Key Considerations for Child Protection-focused Mobile Service Delivery

Before implementing mobile programming or service delivery[1], has your Child Protection Coordination Group considered the following:

Guiding Principles for all Child Protection Interventions: Respect and Dignity, Do No Harm, Confidentiality, Best Interests of the Child, Non-Discrimination, Child Participation, and Child Survival & Development,

Why is mobile service delivery needed in your context? **Thinking about these factors will influence both initial and longer-term project design.*

- **Is mobile programming being considered due to any one or a combination of the following:**
  - Access constraints due to poor infrastructure and/or weather
  - Remote locations, potentially 2-3 hours from base office
  - Inability to set up a base in those locations due to cost-prohibitive office rent or lack of available office space, perhaps in urban settings
  - Newly displaced population or highly mobile displaced populations
  - Urgent needs with few or no actors responding and limited resources among protection agencies to set up stable, daily programmes
  - Access constraints due to insecurity, allowing only for occasional, rapid response missions
  - Other?
- **Other essential factors to reflect upon prior to deciding on mobile programming should include:**
  - Is the team able to complete an on-site assessment prior to implementation?
  - Frequency of planned visits (i.e., how often the team can visit based on security situation, weather, population movement, financial and human resources, etc…). **If only once in 3 – 6 months or once total, then your level of intervention should be designed quite differently from programming involving more frequent missions.* Safety, ethical practice, and continuity of service provision must be considered.
  - Security situation: Relatively stable? Highly unpredictable?
  - What type of displacement (e.g., highly mobile or a camp / settlement)?
  - How many children and families affected in the target locations?
  - Will the mobile programme be multi-sectoral missions or is it only Child Protection?
  - Are other critical services available in the site or nearby (e.g., healthcare, WASH, nutrition, etc)?

[1] Mobile programming and service delivery are used interchangeably since, for the purposes of this note, we are referring only to programming that involves direct service delivery to an affected population. While monitoring is a built-in aspect of any programme or project cycle, we note that specific protection monitoring can be considered a form of intervention. For the purposes of this note, however, we are encouraging protection monitoring (e.g., through the MRM, protection by presence, etc.) only when integrated into an existing service delivery programme and implemented by those skilled in child- and person-centred approaches, including psychological first aid, to promote safe and ethical interventions that directly assist and benefit affected persons (and not used only for reporting, advocacy, fund-raising, etc...).

If mobile programming is determined to be a potential, appropriate approach for your context, what should mobile programming entail and look like in your context?

- **Mobile Approaches could include:**
  - Sustained or regular weekly, bi-weekly, or monthly visits to a displaced *or* remote but mostly stable population, with fixed centres and locations.
  - Mobile teams assigned to a mobile population rather than a particular location that follows the populations and sets up a new "meeting space" each time the population moves. These teams are flexible and responsive based on need and could become a static team if the population "settles."
  - Initial trips to model interventions and select and train community members for the purpose of eventual transition of interventions to affected populations if formal mobile programming cannot be sustained
  - Single, multi-day mission for the purpose of service delivery to extremely remote and often insecure locations, such as through Interagency, Multi-Sector Rapid Response Missions (RRMs). As noted throughout, safety, ethical practice, and continuity of care must be considered. This note *excludes* activities, such as protection monitoring and assessments, if direct services are also not being offered or delivered.

- **An assessment of the situation and thorough project design** are critical to determine which mobile approach and interventions are appropriate.

Table 1: Assessment and Project Design Questions & Considerations

Needs & Targeting
What are the **common concerns and risks** among the affected population as identified by various members of the population, particularly women, that should be prioritized? What observations did experts make regarding concerns and risks?
How many **estimated girls, boys, and families** are in need of services, disaggregated by age if possible (e.g., Under 5, 6-12, 13 – 17)? Any particularly vulnerable groups (e.g., child-headed households, female-headed households, children and adults with disabilities, displaced populations, etc.)?

What services are available, if any? What essential services are unavailable? If several services are unavailable, multi-sector teams are highly recommended. Otherwise, need to engage in multi-sectoral discussions ahead of time regarding what the action plan will be to address needs likely to arise.	◆ **Health care:** Are health workers and appropriate treatment for sexual violence cases available, such as post-exposure prophylaxis to reduce likelihood of HIV infection and emergency contraception to reduce likelihood of pregnancy? What hours are medical facilities open and functioning each day? Check stock and expiration dates. ◆ **Nutrition Services** for pregnant mothers, adolescent girls, and children under 5? ◆ **WASH**, including access to safe latrines, clean water, and appropriate hygiene materials? ◆ **Education**: Schools and Teachers? ◆ If services are unavailable, what are your options? ∞ Multi-sector Teams ∞ Carrying medication with the health teams? ∞ If no health workers on mobile teams, can case workers or others be trained in delivering certain medications, such as to reduce the likelihood of pregnancy following sexual violence (prior to the 72/120 hour window)? Check regulations in conjunction with the Ministry of Health and Health Cluster.
Based on the above, are **child protection and GBV referral pathways**, including contact information, available per mission and location? **"GBV guide for non-GBV Specialists in locations where specialised services are not available" is under development and should be ready by early 2018.*	
Security & Frequency of Missions	
What are current or potential risks and security concerns?	◆ Consider threats to both team members and the affected population. What are the security concerns for children and families when trying to access mobile services or when participating? ◆ Related to the above, has a ***risk assessment*** been conducted that considers the following: ∞ Is there a risk of inter or intra-community tension due to service delivery locations or types of services offered if one community is served and a neighboring community not served? ∞ Is there a risk of discrimination or perceptions of discrimination if a service is provided to specific groups / individuals at the exclusion of other groups/individuals? ∞ Does the timing, content, or location of a service result in empowering/strengthening parties to the conflict or contributing to /increasing political tensions? ∞ Is there a risk of doing harm or perpetuating unintended consequences to girls, and boys (and their caregivers) through the provision of specialised child protection services if service providers do not have a permanent presence in the community to monitor the situation of beneficiaries? ∞ Is there a risk to the physical safety of child protection service providers if they are perceived to be interfering in what may be considered family-based concerns?

	∞ Is there a risk to the physical safety of humanitarian staff by asking questions that are considered too sensitive to a community? ∞ Is there a risk to the staff for being exposed to primary and secondary trauma without any resources or training for self-care? ◆ What permissions are needed and from whom? ◆ Can community engagement mitigate risks *(e.g., having a community focal point to call prior to leaving and nearing arrival, notification of key community leaders as appropriate, agency or government approvals, etc.)* ◆ Are particular issues especially sensitive to address? If so, could different language / terminology be used or should the topic not be discussed or addressed initially? ◆ Will road conditions or other access constraints hamper quick evacuation or movement to safer locations? ◆ Are contingency plans in place? ◆ Is a convoy needed, if driving? How many persons per vehicle? ◆ Is there a need to rotate the meeting locations to avoid a predictable routine or location that could be targeted? If so, how will this location be determined and communicated to families?
Who will provide security assessments and guidance prior to and during each mission? Adapted security approaches will be needed depending upon length of mission (e.g., one day vs. several days).	◆ Each agency as well as an inter-agency coordinator (if appropriate) must ensure each staff has necessary security briefings, equipment (e.g., sat phone, radio, PPE, items for water purification and sleeping if staying overnight) and permissions from relevant authorities if needed. If national NGOs are participating and do not have access to necessary equipment, it is recommended to work with UNICEF and others to ensure all participants have access to essential equipment. ◆ Contingency plans should be set and security protocol reviewed prior to each trip. ◆ Team Leader and security focal point at the base should be in regular communication during the mission.
How often could a team realistically visit this site based on security and weather?	◆ Must consider Continuity of Care and how often a case worker will be able to support that child/family ◆ If a single, multi-day mission, a case management approach is not appropriate. The team will need to think realistically of what interventions can be completed during the mission itself. For example: ∞ could the team decide to ensure unaccompanied children without a caregiver is placed with a family or, if older and no caregiver, lives near a caregiver willing to "check in" daily and be a support person to that child before leaving the mission? ∞ Or, if registering an unaccompanied or separated child, what will be the purpose if there is no intent to follow up or complete family tracing?

	◆ If follow-up missions are planned, how often will they occur and what will be completed between missions in order to be accountable to families and demonstrate progress?
How long can each team spend providing services during each visit (e.g., 3-4 hours every few days for several months vs. 1 week every 3-6 months)?	◆ If a short duration, what interventions can be set up and carried out [well] within that timeframe? ◆ What is the general "community" (e.g., parents/caregivers, teachers, etc.) interest and capacity in running activities beyond the "mission" or when the mobile team is absent? Would it be appropriate to consider training community workers to voluntarily take on particular interventions? Reflect on necessary human resources if a more sustained, frequent intervention: ◆ What is the anticipated caseload? ◆ How many cases are expected to be handled per caseworker? ◆ Are cases often intensive, thereby requiring more time? ◆ Depending on whether children and families are coming to a particular location vs. conducting household visits, how many children/families can one caseworker see in one day?
Community Engagement and Communication prior to and during Implementation	
Are any members of the displaced population already intervening and providing some type of service so that we support and do not undermine existing, positive initiatives?	
Who is available within the affected population to partner with in terms of service delivery?	***For example:*** ◆ Women ◆ Youth groups ◆ Displaced healthcare workers or teachers ◆ Key leaders ◆ Families already providing care to unaccompanied children
What forms of communication will be most useful and appropriate? If population is largely illiterate, verbal messages are best, followed by pictures.	***For example:*** ◆ Radio ◆ Megaphone ◆ Pictures ◆ Posters and Pamphlets ◆ Community-wide dissemination or house to house ◆ Stickers ◆ Laminated Cards for HH use ◆ Materials for persons with disabilities
How often has this population moved?	If often, will your mobile team be assigned to the "community" to follow the population as they move rather than assigned to a specific geographic location? How will you design your interventions and work with families so that key messages and top tips/interventions can "travel" with the population? For example: ◆ ensuring caregivers have reminders of important messages ◆ identification cards kept with young children in the event of separation ◆ pre-paid mobile phones with focal points to provide remote support and follow up on urgent or emerging issues

If a relatively stable population, are they receiving new arrivals regularly? Average numbers and how often?	Should have a plan right from the beginning of how to inform families that you are coming, when you are coming back, where to meet, etc. If the meeting point changes due to the security situation, then should devise a plan of how to determine a new safe meeting point and inform affected families.	
Human and Operational Resources		
How many persons and what types of expertise are necessary to provide an effective response? What role(s) and responsibilities will each of these team members have?	***For example:*** ◆ Protection Team Leader ◆ Case Workers ◆ Community Mobilisers ◆ Drivers / Logistics Officers ◆ Other multi-sector team members	
Based on need, duration of visits, and available human capacity, what frequency is needed in order to adequately respond to urgent protection needs?		
Depending on type of intervention, other resources	◆ Vehicles & motorbikes ◆ Tents ◆ ECD / CFS / Recreation Kits ◆ Pre-paid phones ◆ Training materials, including curriculum, flipchart, markers, etc. ◆ First Aid Kit and Fire extinguisher ◆ Materials to support individual cases requiring case management services (e.g., forms *(if appropriate)*, pens, locked box, folders, clipboard, technology if applicable) ◆ Megaphones ◆ Pamphlets or Picture Books ◆ Posters ◆ Recorded Messages for Radio or Megaphone	
How will the team promote and ensure data security and protection?	***Example from Iraq***: **If a location is deemed too insecure or if security of staff, data, or survivors is uncertain, no hard copies of consent or intake forms should be transported with mobile teams.** In situations considered too risky or insecure, consent should be obtained verbally for case management, referrals and to record data. CP case workers/response officers should then fill in registration / assessment forms once they return to their office in a safe and secure location where data security can be maintained. Hard copies of registration / assessment forms should follow agreed protocols for storage and data management.	
What essential training is needed?	***Example:*** Training for CP Staff: ◆ Frontline Workers Training (e.g., CPiE fundamentals, CP Minimum Standards, etc.) ◆ Case Management ◆ UASC and Alternative Care ◆ Child Friendly Space and PSS Integration ◆ Caring for Child Survivors (IRC) ◆ Positive parenting	***Example:*** Training for All Staff regardless of Sector: ◆ Basic Security ◆ Psychological First Aid ◆ Child-friendly communication skills ◆ Emergency First Aid ◆ CP and GBV Referrals, with knowledge of available services,

	◆ Monitoring and Reporting Mechanism (MRM) ◆ Community Mobilization Techniques ◆ Mine Risk Education	focal points for each service, basic communication skills, and how to give safe and confidential referrals
What competencies, apart from technical skills, are valuable? **Could conduct a one-day simulation for observation in addition to regular observation*	◆ Adaptable ◆ Collaborative ◆ Willing to ask for support	◆ Flexible ◆ Compassionate ◆ Committed to seeing things through ◆ Critical Thinking ◆ Problem solver (taking guiding principles into account)

✦ Themes to consider when designing and implementing each intervention:

- ✧ Continuity of Care: What is safe and ethical to start up in light of frequency and duration of visits and what are the follow-up timelines?
- ✧ Employment of highly qualified staff
- ✧ Child and Family Safeguarding
- ✧ Child and Family Participation
- ✧ Accountability to Children and Families
- ✧ Question and Complaint/Feedback Mechanism
- ✧ Data Protection & Privacy
- ✧ To what extent should we be engaged with the government or ministries, depending on context and type of intervention?
- ✧ How adaptable and flexible is your intervention to adapt and respond to changing needs and situations?

✦ Interventions to consider based on situational factors, including frequency and duration of missions, initial assessment findings, and ongoing monitoring and feedback

✧ **Awareness raising and outreach** on mine risks, other safety messages (e.g., walking in groups with adults), prevention of family separation, positive caregiver support for affected children with psychosocial issues, and information about available services for those affected by violence, abuse, family separation, recruitment, etc.

- ◆ This can be effective, even during short, single missions.
- ◆ Could be helpful to produce 3 – 5 quick messages – either recorded on a megaphone or through picture books. ***Example:*** In some locations with shorter missions, roving teams find children and families, provide messages and answer questions for about 20 minutes, and keep moving to find additional children to share messages. Particularly helpful in high-risk situations when messages about mines and family separation are crucial and teams need to be moving rapidly.

✧ **Psychosocial Support Interventions:**

- ◆ **Psychological First Aid:** all staff should be trained and feel relatively confident in interacting with persons dealing with traumatic events, but serious, emergency cases should be referred immediately to the Team Leader, who will then ensure a team member trained in more specialized care is available to respond

- **Child Friendly Spaces** to promote safe, nurturing environments that emphasize and ensure good levels of engagement through adequate child to CFS facilitator ratios, child-friendly routines, integrated psychosocial support throughout activities, parent/caregiver involvement, and identification of and confidential, ethical referrals for children who are having trouble coping positively (with assent from the child and consent from the caregiver)
  - **Lessons learned from one mobile CFS in the Middle East include:**
    - The team went a day ahead of the initial event to mobilized, and then used a fun, child-friendly bus to attract people and model good approaches for a CFS during the first event day.
    - During previous mobilization and the event, community caregivers were selected to volunteer to continue running the CFS.
    - Applied the same principles and minimum standards as a stable CFS, but the team needed to return to the site at least once or twice per week for the first two – three months as the mobile team was training and mentoring the community-based groups to run the CFS.
    - Integrated PSS was secondary in this model, but used the model to bring host communities and IDP/refugee communities together and provide a safe place for children to play, monitored by local caregivers.
    - Cases identified by community groups were referred to trained case workers who visited at least once per week.
    - Sometimes, a multi-sector team would visit the CFS with WASH, Health, immunization, and nutrition support.

✧ **Identification, Documentation, Tracing, and Reunification services** for unaccompanied and separated children
- Is Family Tracing and Reunification (FTR) covered within a national SOP, either a Case Management SOP or FTR SOP? If so, does this SOP include specifications for mobile delivery of FTR services?
- Are staff trained in PSS and child-friendly interviewing techniques?
- Do staff have a mechanism for ensuring identified unaccompanied children (UAC) are cared for by an adult prior to leaving the mobile site?
- Are staff communicating with children and families about what they can expect from an FTR service in terms of timing of follow-up visits and tracing updates and progress?

✧ **Alternative Care** arrangements for unaccompanied children and ongoing support for temporary / foster carers: This involves identifying and vetting interested families, training, regular follow-up with children in interim care, and continual, consistent support and monitoring of families providing interim care to flag and address any concerns. If single mission or highly mobile population and according to best interest principles, work to ensure unaccompanied children without a caregiver are placed with a family or connected to a caregiver prior to leaving. If possible, find a way to keep in contact with that caregiver or another key community member who can assist with check-ins for that family.

✧ **Case management** services for children with urgent or serious protection concerns, including but not limited to sexual violence, physical violence, child marriage, exploitation, neglect, other forms of abuse, association with an armed group, severe disability, no adult caregiver, adult caregiver who is unable to provide appropriate or adequate care due to illness or disability, etc…
- Is there a national Case Management SOP and does it include guidance for mobile service delivery (if deemed appropriate for the context)?
- What will be the timeline to complete and follow through on referrals?
- How will the team handle urgent, emergency cases requiring more intensive care and intervention?
- Is a Case Management / PSS Specialist available on the team to be a focal point for staff and particularly complex cases?

- Is there a plan in place for children in particularly vulnerable situations (e.g. children with disabilities or other often excluded children)?
- For cases of sexual violence, will the team travel with health care professionals who are carrying or have access to appropriate post-rape medical treatment? If not, how can the team promote timely access to specialized PSS and essential medication? Should be discussed with both GBV and Health colleagues. **Refer to "GBV guide for non-GBV Specialists in locations where specialised services are not available" when available early 2018.*

✧ **Community Engagement**: Several examples of ways to engage community members are listed above. Other means involve training parents / caregivers in positive parenting and caring for children affected by profound stress or traumatic events. Engaging adolescents where possible is vital as they could help and support younger children and/or offer ideas for ways to effectively engage their peers in productive activities & peer support.

✧ **Integration with other sectors:** Integration with health, nutrition, WASH, and education is extremely valuable when possible. As noted above, multi-sector teams are advisable, given that if mobile service delivery is deemed to be a necessary, appropriate intervention, then the population is likely to have multiple unmet needs. Thus, multidisciplinary teams will be beneficial to provide more holistic support.

One key benefit of multi-sector teams is that if a girl, boy, woman, or man is seeking assistance with a sensitive protection concern, reporting to an expert within a "multi-sector team" allows for greater privacy and dignity as the "community" is less likely to be aware of the specific issue they are reporting or the type of intervention / service they are requesting.

✧ **Material Support & Distribution:**

- Assess needs for material support if vouchers are not available in your context, including dignity kit items (e.g., soap, underwear, sanitary pads/cloths), baby kits, clothing, torches/flashlights, protective items (e.g., locks, etc.)
- Consider what protection risks might exist with distributing items, particularly if distributing to particularly vulnerable segments of the population. Will distribution put them at risk for theft or attacks?
- **Click here>>** for Menstrual Hygiene Management Guidance (2017)

Click on these examples and resource menu for more information:

- ✦ Protection Mobile Programming Resource Menu (2017)
- ✦ Iraq CP Coordination Group: CPiE Mobile Teams (2016)
- ✦ Iraq GBV Sub-Cluster: GBV Emergency Mobile Teams (2016)

The Alliance Community-based Child Protection Task Force is currently developing comprehensive guidance on child protection mobile programming, and the Global Protection Cluster is developing a Protection Toolkit, expected to be available by early 2018. Additionally, the Gender-Based Violence Area of Responsibility is developing guidance on GBV referrals and communication skills for non-GBV professionals, focused on locations with limited services available. These documents should be used as companion documents to this *working* document.

For more information or technical support and guidance, please contact the Child Protection Area of Responsibility Help Desk, Lauren Bienkowski at lbienkowski@unicef.org