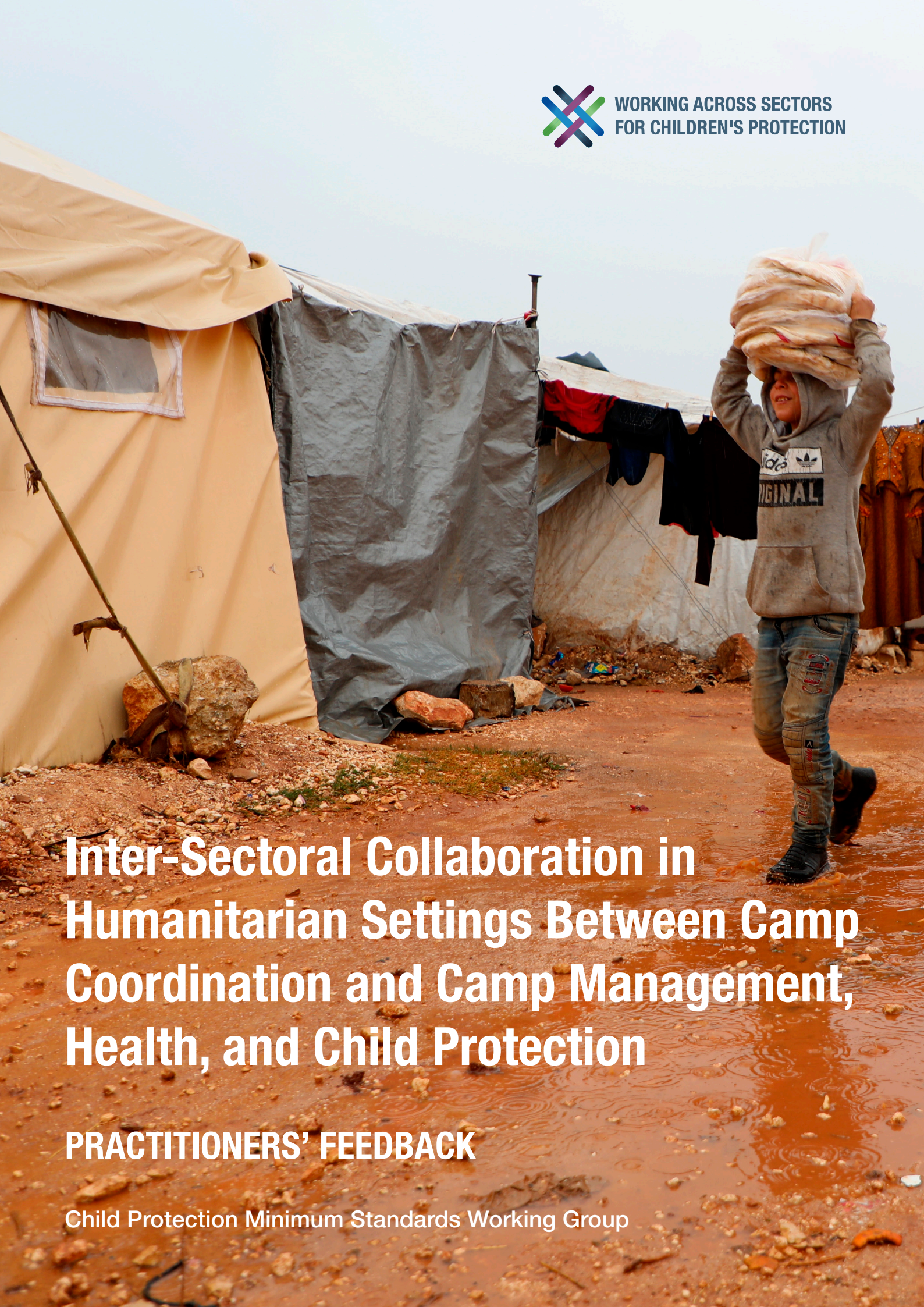

WORKING ACROSS SECTORS
FOR CHILDREN'S PROTECTION

Inter-Sectoral Collaboration in Humanitarian Settings Between Camp Coordination and Camp Management, Health, and Child Protection

PRACTITIONERS' FEEDBACK

Child Protection Minimum Standards Working Group

Gift of the United States Government

Impressum

This report was commissioned by the Child Protection Minimum Standards Working Group of the Alliance for Child Protection in Humanitarian Action. The study was conducted by Marleen Korthals Altes and Sarah Ann Uppard and edited by Janet Poules. Graphic Design: Diana De León. Photo (cover): Hadil Arja / Save the Children. First edition: 2022. For additional information, visit AllianceCPHA.org/en/WorkingTogether

CONTENTS

BACKGROUND

Whilst sector specific interventions are essential, a holistic and multisectoral approach is necessary to address the protection and well-being of children in humanitarian crises. Pillar 4 of the Minimum Standards for Child Protection in Humanitarian Action (CPMS) provides standards and guidance on child protection (CP) mainstreaming and cross-sectoral approaches to support children's protection and well-being. This includes Standard 28 on Camp Management and Child Protection.

In 2013, the Inter-Agency Standing Committee (IASC) made a formal commitment to placing protection at the center of humanitarian action. The Centrality of Protection recognizes that protection is the purpose and intended outcome of humanitarian action and must be at the center of all preparedness and response actions.[1] While there has been some success in promoting greater integration, few humanitarian responses are systematically addressing the centrality of children's protection and well-being across sectors. In 2016, the IASC adopted a Protection Policy to reaffirm the importance of protection in humanitarian action and emphasize its significance as a collective responsibility of all humanitarian actors, building on the commitment to the Centrality of Protection.[2] It aims to elevate protection to a system-wide responsibility rather than just a concern of the Protection sector. Secondly, it framed protection as an outcome that humanitarian actors should seek to achieve in terms of reducing risks to affected populations rather than just an activity to be undertaken.[3]

Furthermore, the Strategy 2021-2025 of the Alliance for Child Protection in Humanitarian Action — *A Clarion Call: The Centrality of Children and their Protection within Humanitarian Action* — reaffirms the centrality of protection. It includes a strategic objective to prioritize cross-sector collaboration, including within multi-sector and integrated programs, and across all humanitarian action.[4]

This practitioners' consultation is part of an initiative to strengthen CP mainstreaming and cross-sectoral/integrated approaches to support children's protection and well-being in humanitarian, refugee, and mixed settings. During the initial phase, four sectors are prioritized: Camp Coordination and Camp Management (CCCM), Food Security (FS), Health, and Education. The consultation focuses on practitioners' experience and knowledge of practices to collectively achieve CP outcomes through CP mainstreaming and cross-sectoral/integrated approaches.

This consultation explores both promising practices and missed opportunities in collaboration between CCCM and CP, and Health and CP. This includes collaboration on implementing activities, efforts to mainstream or integrate CP, and availability of relevant tools and resources for practitioners from each sector.

[1] https://www.globalprotectioncluster.org/tools-and-guidance/protection-cluster-coordination-toolbox/communication-package-on-protection/the-centrality-of-protection-what-it-means-in-practice/toolbox/communication-package-on-protection/the-centrality-of-protection-what-it-means-in-practice

[2] Inter-Agency Standing Committee's Policy on Protection in Humanitarian Action, 2016

[3] Centrality of Protection, Global Protection Cluster, 2017

[4] https://alliancecpha.org/en/child-protection-online-library/alliance-strategy-2021-2025-clarion-call-centrality-children

EXECUTIVE SUMMARY

CAMP COORDINATION AND CAMP MANAGEMENT AND CHILD PROTECTION

Key Informants (KIs) in this review noted several examples of joint action between CCCM and CP actors to reduce CP risks and promote the protection and well-being of children in camp settings, such as participation and consultative processes involving children and young people on CCCM and camps services as well as joint safety audits. However, the review revealed limited coherence across organizations regarding the level and scope of commitments towards the centrality of protection and the implementation of CCCM programs that purposely support the protection and well-being of children and other at-risk groups[5]. There are substantial differences in the modalities of mainstreaming, integration and child safeguarding approaches as KIs had different conceptual understanding of relevant terms, such as 'CP programs', 'CP mainstreaming', 'child safeguarding policies', 'Prevention of Sexual Exploitation and Abuse (PSEA)', and 'cross-sectoral or integrated approaches' across humanitarian organizations within the CCCM sector. KIs reported gaps in collaboration between CP and CCCM, including lack of tools to monitor the impact of collaboration efforts, and limited awareness of CP as a cross-cutting issue unlike GBV and/or PSEA – which are perceived as mandatory by KIs. They reported that guidance and tools focusing on practical tips to integrate CP and safety measures into CCCM, using language that is easily understood by CCCM staff, is most useful and impactful. It was also recognized that a minimum orientation and training on the basics of CP and child safeguarding for CCCM actors is necessary and should be mandatory at country level, but needs to be well-planned, preferably through inter-sectoral coordination.

Overall, there remains significant progress to be made regarding the systematic focus on the protection and well-being of children throughout CCCM programming and the roll-out and implementation of child safeguarding at the institutional level of organizations, both of which are critical to reduce risks and to enhance sector-wide outcomes for children.

HEALTH AND CHILD PROTECTION

Health sector KIs emphasized the fundamental role Health staff play in protecting children when taking a child-centered approach that recognizes children's specific vulnerabilities and the impact of health issues and the response to them. Health workers are often in a unique position through their daily contact with children and families; in some contexts, health services are better known, or considered more socially acceptable than protection services. This review found many examples of opportunities for Health actors to enhance their role in protecting children and the potential risks of not doing so; recent experience with the Covid 19 pandemic exemplifies this.

Broadly speaking, Health actors working for, or in partnership with organizations that have a CP/ child rights focus appear to consider the protection and well-being of children more consistently and to have made more progress in mainstreaming CP. Most key informants commented that it is easy to find intersectional points between Health and CP programs; for example, psychosocial support (PSS) and mental health, prevention and response to gender-based violence (GBV), and other forms of violence and abuse, birth registration and child marriage. Implementation of integrated/ joint programs was found to be more common in development settings where the focus is frequently on prevention and response to GBV. Gaps remain however, even in the application of minimum standards such as identification and referral (to CP actors) of Unaccompanied and Separated Children (UASC), or in cases of abuse, violence, and neglect. These gaps should be urgently addressed through awareness-raising and capacity-building initiatives targeted to Health actors.

Organizations implementing multi-sector programs (including CP) may have greater opportunities for integrated or joint Health and CP responses. For health programs to consistently contribute towards positive CP outcomes, a commitment at all levels of organizations is required, including ensuring sufficient resources for a quality response.

[5] https://interagencystandingcommittee.org/centrality-protection

METHODOLOGY

Both consultations used the same methodology which involved KI interviews and a review of grey literature using agreed search terms. The review tools were developed jointly by consultants with input from project leads.

KIs included CCCM and CP staff of different organizations, mainly at field level, based in different humanitarian contexts, including refugee and internal displacement settings. A standard questionnaire was developed and used for this purpose. A total of 11 KI interviews took place with staff from e.g., IOM, UNICEF, UNHCR, Save the Children and various CCCM Cluster Leads.

KIs for the Health review were identified through formal and informal networks of the involved organizations and included staff from INGO's, UNHCR and UNICEF, with most informants being at the global or country program level. A total of 10 KI interviews were conducted.

Whilst the findings of this brief review underscore the rationale for applying a CP lens in Health and CCCM interventions, it is difficult to reach clear conclusions about how comprehensively and consistently these sectors take the well-being and protection of children into consideration in humanitarian settings. This is due to methodological limitations such as: (a) the brief and limited time for this review; (b) a lack of interviews with field-based staff and national NGOs staff; (c) limited grey literature; and (d), minimal information on modalities and approaches and lack of measurement, particularly of outcomes for children. Finally, conclusions are hard to reach due to the wide variation at both conceptual and implementation levels within and between organizations and in different settings.

FINDINGS

Most of the findings for CCCM and CP relate to CP mainstreaming interventions and coordinated efforts between both sectors. The review captures less examples of integrated/cross-sectoral programs between CCCM and CP, since only a few of the KIs work in organizations that are operational and directly involved in both CCCM and CP. Integrated/cross-sectoral program design and implementation with common goals and outcomes to enhance the protection of children require joint, cross-sectoral strategic and operational planning and capacity as well as integrated monitoring and evaluation mechanisms. This is feasible for organizations which are operational in multiple sectors, including CP.

Within some organizations, there is evidence of increased awareness and a significant amount of activity by Health and CP actors designed to ensure that the protection and well-being of children are considered when implementing health programs. However, the modalities regarding implementation are not well defined and there is limited information on positive outcomes resulting from these activities due to a lack of monitoring, evaluation, accountability, and learning. As this makes it difficult to draw conclusions on promising practices, information in the following section provides a snapshot of what is currently in place and some examples of emerging promising practices.

CP-SENSITIVE CCCM PROGRAMS: GOOD PRACTICES AND DESIRED OUTCOMES

Guidance and tools at global level

At the global level, the Inter-Agency CCCM Toolkit (2015)[6] and the Inter-Agency Minimum Standards for CCCM (2021)[7] refer to the CPMS. The CCCM Toolkit also mentions child-friendly spaces (CFS) and schools or temporary learning spaces (TLS) as part of the guidance for on-site planning. Most CCCM KIs interviewed for the review noted that they are aware of the CPMS and its use.[8] All KIs noted the relevance of implementing CCCM through a CP lens, reducing risks and promoting the protection and well-being of children.

KIs noted that amongst some actors, both CP mainstreaming and integration of programming across sectors is better understood by CP staff after the revision of the CPMS (including Pillar 4) in 2019. KIs also revealed that INGOs that are operational in multiple sectors, including CP, have generally made more progress with regard to CP mainstreaming, integrated/cross-sectoral programming, and child safeguarding measures.

Community participation in CCCM, including of children and young people

Community participation is a cornerstone of CCCM work and is considered an important part of protection mainstreaming. Hence, there are good practices regarding **participatory approaches**. Generally, these involve consultations in camp settings through focus group discussions with different demographics, including children and young people.[9] Findings can provide a more in-depth understanding of the issues that children may face and the gaps that need to be addressed; they also promote meaningful participation, including in the design and running of camps. Consultative processes are considered particularly meaningful, where decision making regarding camp management is influenced by the voices of children and young people.

Other examples include **safety mapping exercises** in camp settings conducted **with children**. Children of different age groups drew a map of the camp and indicated where they felt safe, where experienced — or feared facing — risks and dangers, and the reasons to influence the implementation of certain safety measures in the camps.

In addition, examples of **reporting and feedback mechanisms** concerning camps set-up and management, including services, were cited. These

[6] https://cccmcluster.org/resources/camp-management-toolkit
[7] https://reliefweb.int/report/world/minimum-standards-camp-management-2021-edition
[8] Most respondents stated they were not aware of Pillar 4 of the CPMS and Standard 28 on CCCM and its use by CP actors.
[9] This review did not look into practices of children participation within the CCCM sector at a more detailed level, such as standards, principles and ethical considerations being applied by different CCCM actors, as this was beyond its scope.

mechanisms are also accessible to children and in some instances, reveal issues concerning the protection and well-being of children that need to be addressed by camp management, in coordination with CP actors. Most examples related to 'complaints boxes', where children and young people can submit suggestions and feedback regarding CCCM and services provided in the camp.

Joint sector-wide initiatives to promote children's protection

Examples also included the development of **safety audits and tools** to be used at camp level by CCCM staff assessing protection risks factors faced by different groups, including children and their families. In Somalia, the CCCM Cluster carried out inter-cluster safety audits in IDP camps, jointly with several other clusters, including the CP Sub-Cluster, and issued a joint report, reflecting on findings and recommendations for the way forward. KIs highlighted that safety mapping and planning, including through a child lens, is particularly impactful, when it takes place prior to and/or during the construction and/or set-up of the camp.

Another good example of a coordinated, cross-sectorial approach is guidance regarding the **set-up of quarantine and isolation areas in IDP camps**, which was developed jointly by the Iraq Health Cluster and the Iraq Shelter Cluster, with inputs from several sectors, including CP and CCCM, following the outbreak of Covid-19.[10] The guidance lays out measures for children and families that are separated while residing in quarantine and isolation areas, such as referral of such cases to CP actors, to arrange for temporary alternative care and monitoring and support.

CP services at camp level and coordination

Several staff interviewed for this review mentioned the importance of their role in **coordinating and monitoring services** in camp settings, including **CP services** and **referral mechanisms.** Interviews noted that CCCM staff are sometimes trained on **basic referral and identification of children at risk**.

Capacity strengthening

NGOs with a CP mandate also deliver training or awareness-raising sessions on CP mainstreaming for staff of other sectors, including CCCM, however, often on a more ad-hoc basis, depending on available resources, as noted by different KIs.

Efforts to institutionalize working across the CP and CCCM sectors

NGOs with a CP mandate and multiple sectoral programs generally demonstrate progress and strengths in cross-sectoral or joint programming and CP mainstreaming initiatives targeting internal and partner staff. Regarding CCCM, this seems to be the case for NGOs involved in CP, Shelter, and WASH programs, working closely with CCCM actors.

The review noted that **Save the Children has adopted a Centrality of Protection Policy in 2021**, which outlines the collective responsibility for protecting the most vulnerable children from harm by achieving protection outcomes for children across their humanitarian response. The approach has been piloted in several countries and the policy has been rolled out across the organization. This example is unique.[11] One KI, who works in the Shelter sector in a country where the strategy is currently being rolled out, showed a high level of knowledge and understanding and a clear sense of common responsibility towards CP and child safeguarding and how to integrate this in daily CCCM and Shelter activities to reduce risks and promote sector-wide outcomes for the protection and well-being of children. The roll-out of this strategy can lead to a positive impact on outcomes for children in camp settings, where the organization plays a role in sectors closely linked to CCCM, such as WASH and Shelter.

CP-SENSITIVE HEALTH PROGRAMS: GOOD PRACTICES AND DESIRED OUTCOMES

Training and capacity strengthening

This review found frequent references to training in program proposals and KI interviews. Those training activities include child safeguarding, mainstreaming, identification, and referral of children facing CP risks

[10] COVID-19 Outbreak Preparedness and Response in IDP Camps Establishment and management of Quarantine and Isolation areas, Iraq Health Cluster, Iraq Shelter Cluster, October 2020 https://reliefweb.int/report/iraq/covid-19-outbreak-preparedness-and-response-idp-camps-establishment-and-management

[11] Independent Review of the IASC Protection Policy, First Draft, March 2022

such as UASC, prevention and response to GBV/violence/abuse, psychological first aid (PFA) and PSS. Target groups include agency Health staff and partners, including health surveillance teams, community volunteers and in some cases Health staff from government ministries of Health. Training at country program/field level is likely to be delivered through one-off workshops conducted by CP staff. Capacity strengthening through for example coaching, mentoring or on-the-job training is much less frequent.

Core Health staff working for one humanitarian INGO participate in mandatory and repeated child safeguarding and CP trainings; even though time consuming, this had the effect of ensuring a continued awareness on CP and well-being as well as clinical issues. Senior Health staff who had participated in these training activities demonstrated an understanding of safeguarding.

Program design and development

Interventions and approaches related to program design and development included involving children in participatory program design and using a CP lens when developing health facilities and services. Examples of the latter are ensuring that clinical response for GBV survivors involves child-appropriate medications and medical instruments, and health settings are child-friendly and gender-sensitive; including Mental Health and Psychosocial Support (MHPSS) staff within mobile health programs; setting aside a physical space in health facilities for the provision of PSS/mental health support and counselling for children; and appointing CP focal points or setting up CP desks at health clinics and therapeutic feeding centers for reporting of GBV and family violence. KIs also highlighted the importance of program managers/advisors contributing to proposal development across sectors and facilitating the review of guidance for development of health settings by a CP specialist.

The importance of geographical integration e.g., locating CFS's next to health facilities was highlighted by KI's. One health program is developing the use of an 'integration marker'; a matrix showing where issues intersect across sectors to highlight the need for cross sectoral work and in another example designed to promote integration, an approach is being piloted whereby generic program officer (PO) job titles are used (whilst the PO's maintain responsibility for their own sectors).

Joint program activities

KIs referred to the following joint activities as frequently implemented between Health and CP: awareness-raising and provision of information on common childhood illnesses at child-friendly spaces; awareness-raising of CP issues through health interventions, including mother-to-mother support groups, life skills sessions for adolescents, and child-friendly GBV interventions such as clinical services, GBV helplines and work with men and boys. Greater integration of sectoral community volunteers through joint training/regular meetings across sectors and cross referral was seen as an important means of improving CP outcomes.

Health and CP staff have worked together to develop CP messages for dissemination through health programs, child-friendly messaging on health issues for dissemination through CP programs, and common procedures for documentation and mutual referral. Additionally, joint case reviews are sometimes conducted when GBV survivors are referred from Health to CP teams and selection criteria for program activities is shared between sectors.

CHALLENGES AND MISSED OPPORTUNITIES IN COLLABORATION BETWEEN CCCM, HEALTH AND CP

Common challenges

While all interviews noted that a collaborative approach and awareness on CP across sectors, including CCCM and Health, is crucial to meet the holistic needs of children and to ensure adequate measures are taken to work towards collective outcomes for the protection of children, it was acknowledged that there is still **need to strengthen common, institutionalized practices in a more organized and systematic manner**. The following challenges were identified by KIs from both CCCM and Health sectors (organizational and cluster/sector level).

- Both CCCM and Health staff who are not working for organizations implementing CP programs usually have a less clear understanding of CP programming, risks, and vulnerabilities. This in turn makes these vulnerabilities and risks less reflected in programming;

- Capacity building is not structured nor systematized: trainings on CP issues for Health and CCCM workers take place either at an ad-hoc level, are not organized through coordination groups (clusters/sectors) or are not followed up upon (one-off training activities);
- Capacity building may not respond to actual needs of Health and CCCM workers in a way that would strengthen their capacity to identify, mitigate, refer and respond to sensitive CP situations;
- Insufficient human resources at organizational level to provide capacity building for sectoral staff members;
- There is a limited understanding of definitions and concepts such as CP mainstreaming, integration, joint programming, child safeguarding, PSEA and age, gender, and diversity;
- Organizations are at different stages in the way their health programs support children's protection and well-being. While there are variations within organizations, findings seem to suggest that health programs which are not part of multi-sector (i.e., CP and other sectors) organizations are less likely to systematically integrate CP considerations. However, given the limitations of the review, further/research it this regard is needed.
- Lack of commitment at all levels of an organization to institutionalize the efforts to promote children protection and well-being across programs;
- Lack of geographical integration, particularly in a large-scale emergency response where the needs are extensive;
- Lack of practical information, tools, as well as measurement indicators (e.g., for safe identification and referral);
- Lack of detail on modalities for implementation and limited evidence on the impact of training or program activities on outcomes for children.

Missed opportunities and unaddressed risks

The section below highlights **missed opportunities** in the collaboration between the CP and Health and CP and CCCM sectors, and the **risks** for children due to such missed opportunities.

CCCM: Physical risks

Several KIs provided examples of accidental deaths of children due to physical hazards. One example related to children who fell into a landslide because of excavation work in a refugee camp. Another example described children who accidentally died after falling into a water stream that was not well fenced off just outside the camp. Also, children accidentally died because of traffic accidents in camp settings or due to electric wiring that was not well finished off or maintained in informal displacement settlements. Other examples related to pit latrines that are too large for children and involved the risk of falling into them.

One example cited an area hosting very large numbers of IDPs in which many children swam in flooded zones nearby the camps, due to limited availability of daily activities for children and young people in the camps, such as PSS, life skills, and informal and formal learning activities. KIs noted that children drowned and accidentally died on a regular basis, and their deaths were recorded in monthly incident reports by the CCCM sector. In that area, CP and education programs were scaled down or ended because of significantly reduced funding over the years.

CCCM: Other CP risks

Some examples of child labor incidents involved companies contracted by humanitarian actors. During interviews, CCCM staff mentioned other CP risks, e.g., recruitment by armed groups, abduction, exploitation, and neglect, but stated they did not know of concrete examples.

CCCM: Lack of emphasis on CP and safeguarding

Several interviews noted an overall emphasis on awareness-raising and training of CCCM staff on GBV and PSEA affecting women and girls, rather than the prevention of harm to children and/or other vulnerable groups, such as persons with disabilities and/or persons who are part of the LGBTI community. The majority of CCCM staff interviewed for the review perceive GBV as a cross-cutting issue, while there is not yet the same level of understanding regarding the protection of children as a cross-cutting issue. KIs noted that in most organizations training on GBV and/or PSEA is mandatory, while

within various organizations, including some that are active in CCCM, training on the protection of children, child safeguarding and other cross-cutting themes is optional. Some KIs from both the CCCM and Health sectors felt that the emphasis on PSEA and GBV is disproportionate and that, as a result, CP, inclusion, and diversity mainstreaming exercises have been deprioritized.

Regarding CCCM, this may in part result from the structure and contents of the global CCCM Toolkit. Potential CP risks and mitigation and response measures at camp level are merged into the chapters covering Protection and People with Special Needs (PSN), whereas there is a separate chapter dedicated to GBV and an emphasis on GBV as a cross-cutting issue throughout the toolkit.

Also, both the CCCM Toolkit and Minimum Standards mainly refer to CP in terms of specific categories of children at risk or specific CP issues, but a clear definition of CP is currently missing.

Health: Sectoral community volunteers

The common practice whereby each sector works with their own community volunteers can hinder the integration of CP or lead to missed opportunities, according to some KIs. All too often community volunteers work in silos, with no structure for communicating with one another. This is particularly important in relation to Health and CP, where community volunteers can have a critical role as the 'eyes and ears' of communities. There is also a concern that communities 'switch off' due to multiple messages from different sectors.

Health: Unaligned sectoral ways of working

Differences in organizational culture, approach and operating principles between Health and CP actors could present missed opportunities according to some KIs, especially if these differences are not recognized and addressed. KIs mentioned that some Health actors working in humanitarian settings could be more likely to implement their programs in a more independent and autonomous way. They may focus on immediate emergency needs, without necessarily linking to broader systems, and on clinical aspects of healthcare, as opposed to taking into greater consideration the role of social determinants of health. These approaches may lead to missed opportunities in collaborating with CP. Concerns about confidentiality and information sharing, especially with non-medical actors and particularly where mandatory reporting is required, also hinder potential collaboration between CP and Health.

GOOD PRACTICES AND OPPORTUNITIES IN COLLABORATION BETWEEN CCCM, HEALTH AND CP

CCCM and CP

Both the Inter-agency CCCM Toolkit (2015) and the Inter-Agency Minimum Standards for CCCM (2021) refer to the CPMS and include relevant elements on mainstreaming and cross-sectoral/integrated programming to promote sector-wide outcomes for children.

There are some good examples of INGOs, which are operational in CP and other sectors, making significant progress in terms of supporting children's protection and well-being. This review's findings indicate that the capacity, quality, and level of commitment towards CP mainstreaming and cross-sectoral approaches differ among humanitarian actors, including those responsible for CCCM, and are linked to organizational priorities, strengths, and gaps. Additionally, the review demonstrates that CP mainstreaming and integrated, cross-sectoral approaches to achieve holistic CP outcomes can only be effective if the necessary, additional human resources are in place, as well as commitment of senior management within organizations.

According to CCCM staff interviewed for this review, the level of mainstreaming and cross-sectoral exercises is often influenced by the availability of resources, personal relationships, and the presence of a driving force on the part of the CP sector and senior management within organizations and at coordination level.

Several respondents indicated that the involvement in — and commitment towards — CP mainstreaming and cross-sectoral/integrated programming varies across country operations within their organization, which makes it difficult to draw general conclusions regarding progress towards achieving collective CP outcomes. Barriers for cross-sectoral collaboration also relate to the current humanitarian architecture, funding cycles, the drive to meet sector-specific outcomes and

competition for funding. Several KIs working in the CCCM sector mentioned the difficulty of some donors pushing to work in sector-specific areas.[12]

It was recognized that more systematic orientation and capacity strengthening on CP-sensitive programming would be necessary and beneficial for the CCCM sector. One-off awareness-raising sessions on mainstreaming-related matters are generally found less effective and can easily become a tick-box exercise. More regular, practical, short sessions would create awareness among staff of the relevance of CP mainstreaming and how to apply this in their day-to-day work. Several interviewees stated that training on CP should be mandatory across all organizations and not optional. Staff interviewed for the review also underlined that capacity-strengthening initiatives regarding CP should be part of a wider protection training package, covering protection, CP, GBV, and inclusion and diversity.[13] Careful planning of such orientation and training sessions needs to be strengthened, to avoid overburdening staff with training and awareness-raising sessions, considering their often-heavy workloads.

Initiatives regarding safety mappings or audits and the development of accompanying tools, including through joint efforts with the Protection and GBV sectors, are positive examples within the CCCM sector of reducing risks and promoting children's protection. Sharing of such country-specific good practices and relevant guidance and tools, as well as the development of standardized guidance and tools within the CCCM sector, would help to further advance ways to work towards collective CP outcomes. The use of guidance and tools for safety mapping and planning through a child lens, to be rolled out in camp settings prior to and/or during the construction and/or set-up of camps, could be included in sector work and preparedness plans.

Within the CCCM sector, the use of participatory methods to hear children's and young people's voices regarding the planning and services provided in camps is promising. Learning could be generated relating to methods and approaches of participatory consultation processes and experiences of CCCM actors to further promote standardized and child-friendly methodologies and to support other sectors.

As highlighted by most staff interviewed for this review, the GBV sector has made significant progress regarding GBV mainstreaming and reporting, and the development of practical guidance, tools and training materials, including at inter-agency working group or cluster level, and especially where GBV actors and/or GBV sub-clusters are actively driving these efforts.

Generally, the use of practical tools, such as tip sheets in an easy-to-understand language, are found most effective and 'doable' for non-specialized staff, while guidance containing technical language, theoretical concepts and/or aspirational goals are found less effective as they can be perceived as 'daunting' and unintentionally create the belief that specialized knowledge and skills are required to implement them.

It was noted that the above-mentioned efforts are not yet driven by the CP sector on a systematic or regular scale. More recently, some organizations are working to add CP as well as inclusion and diversity-related matters to training and awareness-raising sessions for CCCM and other sectors' staff.

The CP sector can learn from the GBV sector what works and what doesn't with regard to GBV mainstreaming and integration, and review existing tools, resources and lessons learned.

Health and CP

Emerging approaches

There is a natural synergy between Health and CP in relation to preventing violence against children (particularly in relation to maternal and child health) and developing programs for adolescents. Both issues were the focus of a range of integrated CP and health interventions, some grounded in evidence-based approaches, and these are summarized below. Further analysis, including application of learning from development settings could lead to identification of promising practices.

[12] More broadly, other frequently cited factors mentioned during interviews are that the level of collaboration and coordination across sectors within and across organizations are substantially impacted by the priorities of their leadership and/or the humanitarian coordination structures (e.g., the Humanitarian Country Coordinator, Humanitarian Country Team, Sector Coordinators, etc.).

[13] Building on the existing Protection Mainstreaming Toolkit, Global Protection Cluster, Task Team of Protection Mainstreaming, 2017

A focus on preventing violence against children and promoting healthy child development[14]

Strengthening the capacity of Health staff working in primary and secondary healthcare can have a significant impact on the protection of children. Community Health Workers (CHWs) frequently encounter violence against children in households and more broadly through their work and can play a key role by educating parents, promoting caregiver skills, identifying children and families at risk, and providing community-level referrals for CP interventions. A 2019 study of the work of CHWs by World Vision covered four countries and concluded that given CHWs role in actively responding to violence against children on a regular basis, policy changes should ensure adequate support for them, such as training, supervision, and safety mechanisms to support their work with families[15]. According to the study, there is significant potential to scale up interventions to end violence against children through CHWs. Also, several KIs mentioned WHO's INSPIRE strategies and the Nurturing Care Framework[16], which provide tools, approaches, and strategies to address violence against children and support their well-being in early years.

A focus on programming for adolescents

In addition to infants and young children, Health workers frequently come into contact with adolescents, particularly in relation to sexual and reproductive healthcare, and because of public health programs that often target adolescents. Health sector activities identified in this review included establishing youth-friendly services; developing youth peer groups; working with school nurses, teachers and community partners to increase knowledge on Adolescent Sexual and Reproductive Health (ASRH) as well as providing clinical services in ASRH; strengthening referral mechanisms; establishing crisis help lines or counselling services; building of positive relationships with peers and family and advocacy with government ministries to improve the policy environment for adolescents. Several organizations have developed and implemented life skills curricula encompassing SGBV, ASRH, resilience and mental health, diet and nutrition, addiction (drugs, alcohol, and smoking), and prevention of violence. It was noted that health responses for GBV or working with youth affected by HIV are more likely to include a social worker as part of the team. The importance of applying a gender lens when developing programs for adolescents was highlighted, for example using the IASC Gender with Age Marker[17].

Child marriage was highlighted by several KIs as a key CP concern where health programs can make a valuable contribution. The importance of a multisectoral response was emphasized noting that rather than approaching from a perspective of child rights/child abuse, which might clash with cultural beliefs, Health actors have focused their discussions with communities on the physical consequences and psychological impact of early pregnancy on young girls who are not fully developed for childbirth. World Vision's campaign materials on taking action to end child marriage provide examples of health program interventions and indicators for monitoring and evaluation.

Infectious disease outbreaks: Covid 19 response

The Covid 19 pandemic brought new challenges, further highlighting the importance of integrated CP and health programs. New potential CP risks arose, and existing protection concerns and vulnerabilities were exacerbated, especially for children in displacement settings, as a direct consequence of the infectious disease and of the response measures. As Health actors were more likely to have direct face-to-face contact with parents/carers and children during this time, their role in supporting well-being, identification of CP concerns ,and referrals was crucial.

The CP sector rapidly generated an extensive body of guidelines, tips and protocols relating to CP and Health in relation to Covid 19. The Health sector, including the World Health Organization, also generated guidance, which contained information on provision for children and prevention of separation at quarantine facilities, such as

[14] The focus of this review was on integrated health and CP programs, but the role of nutrition actors, especially infant and young children feeding (IYCF), and education actors through early childhood development (ECD), are often critical components along with health in relation to maternal and child health.

[15] World Vision, It Takes a Community: Health Workers to End Violence Against Children, 2019, Summary of new research findings by World Vision, 2019.

[16] WHO, INSPIRE: Seven Strategies for Ending Violence Against Children, led by the World Health Organization (WHO) 2016, Nurturing Care Framework and associated guidance: https://nurturing-care.org

[17] https://www.iascgenderwithagemarker.com

appointing a CP focal person for each facility. Country programs also developed their own recommendations – for example in Cox's Bazar comprehensive guidelines and training materials were developed through the CPWG and PWG. In Erbil, Iraq, the Health and Shelter clusters produced an extremely comprehensive preparedness document[18], which included guidance in relation to potential alternative care needs linked to Covid infection. According to KIs interviews, there was strong awareness of CP concerns, reflected in the inclusion of appropriate activities to mitigate and respond to these, for example training on CP, development of child-friendly messaging, integration of case management into Covid response, and strengthening of referral mechanisms. However, this was not the case in all settings and a review of grey literature highlighted important gaps in planning for or addressing CP issues when responding to Covid 19.

[18] COVID-19 Outbreak Preparedness and Response in IDP Camps Establishment and management of Quarantine and Isolation areas, 7 October 202

OPERATIONAL RECOMMENDATIONS

CAPACITY-BUILDING RECOMMENDATIONS FOR ALL SECTORS

Capacity building should be coordinated at cluster/ sector level and done in a systematic way within a holistic plan, thus moving away from one-off training activities that may not respond to specific needs of cross-sector staff:

- Develop capacity building plans at inter-sectoral/inter-cluster levels to build capacities on centrality of protection and working across sectors.
- Systematically train all new Health and CCCM staff on child safeguarding policy and protocols (with annual refresher training for existing staff).
- Consider collaborating with the Health and CCCM sectors to agree on minimum mandatory staff training/orientation on child protection and safeguarding.
- Train and strengthen the capacity of CCCM and Health staff on CP principles, approaches and concerns, including identification of abuse, violence and neglect and referral pathways.
- Strengthen CCCM, Health and CP staff capacities on core humanitarian standards, the cluster system, and each sector's mandates to promote a deeper understanding of possible ways of collaboration.
- CCCM: Explore opportunities to pilot a CP mainstreaming training at the CCCM cluster/ working group level in selected pilot countries.
- Health: Promote the rollout of WHO's forthcoming publication Responding to child maltreatment: A clinical handbook for health professionals.
- Health: Train CP staff on healthcare referral mechanisms and disease early detection.
- Health: Deliver additional training and capacity strengthening for Health actors working on integrated/joint programs who need a wider understanding of CP/topic-specific knowledge through e.g., blended learning approaches, on the-job-training and mentoring.

RECOMMENDATIONS FOR THE CP SECTOR

- Continue running presentations on CPMS Pillar 4 for other sectors, including CCCM and Health, through in-country coordination mechanisms.
- Develop user-friendly IEC materials on working across sectors, including for electronic dissemination.
- Collaborate with the CCCM sector on the development of standardized CP safety audit tools and child-sensitive feedback mechanisms (to be contextualized) for camp settings.
- CP actors should redouble their efforts to ensure Health actors are fully aware of the potential direct and indirect impact of IDO's and the response measures e.g., lockdown and confinement, on the protection and well-being of children in order to:
  a) improve the response of Health actors, particularly in relation to identification and referral of CP concerns, and
  b) provide Health actors with the necessary information and knowledge to enable them to advocate for face-to-face CP services to be maintained.
- CP actors should engage with other sectors to agree upon relevant information-sharing protocols between CP and other sectors, including Health, as well as the means to track and follow up on referrals.
- Monitor and analyze referrals of at-risk children done by Health staff to CP programs to measure success and provide information on trends and issues.
- Engage with and support CP sub-clusters and working groups at field level through standardized monitoring and evaluation tools to measure collective, cross-sector CP outcomes.
- Build on successful initiatives, such as collaboration between GBV and other sectors and the growing emphasis on PSEA, and seize opportunities to engage in other sectors' standards revisions.

RECOMMENDATIONS FOR THE HEALTH SECTOR

The following are important ways in which the Health sector can contribute to the protection and well-being of children and priority areas for capacity strengthening and integrated CP and health interventions.

- Identification, response, referral and follow up of child abuse, violence, including sexual violence, and neglect and other CP concerns such as UASC.
- Health interventions in schools e.g., supporting school nurses and social workers in relation to identification, response and referral of child abuse, violence and neglect as well as implementing prevention programs around physical and sexual violence.
- Supporting parents through (a) home visits by Health workers, particularly in relation to those who find it difficult to access healthcare e.g., due to marginalization, distance from service providers or vulnerability such as disability and (b) stand-alone programs to support parents such as positive parenting or mother-to-mother support groups.
- Include children's protection and well-being in measurements and outcome and output indicators and qualitative data collection in program evaluations where relevant and possible.
- Include CP-related issues in health quality benchmark checklists for regular health service delivery points, including an indicator on identification and referral of children at risk.

RECOMMENDATIONS FOR THE CCCM SECTOR

- Explore possibilities to include response plan indicators on basic identification and referral of children at risk by CCCM actors, aiming to measure progress and analyze data to draw lessons.
- Review participative methodologies involving children and young people and support standardized, child-friendly consultative processes in line with the CPMS to reduce risks and promote children's protection and well-being.
- Include children's protection and well-being in measurements and outcome and output indicators and qualitative data collection in program evaluations where relevant and possible.

RECOMMENDATIONS FOR ALL SECTORS

- Provide support for quality monitoring, evaluation, learning and accountability to measure the impact of activities to promote children's protection and well-being and to draw lessons from them.
- Promote youth-led participation in monitoring and evaluation and advocacy initiatives.
- Include CP-related issues in health quality benchmark checklists for regular health service delivery points including an indicator on identification and referral of children at risk.

RECOMMENDATIONS AT ORGANIZATIONAL LEVEL

- A commitment to the centrality of children's protection should be clearly communicated at all levels of organizations and the necessary human and financial resources made available to support a quality response.
- Organizations working across sectors should consider geographical integration during program design to encourage greater integration of CP considerations in health programming where possible and appropriate.
- Encourage the inclusion of references to children's protection and well-being and child safeguarding in line with the CPMS (including Standard 28, Pillar 4) in partnership agreements.

RECOMMENDATIONS FOR DONORS

- Grants to be linked to activities that support the protection and well-being of children and working across sectors.
- A more flexible timeline for submission of integrated program proposals to allow for joint participatory assessments and development of joint indicators. -