deceased[3].

a). COVID-19 Scenarios, Risks and Criteria for UAC in need of Alternative Care:

Scenarios	Risks Associated
1. Child separated from caregiver in and outside of camps	Children whose caregivers fall ill, are quarantined, hospitalized or die are at high risk of being left without protection and care. Children whose family members are sick are likely to be stigmatized, socially excluded and discriminated against.
2. Child identified as separated in hospital or health/quarantine facility at the camp level[4]	Young children whose caregivers are hospitalized may remain with the caregiver and be exposed to the virus. Children under quarantine and treatment may be deprived of parental care. Abandonment of children after they have received treatment or have been quarantined. Risks may exist for children who remain at the hospital e.g. risks of abuse exploitation, neglect and trafficking. Quarantine facilities may be established at the camp level which could be another location where children become separated. Such spaces are high risk enviroments for abuse, eploitation and harm of children.

[1] The Alliance for Child Protection in Humanitarian Action, *Guidance Note on the Protection of Children During Infectious Disease Outbreaks*, 2018.

[2] The situation of COVID-19 and impacts to children and the forms of alternative care available in Iraq is constantly evolving. This guidance is correct as of the 19th March, and will be updated as necessary depending on major changes.

[3] For medium to long-term alternative care arrangement please refer to Guidance Note Alternative Care – CMWG Iraq 2018

[4] On the 5th March, 2020 an action point from the 1st COVID-19 Operations Cell meeting was that quarantine locations must be set up in camps – however currently suspected cases in IDP and refugee camps are being referred to local hospitals for testing. In this case, the priority is currently to plan for referrals for children identified as separated at the hospital level for scenario 2.

3. Children in institutions	Children in detention, state homes/orphanages and children with their parents in prison may be exposed to the virus. Measures taken to prevent the spread of COVID-19 could impact scheduled activities and visitations in the institutions. Children with their parents in prison may require alternative care if parent undergoes quarantine or treatment. Staff numbers may also deminish as they too fear working in the insitutions and contracting the virus thus leaving children at increased risk of abuse and harm.

b). COVID-19 Situation and Impact to available forms of Alternative Care

The first recorded case of COVID-19 (also colloquially known as "coronavirus") was recorded in Iraq on 24th February 2020, in the city of Najaf. Since then, 73 additional cases have been confirmed, with the majority of affected persons in Federal Iraq and approximately one-quarter of confirmed cases in the Kurdistan Region of Iraq. 12 fatalities due to COVID-19 have been confirmed as of 18th March, 2020. The World Health Organization has declared COVID-19 to be a global pandemic.[5] Whilst there is currently no known cases of adults or children contracting COVID-19 in the IDP or refugee camps in Iraq, 3 suspected cases were recently identified in Salamiyah IDP camp in Ninewa governorate which were found to be negative[6]. Preparedness planning for COVID-19 outbreak has become a priority, under the leadership of the COVID-19 Operational Cell appointed by the HCT to make programmatic decisions about the humanitarian response. Case management and alternative care has been prioritised as a life-saving activity in relation to the COVID-19 situation by the CPSC, particularly due to the risks which the COVID-19 presents for children as outlined above[7].

Current impacts of the COVID-19 situation on the child protection response include: Limitation of child protection services being delivered due to the closure of government offices and restrictions on group activities (e.g. including in child-friendly spaces in camps), humanitarian access issues in Ninewa governorate, misinformation and rumors amongst the community creating fear, limitations to activities in institutions such as the stopping of family visits in detention centres.

Of major concern is the potential impacts of loss of access to camps if a case is identified in or around the camp locations (e.g. camps being unaccessible to humantiarian actors). This has been given particular consideration in providing guidance for the scenarios below, with planning covering if child protection actors have access to the affected population in and outside of the camps or not. Another concern is the potential stigmatization of adults and children who have, or who are suspected to have, contracted the virus. In this case, both kinship care and foster families as forms of alternative care have not been identified initially as highly viable options for the COVID-19 response in Iraq due to the stigmatization being assessed as a barrier for the families to agree to look after the children[8]. Awareness raising messaging will be developed in order to sensitize families however this may take time to coordinate and implement in the current scenario of limited access and movement in the country. Based on the current and potential impacts of the COVID-19 situation, the following forms of alternative care in Iraq as outlined in the *Guidance Note Alternative Care – CMWG Iraq 2018* are assessed as follows in Table 1.

[5] OCHA, *IRAQ: COVID-19, Situation Report No. 5*, 12 March 2020.
[6] Ibid.
[7] For further information regarding the prioritised CP activities please refer to document: *NPC Priority HRP Activities during COVID-19 (as of 13 March 2020).*
[8] Iraq UASC TF - Alternative Care for COVID-19 Preparedness Meeting Minutes, 12th March, 2020.

Table 1: The Viability of forms of Alternative Care in Iraq in Emergency & Post-Emergency Settings in the situation of COVID-19 in Iraq

Alternative Care Modalities	Viability for COVID-19 situation	Guidance
Kinship Care	Based on the assessment[9]	Based on the assessment of care arrangements and interview with the child's caregiver or with the child(ren) themselves, there may be the option of the extended family to provide kinship care for the child. The assessment will inform the frequency of the visit by Child Protection actors. While kinship care is the preferred modality of alternative care, in the context of COVID-19, it is important to note that the possibility of kindship care arrangement could be limited as a child's extended family or close friends of the family known to the child may not be willing to provide the care, due to the stigma associated with the children being separated from an infected caregiver or due to movement restrictions.
Foster care	No	Placement with foster care arrangements is predicted to be difficult due to the stigma associated with the children being separated from an infected caregiver and the fear and misinformation that currently exists in the community around possible transmission of the disease.
Supported (semi-) Independent Living Arrangements	Yes	In the case of a child being separated from their caregiver when they are quarantined or hospitalized, if the CP actor or community-based CP focal point are available to mentor the children 24/7 and provide for their basic needs, the supported (semi-) independent living arrangement- adolescent headed household is considered to be a viable form of alternative care.
Residential care	Yes	Opportunities to support State Homes adapt existing facilities to provide care for children from out of camp locations to be explored with MoLSA/DoLSA to facilitate the placement of children where necessary. To note, due to the high number children already in residential care in KRI and Federal Iraq it is expected that there will be limited capacity to host additional children. Also to note, orphanages do not receive Syrian refugee children based on the Iraqi care law.
Small Group-Home based Care	Yes	This modality refers to a small group of generally maximum 8 children placed together in a home in a 'family-like environment', who receive 24/7 care by designated caretakers and other staff for both in and out of camp locations. If community-based CP focal points as well as CP actors will be available to monitor the children with the support of camp management where applicable to provide the required resources such as shelter (tents), and food and non-food items, then this is a viable form of alternative care.
Emergency Transit Shelters/ Centers	Yes	In emergencies, interim or emergency shelter to temporarily host unaccompanied children in need of short-term interim care, may be necessary and appropriate in some circumstances for in and out of camp locations. Interim care is provided for unaccompanied children for the shortest period possible, until the child can be reunified.

In reference to all forms of alternative care assessed as viable in regards to the COVID-19 situation, MoLSA and DoSA should be involved in the planning and implementation if they have the capacity to support where possible.

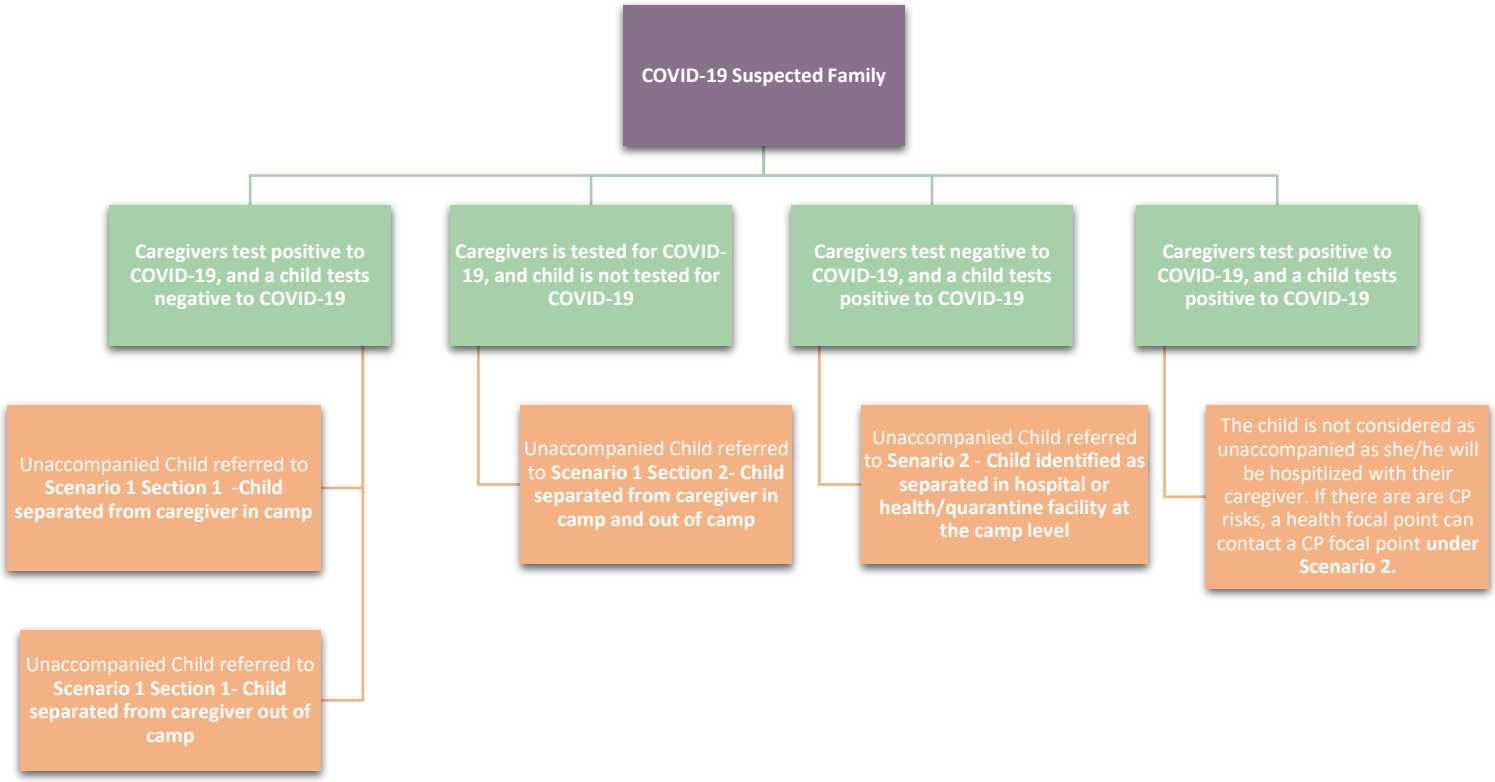
[9] For assessment procedures and forms can be found in Inter-agency standard operation procedures for child protection case management in KRI (2019) and in Central and South Iraq (2019).

c). Coordination & Engagement with Key Stakeholders

Coordination and engagement with the Ministry of Labour and Social Affairs (MoLSA) and the Ministry of Health will be a key part of the planning process for identification of opportunities for alternative care for children in each of the agreed scenarios. In addition, coordination with the CCCM Cluster about possible need for support particulary at the camp level will be necessary. Coordination will be required at both the national, governorate and site levels. This will be facilitated by the Case Management Working Group, supported by the National Child Protection Sub-Cluster. At the governorate level the Child Protection Working Group Coordinators and the agency focal points to be assigned through the Case Management Working Group will lead on this engagement and localised operational planning.coordination with other services provider to enusre that child needs will be addressed such as MHPSS actors, GBV and Protection.

d). Alternative Care Scenarios for COVID-19 in Iraq

Flow Chart: Referral of cases per scenario for Alternative Care Arrangment for COVID-19



Scenario 1. Child separated from caregiver in and outside of camps

Section 1: Caregivers tests positive to COVID-19, and child tests negative to COVID-19: Children whose caregivers fall ill, are quarantined, hospitalized or die are at high risk of being left without protection and care. Children whose family members are sick are likely to be stigmatized, socially excluded and discriminated against.		
	In the Camp	**Outside the Camp**
Modalities	*If a child tests negative to COVID-19 and is without appropriate parental care then the following forms of alternative care are considered relevant depending on the age of the child including: kinship care, emergency transit shelter, supported semi-independent living arrangements and child-headed household. These activities will need to be implemented in coordination with the community-based child protection mechanisms (CBCPMs) which exist in the camp as well as Camp Management, Shelter/NFI and Food Security Clusters.*	*If a child tests negative to COVID-19 and is without appropriate parental care, then the following forms of alternative care are considered relevant depending on the age of the child: kinship care, emergency shelter, supported semi-independent living arrangements and child-headed household.*
Kinship Care	There are detailed guidance available for case management actors in the existing *Guidance Note Alternative Care – CMWG Iraq 2018*	
Supported (semi-) Independent Living Arrangements, especially Supported Child Headed Households	In some circumstances, unaccompanied children live in "child or peer-headed household", it can be a group of siblings or children that are related to each other. They may be informally supported by extended family, other community members, CP actor or DoSA, who do not live in the same household. It means that children have to fulfill responsibilities which are normally attributed to adults. Children, especially girls in child-headed households can be exposed to high risks of abuse and exploitation and need to be thoroughly assessed, closely monitored and supported and alternative arrangements need to be found, when this living arrangement is not in their best interests. Generally, child-headed households benefit from a designated family or 'mentor' in the community. CP actors or DoSA staff can play this role - assisting with daily tasks, providing regular support and act as a point of reference for the children.	
Residential Care	Not applicable	Residential Care facilities such as State Homes are managed by the Government. CP actors to coordinate with DoLSA regarding availability of placements.

		For children in State homes, quality support, access to basic services and individual and group activities need to be available and contact with family should be maintained, where possible and in the best interests of the child, while tracing is on-going. Children need to be monitored closely and should stay there only until a more suitable care arrangement can be implemented.
Small Group-Home based Care	Small Group care arrangement generally refers to a small group of maximum 8 children placed together in a home in 'family-like environment', who receive 24/7 care by designated caretakers and other staff. Care and protection, access to basic services, and daily activities is provided by skilled, trained staff during day and night shifts. In camps, CP actor in coordination with the CBCPM and camp magamgement may explore to setup small 'emergency group home' in tents in IDP/refugee camp settings which provide a interim care until they could be reunified with their family or other relatives. This arrangement had been used for boys between 13 and 17 years old in Iraq. There should be 24/7 care and guards at night. CP partners would need to inform DoLSA and MoLSA for the group care arrangement in camps.	Small Group Care Arrangements generally refer to a small group of generally maximum 8 children placed together in a home in 'family-like environment', who receive 24/7 care by designated caretakers and other staff. Care and protection, access to basic services, and daily activities is provided by skilled, trained staff during day and night shifts. CP actor needs to coordinate with DoSA and CBCPM if it exists to set up small 'emergency group homes' in identified shelter (e.g. hotel building) in urban settings which provide a viable interim care solution, until they could be reunified with their family or other relatives. Such group home arrangement has been used for boys between 13 and 17 years old in Iraq. There should be 24/7 care and guards at night. DoLSA and MoLSA will play a major role in the implementation of this alternative care modality.

Emergency Transit Shelters/ Centers	Interim or emergency shelter to temporarily host unaccompanied children in need of short term interim care, may be necessary in some circumstances such as Scenario 1 of COVID-19 Iraq. Emergency transit shelters or centers can be set-up and used to provide interim care for children separated from their families due to disease outbreak. Interim care is provided for the shortest period possible, until the child can be reunified. In disease outbreak context child protection actors may need to set up transit shelters for UACs using the Iraq Alternative Care guidance 2018, which provided a viable short term care solution for the high numbers of UAC, who could generally be reunified very quickly, generally varying from a few days to a few weeks. DoLSA will need to be engaged in the planning of these facilities and coordination will also be required with the camp management and CBCPMs.	Interim or emergency shelter to temporarily host unaccompanied children in need of short term interim care, may be necessary in some circumstances such as Scenario 1 of COVID-19 Iraq. Emergency transit shelters or centers can besetup and used during an emergency based on Scenario 1 of COVID-19 , it aims to provide interim care for children separated from their families due to disease outbreak. Interim care is provided for unaccompanied children for the shortest period possible, until the child can be reunified. Child protection actors or the Government (DoSA) may setup transit shelters for UAC during the emergency, which provided a viable short term care solution for the high numbers of UAC, who could generally be reunified very quickly, generally varying from a few days to a few weeks. The CP actor or the Government can identify a building such as hotel or other shelter which can be used as an emergency shelter. Coordination will be required with other Clusters to provide food and non-food items.

Section 2 : Caregivers is tested for COVID-19, and a child is not tested for COVID-19:

The caregiver has been taken to the hospital to be tested for COVID-19 and the child(ren) have been left behind in the camp or outside of the camp (as the child(ren) do not show symptoms) and do not have any parental supervision. Children could face stigmatization, social exclusion and discrimination which could limit opportunities for alternative care available.

Children Under 10 years old	Children above 10 years old
• This form of alternative care will be for 24 – 72 hours until the COVID-19 test results of the caregiver will be available. If the caregiver is tested negative, the child(ren) will be reunified with the caregiver. If the caregiver is tested positive, the MoH will also refer the child(ren) and other close contacts for COVID-19 testing. • Explore the kinship care options first, while understanding the possibility of the extended family members may show the strong concerns over possible infection to COVID 19.	• Explore the kinship care options first, while understanding the possibility of the extended family members may show strong concerns over possible infection to COVID 19. • If Kinship care is not possible, other alternative care options such as Supported (semi-) Independent Living Arrangements; Small Group-Home based Care Arrangement and Emergency Transit Shelters/ Centers can be applicable with safety measures: 1- Children may need to be isolated in or out of the camp, due to the possible infection. CP actors or government will provide basic needs to those children (food, non-food items)

• If Kinship care is not possible, CP actors and DoSA will identify the opportunity for care arrangement which can be applicable with safety measures including: 1- Adequate precaution should be taken for home visits at this moment. 2- Each visitor should wear a Surgical Mask, Surgical Gown, Gloves and carry a bottle of sanitizer. 3- They should maintain safe distance with the children and wash their hands with sanitizer after every home visits. 4- Change their clothes and dispose of before they enter their home or offices.	2- CP actor may provide the phones and credit to the children, in order to maintain the communication between the children and their caregivers. 3- CP staff need to follow up and monitor remotely and address concerns related to children. 4- CPCBM and the Camp Management in the camp and the Government/ DoSA need to support monitoring of the care arrangement.
Roles and Responsibilities	
In the Camp	Outside the Camp
Child Protection actors: • Conduct assessment to ensure the resources and capacities are available to provide alternative care within the camps (refer to Annex A Checklist).). Ensure all contact information is gathered to link and maintain communication between child and primary caregivers while they are separated • Ensure that there is CBCPM established in the camp • Identify CPCBM focal point (ensuring gender is considered when selecting the focal point) to ensure the possibility of monitoring children in alternative care arrangements 24/7. • Provide support to CPCBM focal points with relevant resources and materials (incentives, phone credit), • Ensure that CPCBM focal points have been trained on Child Protection core concept, their roles and responsibilities during COVID-19 response (particularly if changed from prior to the outbreak) and this alternative care guidance note. • Ensure that CPCBM focal points have signed and have been trained in Child Safeguarding procedures in protocols including	Child Protection actors: (where CBCPMs are existing at the out of camp location) • Conduct assessment to ensure the resources and capacities are available to provide alternative care in the location in coordination with DoSA (refer to Annex B Checklist) Ensure all contact information is gathered to link and maintain communication between child and primary caregivers while they are separated. • Coordinate with DoSAs to assess the viability of establishing a UAC emergency shelter and identify what resources and capacities exist and what is the gap. • Child Protection need to train DoSA staff on alternative care specifically emergency transit shelter and supported semi-independent living arrangements and child-headed household. • Ensure that there is CBCPM established in the location. • Identify CPCBM focal point (ensuring gender is considered when selecting the focal point) to ensure the possibility of monitoring children in alternative care arrangements 24/7. • Provide support to CPCBM focal points with relevant resources and materials (incentives, phone credit).

how to identify signs of abuse, appropriate response and reporting mechanisms. • Ensure the CP staff will be available physically or remotely in case there is no access to support the CPCMB focal points to address the needs of unaccompanied minors and alternative care arrangements. • Coordinate with DoSA, Camp Management and other relevant stakeholders regarding the establishment of alternative care arrangements in the camps and to ensure that services are provided including food and non-food items for unaccompanied children. • Ensure that there are child friendly feedback mechanisms established Community-based Child Protection Focal Point: • Be available and willing to support the alternative care arrangements in the camp. • Be aware of CP core concepts and alternative care arrangements guidance related to COVID-19 specifically for emergency transit shelter and supported semi-independent living arrangements and child-headed household. Must sign child safeguarding policy. • Be available to monitor UC in alternative care arrangements 24/7 and provide support to children who have been separated from their caregivers due to COVID-19 in the different scenarios that may arise in the camp. • Communicate regularly with CP actor to allow remote monitoring of alternative care arrangement if CP actor is unable to access the camp. • Sign and be trained in child safeguarding including recognizing the signs, when to report and the appropriate response. CCCM Partners (Camp Management) : • CCCM Partners (Camp Management) in coordination with CP will identify safe space to set-up alternative care shelter in the camps.	• Ensure that CPCBM focal points have signed and have been trained in Child Safeguarding procedures in protocols including how to identify signs of abuse, appropriate response and reporting mechanisms • Ensure that CPCBM focal points have been trained on Child Protection core concept, their roles and responsibilities during COVID-19 response (particularly if changed from prior to the outbreak) and this alternative care guidance note. • Ensure the CP staff will be available physically or remotely in case there is not access to support the CPCMB focal points to address the needs of unaccompanied minors and alternative care arrangements. • Coordinate with Government and other relevant stakeholders regarding the establishment of alternative care arrangements outside the camps and ensure that services are provides including food and non-food items for unaccompanied children. Community-based Child Protection Focal Point: • Willing to be part of this alternative care arrangement and Support CP and DoSA if needed. • To get training of CP core concept and on this alternative care arrangements specifically emergency transit shelter and supported semi-independent living arrangements and child-headed household. • CPCBM FP will be available to mentor UC in alternative care arrangements 24/7. Must sign child safeguarding policy. • To communicate with CP focal point for better respond. DoSAs: • DoSAs have the capacity to support the emergency. • DoSAs can provide resources for alternative care arrangements based on their capacity. • DoSAs maintain coordination with CP actors and CBCPM focal points to ensure the care arrangements in place are appropriate, safe and positive experiences for children.

• The pace can be established near CPCMB focal point tent or camp management office for close monitoring and safety. • If an unaccompanied child is identified in the camp, CCCM will refer the child to CP actor immediately. • CCCM Partners with Child Protection actor should liaise with other partners such as NFI, food and shelter to provide all the necessary items to set up and support the alternative care arrangement in the camp.	• In the case of CBCPM FP does not exist, DoSA staff will be available to mentor UC in alternative care arrangements 24/7.

<u>Points to be considered when implementing the above:</u>

- Case management registration forms should be completed with basic child information to register separated children
- Database of UAC should be filled by CM actors and be updated regularly
- Provide PFA and PSS at any time to the child that is separated and provide him/her clear information about the options and the steps that will be taken
- Ensure procedures are put in place to support continued remote or virtual contact between children and caregivers who are physically separated due to quarantine, isolation or treatment
- Reunification will take place after the caregivers is considered recovered form COVID-19, the reunification forms should be signed by the caregiver and be approved by CP actor, especially for the 'in camp' context.
- All Case Management Principle should be in Place (Child Participation in decision making, Best Interest of the child, Do no harm and Nondiscrimination)
- Any change of care arrangement should be completed after consulting and gaining the permission of CP actors, especially for the 'in camp' context.
- If the child is unable to be reunified with family after 12 weeks of separation due to the caregiver's death as a result of COVID-19 or the reunification with their caregiver is no longer an option, case management actors should refer to *the Guidance Note Alternative Care – CMWG Iraq 2018* for identification of longer-term solutions and processes to follow.

Scenario 2. Child identified as separated in hospital

Scenario 2. Child identified as separated in hospital Young children whose caregivers are hospitalized may remain with the caregiver and be exposed to the virus in case that the children will be unccopained their infected caregivers to hospitals. Children under quarantine and treatment may be deprived by parental care. Abandonment of children after they have received treatment or have been quarantined. Risks may exist for children who remain at the hospital e.g. risks of abuse. Quarantine facilities may be established at the camp level or out of camps such as hotels which could be another location where children become separated.	
Key Actions	Establishment of referral pathway between hospitals assigned to treat COVID-19 cases (including identification of health focal point in each) and Case Management actors. List of hospitals assigned for referral for COVID-19 cases in Annex. - Training and orientation of health focal points by Case Management actors including: 1). Rapid registration form for non-case management actors and process of communication with the CP actor if separated child is identified 2). PSEA and Child Safeguarding 3). Confirmation of methods of communication between child and family (e.g. safe options for visiting (if proper precautions are in place), phone calls etc. 4). PSS, Psychological First Aid, and awareness raising materials/resources available from the CPSC. - See Checklist C in Annex for case management actors who will be the focal point for the hospital per governorate to assess the current needs and resources available, and key proccesses to be in place.

Scenario 3. Children in institutions

Scenario 3. Children in institutions Children in detention, state homes and children with their parents in prison may be exposed to the virus. Measures taken to prevent the spread of COVID-19 could impact scheduled activities and visitations in the institutions. Children with their parents in prison may require alternative care if parent undergoes quarantine or treatment.	
Key Actions	Children in detention, state homes and with their parents in prison are already under the care of the Government, then the Government will provide the response to any needs for alternative care related to COVID-19. UNICEF will lead supporting the government to provide alternative care for cases related to COVID-19 in 38 facilities where necessary. This will include support on provision of psychosocial support, case management, referral to critical services and awareness on personal protective measures and coping strategies for psychological distress.

ANNEX A - COVID -19 Alternative Care Arrangement- In Camps Checklist

This Checklist will enable Child Protection actors to define alternative care arrangment modalities at the camp level as well as identify existing resources and gaps that needs to be addressed in order to provide safe and appropriate forms of alternative care for children left without appropriate care due to COVID-19.

Name of Camp: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Do Child Protection actors have access to the camp?			*If CP actor does not have access to the camp, then remote follow-up is required*
Is there trained Case Management staff to follow-up on children at risk?			*If no, alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangements including emergency shelter?			*If not, please request training from UASC TF*
Are CP staff available to monitor alternative care arrangement (physical or remote)?			*If staff are not availale, additoinal staff need ot be identified or alternative care is not possible*
Is there any community-based Child Protection mechanisms (e.g. groups, focal points)			*If no, focal point from community needs to be identified*
Has a community-based CP focal point been identified to support (if CP actor has access) or monitor (if CP actor does not have access) Alternative Care Arrangement?			
Has the community-based CP focal point been trained on CP core concepts?			*If no, provide training*
Has the community-based CP focal point been briefed on COVID-19 Alternative care arrangment guidence note?			*If no, conduct the briefing*
Are there community-based CP focal points available and willing to monitor the 24/7 emergency shelter for unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for this camp*
Are there female community-based CP focal points available and willing to monitor the 24/7 emergency shelter for under-5 years unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for children under 5 years for this camp*
Is the Camp Management agency ready and willing to support alternative care arragements identified in this camp? (Please ensure that you discuss this with the agency)?			*Please provide the contact details of the camp management agency*
Does Camp Managament have any additional tents at the camp level to support accomodation arranagements (emergency shelters, CHHs shelter)?			*If not, please look for opportunities to source these*
Is camp management willing to install the tents used to accommodate the unaccompanied children near by the Camp Management officeÉ			*If not, please identify safe location near community-based CP focal point's shelter*
Is camp management able to support unaccompanied children in emergency shelter by providing non-food items?			*If not, please look for opportunities to source these*
Is camp managemnt able to support unaccompanied children in emergency shelter by providing food items?			*If not, please look for opportunities to source these*
Has the CP focal point been trainied in Child Safeguarding and PSEA including reporting mechanisms			

ANNEX B - COVID -19 Alernative Care Arrangement- Out of Camps Checklist

This Checklist will enable Child Protection actors to define alternative care arrangment modalities in locations out of camps and urban areas as well as identify existing resources and gaps that needs to be addressed in order to provide safe and appropriate forms of alternative care for children left without appropriate care due to COVID-19. In this context coordination with Government and DoSA is required in the identification of alternative care arrangement for IDP, refugees and host community children.

Name of Location: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Child Protection actors have access into the mentioned location?			*If CP actor does not have access to the mentioned location, then remote follow-up is required*
Is there trained Case Management staff to follow-up children at risk?			*If no, alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangements including emergency shelter?			*If not, please request training from UASC TF*
Are CP staff available to monitor alternative care arrangements (physical or remote)?			*If staff are not availale, additoinal staff need ot be identified or alternative care is not possible*
Is there any community-based Child Protection mechanisms (e.g. groups, focal points) at this location?			*If no, focal point from community or DoSA staff needs to be identified*
Has a community-based CP focal point or DoSA staff been identified to support (if CP actor has access) or monitor (if CP actor does not have access) alternative care arrangement?			
Has the community-based CP focal point been trained on CP core concepts?			*If no, provide training*
Has the community-based CP focal point been or DoSA briefed on COVID-19 Alternative care arrangment guidence note?			*If no, conduct the briefing*
Are there community-based CP focal points or DoSA available and willing to monitor the 24/7 emergency shelter for unaccompanied children due to COVID-19 in the camp?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for this location*
Are there female community-based CP focal points or female staff from DoSA available and willing to monitor the 24/7 emergency shelter for under-5 years unaccompanied children due to COVID-19 in this location?			*If no, then the 24/7 emergency shelter is not a viable form of alternative care for children under 5 years for this location*
Is the Government/DoSA ready and willing to support alternative care arragements identified in this location? (Please ensure that you discuss this with the agency)?			*Please provide the contact details of the DoSA Focal point in this location*
Does Government/DoSA have any idintefied building in mentioned location to support accomodation arranagements (emergency shelters, CHHs)?			*If not, please look for opportunities to source these*
Is Government/DoSA able to support unaccompanied children in emergency shelter by providing non-food items?			*If not, please look for opportunities to source these*
Is Government/DoSA able to support unaccomapnied children in emergency shelter by providing food items?			*If not, please look for opportunities to source these*

Child Protection
Iraq Child Protection Sub-Cluster

Annex C - COVID -19 Alernative Care Arrangement- Hospital/Heath Facilitlies

This Checklist will enable Child Protection actors to assess the current arrangements and capacity at the hospital or health facility in relation to providing care to separated children, as well as to establish a referral pathway between appointed health and child protection actors to coordinate on child protection issues such as family tracing and alternative care.

Name of Hospital/Health Facility: _____ Organization: _____ Date: _____

Checklist Questions	Yes	No	Comments
Do Child Protection actors have access to the Hospital/Health Facility?			*If no, please advise why* *If CP actor does not have access to the mentioned location, then remote follow-up is required*
Is there a health focal point available to coordinate with?			*If yes, please record the details of the focal point:* *If no, what actions needs to be taken in order to have this focal point nominated?*
Is there trained Case Management staff available to follow-up children at risk and provide support to health staff focal point?			*If no, case management and alternative care arrangement is not possible*
Have CP staff been trained on alternative care arrangement, and are able to provide this technical support to the health staff focal point?			*If not, please request training from UASC TF*
Has a discussion on the process of communication following the referral pathway occurred with the Health focal point – particularly how the case will be referred if a separated child is identified?			*If not, please have this discussion so it is clear the mode of communication with the health actor.*
Has the Health Focal Point been trained on the Rapid registration form for non-case management actors?			*If not, please provide training or request support from UASC TF*
Are CP staff available to support the Health focal point to receive referrals?			*If staff are not availale, additoinal staff need to be identified*
Has the Health focal point been trained on CP core concepts? Has the Health focal point attended PSEA and Child Safeguarding training? (With the health focal point spend time discussing the possible CP risks that may exist for particularly separated children at the hospital (e.g. abuse) and identify ways to mitigate this).			*If the health focal point has not received training, please refer the DoLSA focal point in that location to provide support.* *Please details any risks and mitigation strategies discussed*
Has the Health staff CP focal point been briefed on COVID-19 Alternative care arrangement guidence note?			*If no, conduct the briefing*
What are the methods of communication between child and family being used at the hosptial or health facility (e.g. safe options for visiting (if proper precautions are in place), phone calls etc.			*Please detail the methods that will be used:*