Global Child Protection Area of Responsibility

Response framework guidance

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1 INTRODUCTION

Purpose of the Document

This document serves as a structured framework for monitoring and reporting child protection interventions within intersectoral humanitarian response operations. It is designed to standardize data collection, enhance results-based reporting, and ensure alignment with the Humanitarian Needs and Response Plans **(HNRP)**. The framework supports partners in tracking key child protection activities, outputs, and outcomes, providing critical evidence for response planning, resource allocation, and advocacy efforts.

Link to the HNRP and Sectoral Standardization

The **HNRP process, led by OCHA**, seeks to standardize data collection and reporting across humanitarian sectors. This document aligns with those efforts by establishing a consistent set of child protection indicators that reflect key interventions and their impact on affected populations.

Integration with the 5Ws and Reporting Mechanisms

This framework is designed to facilitate the use of existing humanitarian reporting tools, particularly the **5Ws**. The indicators included in this document support and refine 5W reporting by providing:

- Clear definitions of what needs to be measured.
- Consistent data collection methods that allow for comparative analysis across agencies.
- Guidance on interpreting output-level data to infer child protection outcomes.

Data collection frequency will be determined by the CP AOR in coordination with partners, aligned with their reporting cycles and operational timelines.By aligning with the **5Ws and HNRP reporting requirements**, this framework enables **stronger coordination, minimizes duplication, and ensures that child protection interventions** are well-documented and effectively integrated into broader humanitarian response efforts.

2 HOW TO USE THIS DOCUMENT

- **For Program Planning** – Use the indicators to design child protection programs aligned with global humanitarian standards.
- **For Data Collection** – Follow the outlined definitions and methodologies to ensure accurate and consistent data reporting.
- **For Analysis and Advocacy** – Utilize the **Outcome Analysis Cheat Sheet** to interpret raw data and demonstrate progress toward child protection outcomes.
- **For Coordination** – Align reporting with the **5Ws** to contribute to a consolidated picture of child protection interventions across agencies.

This framework is a **living document**, subject to further developments as the **HNRP process evolves** and reporting standards across sectors continue to improve. **Partners are encouraged to engage in continuous feedback and collaboration** to enhance its effectiveness in driving evidence-based child protection responses.

- All indicators listed in this framework will be available in an Excel sheet annex. The annex includes:
    - Expanded indicator definitions
    - Information on data collection methods
    - Disaggregation requirements
    - Collection frequency
    - Sector cross-tagging where relevant
- Users should refer to the annex to access full details on each indicator before deciding which indicators to implement in their context.

2.1 Key Components in the Response Framework Indicators Document

Each column in the framework is designed to **capture essential data** that supports **evidence-based planning** and alignment with the **HNRP**.

1. Sub-Theme

Specifies the category or area within child protection that the indicator addresses, aligned with **CPMS indicators**.

2. Indicator

- The measurable aspect of a program or service being tracked. Provides a clear measurement of activities, outputs, and outcomes to assess progress.

3. Level of Indicator

Specifies whether the indicator measures **inputs, outputs, or outcomes**.

4. Unit of Measurement

Indicates how the indicator is quantified, for example Number or Percentage or Ratio**.** calculated based on the numerator and denominator

Numerator: The specific count or subset being measured (e.g., *number of children attending psychosocial sessions*).
Denominator: The total population or group relevant to the indicator (e.g., *total number of registered children in the program*).

Note: Most indicators in this framework are quantitative (e.g., co unts, totals, or percentages). Ratios are rarely used and only applied where comparative analysis is critical (e.g., calculating caseworker-to-child ratios for service quality).

5. Indicator Definition

Provides a detailed explanation of what the indicator measures and how it is calculated.

Ensures clarity and comparability across different partners.

6. Disaggregation

Specifies how the data should be broken down for detailed analysis.

- **Examples:** Age, gender, disability status, geographic location, vulnerability status.

Ensures equity in programming and allows for targeted interventions.

7. Data Collection Method

- **Definition:** Describes the tools or processes used to gather data.
    - Surveys (household, facility-based).
    - Attendance sheets, records.Focus group discussions.
    - Service records (case management databases like CPIMS+).
    - Monitoring reports.

8. Data Collection Frequency

- Specifies how often data is collected and reported.

9. Sector Cross-Tagging

Identifies how the indicator aligns with **other humanitarian sectors**.

11. Outcome Analysis Cheat Sheet

Provides guidance on how to analyze and interpret output-level indicators to infer broader protection outcomes without requiring additional data collection.

- Helps translate raw output data into actionable insights.
- Assists in assessing whether outputs contribute to expected child protection outcomes.
- Provides an analytical lens to evaluate effectiveness beyond numbers.

3 GUIDANCE FOR DEVELOPING MULTI-AGENCY, MULTI-PROGRAM OUTCOME ANALYSIS FOR HNRP REPORTING

This guidance is tailored for synthesizing outcome-level analysis for **HNRP**. It focuses on aggregating data from multiple agencies and programs to provide a comprehensive overview of progress toward collective outcomes. Below are the steps and considerations for developing HNRP-related outcome analysis:

Step 1: Define Collective Outcomes

- Align the analysis with the HNRP's strategic objectives and sectoral outcomes.
- Focus on collective outcomes that reflect the combined impact of multiple agencies and programs.

Step 2: Aggregate Multi-Agency Data

- Collect and consolidate output-level data from partners' agencies and programs using the 5Ws and the indicators from this tool.
- Using the indicators from this list will ensure that data is standardized and comparable

Step 3: Analyze Trends and Patterns

- Identify trends across agencies and programs to assess collective progress.
- Look for patterns in service delivery, geographic coverage, and demographic reach.

Step 4: Assess Equity and Inclusion

- Disaggregate data by age, gender, disability, and geographic location to evaluate equitable access to services.
- Identify gaps in reaching marginalized or underserved populations.

Step 5: Evaluate System-Wide Functionality

- Assess the functionality of cross-sectoral systems (e.g., referral pathways, case management, or community-based structures).

Step 6: Share Analysis with CP Coordination Groups

- Map and share the aggregated analysis with partners in the CP coordination group. This step ensures that the analysis adds value to partners and informs their planning efforts. Facilitating discussions around the data can support operational decision-making, address identified gaps, and strengthen collective response efforts.

Step 7: Synthesize Findings into a Collective Outcome Statement

- Combine quantitative and qualitative insights into a concise narrative that highlights collective progress, challenges, and recommendations.

Step 8: Highlight System-Wide Challenges and Recommendations

- Identify systemic challenges that hinder collective progress (e.g., coordination gaps, resource constraints, or geographic barriers).
- Provide actionable recommendations to address these challenges at the inter-agency level.

Step 9 Tailor the Analysis to HNRP Stakeholders

- Adapt the level of detail and language to suit **HNRP stakeholders** (e.g., donors, government partners, or cluster leads).
- Example: For donors, emphasize measurable progress and return on investment. For government partners, focus on alignment with national priorities and sustainability.

3.1 Key Outcome Analysis Components

1. **Access & Equity**
    - Examine if services are equitably distributed across demographics and regions. also assessing referral effectiveness across Sectors to determine if referrals from schools, health facilities, and other sectors are functioning effectively,
    - **Data Analysis Tip:** Use **disaggregated data** to identify gaps in services.
2. **Service Utilization**
    - Analyze how well the services meet identified needs.
    - **Data Analysis Tip:** Compare service figures against the **population in need**.
3. **Sustainability of Services**
    - Assess long-term **stability and effectiveness** of interventions.
    - **Data Analysis Tip:** Use **case management files** and **follow-up reports**.
4. **Link to Child Protection Systems**
    - Evaluate how interventions integrate into the **broader child protection system**.
    - **Data Analysis Tip:** Analyze **referrals and case management linkages**.
5. **Alignment with Needs**
    - Determine if interventions address the **highest priority areas**.
    - **Data Analysis Tip:** Compare intervention data with the **HNRP needs analysis**.

4 GUIDANCE FOR PRIORITIZATION FRAMEWORK FOR CHILD PROTECTION INDICATORS

Purpose:

This prioritization framework provides guidance on how to phase the implementation of child protection indicators based on urgency, feasibility, and program maturity. It ensures that key indicators are monitored from the outset while allowing for the gradual integration of more detailed or context-specific indicators as response mechanisms strengthen.

However, this prioritization is a suggested approach and remains flexible. The selection and sequencing of indicators should be adapted to the specific context of each country, as local capacities, available resources, and existing monitoring systems may influence the prioritization process. Some countries may already have the technical capacity and resources to implement indicators classified as Phase 2 immediately, while others may need to start with foundational indicators before scaling up.

4.1 DESCRIPTION

This section outlines the prioritization principles of child protection indicators, emphasizing their role in addressing immediate threats to children's survival, safety, and dignity. The phased approach ensures a balance between urgent life-saving actions and the gradual integration of context-specific or complex indicators as capacities strengthen. **Guidance for Prioritizing Child Protection Indicators**

This framework categorizes indicators into **Phase 1 (Priority)** and **Phase 2 (Expanded)** to align with operational contexts, resource availability, and program maturity.

- **Phase 1 (Priority Indicators)**
    - Focuses on life-saving and core child protection interventions and service delivery.
    - Requires **low resources and minimal capacity-building**
    - Ensures **essential monitoring of child protection risks and responses**
    - Can be implemented in **emergency or low-capacity settings**
- **Phase 2 (Expanded Indicators)**
    - Requires **additional technical expertise, system strengthening, and capacity-building**
    - Supports **longer-term program effectiveness and sustainability**
    - Introduces **more complex data collection and integration with other sectors**

How and When to Use This Framework

1. Assess Contextual Needs:

- **First phase Emergencies:** Start with **Phase 1 indicators** to address immediate risks (e.g., grave violations, family separation).
- **Protracted context :** Begin with **Phase 1** but transition earlier to **Phase 2** to build sustainable systems.

2. Evaluate Capacity:

- **Low Capacity:** Prioritize Phase 1 indicators requiring minimal training (e.g., counting beneficiaries of child-friendly spaces).
- **Existing Systems:** Integrate Phase 2 indicators (e.g., referral pathways) if staff are trained and tools are available.

3. Align with Program Goals:

- **Short-Term:** Use Phase 1 for rapid response (e.g., cash assistance for acute needs).
- **Long-Term:** Use Phase 2 for outcomes like community resilience (e.g., training caregivers in positive parenting).

4. Adapt Flexibly:

- Combine Phase 1 and 2 indicators where feasible (e.g., track reunified children *and* follow-up rates).
- Revisit priorities as contexts evolve.

This phased approach allows child protection actors to **start with core indicators** that inform immediate action while progressively integrating **more advanced indicators** as systems strengthen and programmatic capacity increases. However, **it is not a rigid sequence**, and **country teams are encouraged to determine their own prioritization based on their operational realities**.

1. Mental Health and Psychosocial Distress (CPMS Standard 10)

Phase 1 (Priority Indicators),

- Number of girls, boys, and caregivers benefiting from age-, gender-, and disability-sensitive psychosocial support through group activities
- Number of safe, inclusive group activity locations established and maintained for child well-being
- Number of operational mobile group activity teams reaching children with structured, inclusive group sessions
- Number of children participating in structured and sustained group activities for well-being in safe, child-friendly locations

Phase 2 (Expanded Indicators)

- Number of parents/caregivers receiving psychosocial support services.
- Number of parents/caregivers participating in positive parenting sessions that integrate MHPSS objectives.

- Number of targeted communities with established, functional, and monitored referral systems for MHPSS services, integrated across sectors.

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2. Case Management (CPMS Standard 18)

Phase 1 (Priority Indicators)

- Number of at-risk girls and boys receiving case management services tailored to their needs.
- Number of children receiving emergency case management funds (e.g., cash assistance).

Phase 2 (Expanded Indicators)

- Number of children and caregivers receiving legal assistance related to child protection issues.

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3. Family Reunification and Alternative Care (CPMS Standard 13 & 16)

Phase 1 (Priority Indicators)

- Number of unaccompanied and separated children identified and documented.
- Number of girls and boys reunified with their families.
- Number of girls and boys placed in alternative family-based care arrangements.

Phase 2 (Expanded Indicators)

- % of children who have received at least one follow-up visit within one month of being reunited with a caregiver.

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4. Community-Level Approaches (CPMS Standard 17)

Phase 1 (Priority Indicators)

- Number of community-based child protection structures or groups established or revitalized to ensure community participation in child protection.
- Number of children and caregivers reached through awareness-raising activities on child protection risks and services.

Phase 2 (Expanded Indicators)

- Number of members of community-based child protection structures trained on child protection approaches and referral mechanisms.

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5. Sexual and Gender-Based Violence (CPMS Standard 9)

Phase 1 (Priority Indicators)

- Number of child survivors of SGBV referred to appropriate and accessible services by CBCPM through established referral systems.
- % of girls, boys, women, and men aware of the ways to report SGBV, including PSEA allegations.

Phase 2 (Expanded Indicators)

- Number of SGBV child survivors currently part of the case management caseload and receiving appropriate case management services.

  📌 Note: Coordination with the GBV AoR is essential to avoid double counting and ensure accurate reporting. Agreements should be in place to clarify roles and data consolidation mechanisms between CP and GBV AoRs.

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6. Child Protection Monitoring (CPMS Standard 6)

Phase 1 (Priority Indicators)

- Number of detected grave violations against children documented and reported in compliance with the MRM Field Manual.

Phase 2 (Expanded Indicators)

- Number of child protection monitoring systems established at national and subnational levels.

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7. Children Associated with Armed Forces or Armed Groups (CPMS Standard 11)

Phase 1 (Priority Indicators)

- Number of children demobilized from armed forces or armed groups who were placed in a family environment (biological or alternative).
- Number of children demobilized from armed forces or armed groups who were provided livelihoods services (e.g., vocational training, income-generating activities) to support their recovery.
- Number of school-age children formerly associated with armed forces or armed groups supported to enroll or re-enroll in formal or non-formal educational opportunities.

Phase 2 (Expanded Indicators)

- Number of children demobilized from armed forces or armed groups who received basic recovery services (e.g., healthcare, MHPSS, education).
- Number of community members reached through awareness-raising activities or training sessions on preventing and reporting child recruitment.

- **8. Cross-Sectoral Child Protection Indicator**

Phase 1 (Priority Indicators)

- Number of humanitarian workers across sectors trained on child protection principles, approaches and standards.
- Number of children identified through integrated services who are referred for specialized child protection support.
- Number of functional referral pathways established across sectors for child protection concerns.

Phase 2 (Expanded Indicators)

- Number of integrated child protection service delivery points established in affected communities.

This prioritization framework is not prescriptive but rather a suggested approach to guide practitioners, program managers, and decision-makers in implementing core, life-saving indicators first, while progressively introducing more complex indicators that require additional resources, technical capacity, and system integration. The prioritization of indicators should be adapted to the context of each country, recognizing that existing capacities, operational needs, and programmatic priorities may influence which indicators are feasible at different stages.

5 ANNEXES

Annex 1 List of indicators and definitions

Indicator	Indicator definition
Mental Health and Psychosocial distress (CPMS Standard 10)	
Number of girls, boys, and caregivers benefiting from age-, gender-, and disability-sensitive MHPSS services.	Definition/Purpose: Tracks the number of children (girls and boys) and caregivers who participate in structured, inclusive group activities that promote psychosocial well-being. These activities are designed to be age-, gender-, and disability-sensitive, and may include play, arts, life skills, support groups etc... delivered in a safe and predictable environment. Key Components/Criteria for Counting: ligibility: Participants must take part in structured group activities led by trained facilitators. Group sessions must be part of a defined program or recurring activity schedule, not one-off or ad hoc events. **Benchmarks:** Single-session group interventions: Counted if designed to deliver a specific psychosocial objective (e.g., stress reduction, connection, expression). Multi-session programs: Participants must complete at least 50% of scheduled sessions. Activities must be inclusive and developmentally appropriate, targeting psychosocial well-being, resilience, or caregiver-child interaction. **Data Collection/Documentation:** Use group activity attendance sheets disaggregated by age, sex, and disability. Document the type of activity, target group (e.g., adolescents, caregivers), frequency, and duration. Avoiding Double Counting: Each participant is counted once per program cycle or reporting period, regardless of participation in multiple sessions or activities within that cycle.

Number of children participating in structured and sustained group activities for well-being in safe, child-friendly locations	Definition/Purpose: Captures the number of children actively involved in programs implemented in safe, designated spaces. These structured programs use organized methodologies and are delivered over a set duration to achieve long-term outcomes. Key Components/Criteria for Counting: Eligibility: Children must actively participate in structured activities aiming to improve mental health and psychosocial wellbeing. Benchmarks: Programs must include evidence-based activities aligned with developmental needs. Recreational or art-based activities are only counted if they are part of a structured MHPSS agenda. Data Collection/Documentation: Maintain program attendance logs and activity reports. Record demographic information for all children involved. Avoiding Double Counting: Count each child only once per reporting period, once the child has fulfilled the attendance benchmark. *(Mental Health and Psychosocial Support (MHPSS) in Child Protection at UNICEF)*
Number of parents/caregivers receiving psychosocial support services.	Measures the number of caregivers provided with support to manage stress and emotional difficulties. Includes services delivered through in-person or remote platforms. **Benchmark to count benficiariese:** Participate in at least one structured session of professional support (in-person or remote) addressing stress and emotional difficulties. Complete a minimum threshold of engagement, such as: Completing multiple sessions or a defined program cycle. Actively participating in required activities within the program framework. qualitative consideration that should be included in activity delivery should include among others Demonstrate measurable improvement in stress management, emotional well-being, or parenting capacity as a direct result of the intervention. Show evidence of achieving the minimum expected skills, knowledge, or behavioralu changes targeted by the intervention. This includes but is not limited to: Improved ability to identify and manage sources of stress. Ability to identify symptoms of psychosocial distress among their children Increased emotional resilience and coping strategies.

Number of parents/caregivers participating in positive parenting sessions that integrate MHPSS objectives.	Tracks the number of caregivers engaged in sessions designed to improve parenting skills and strengthen caregiver-child relationships. Sessions must follow a structured curriculum. **A parent or caregiver will be counted if they meet the following criteria:** Attend the required minimum number of sessions outlined in the structured curriculum (e.g., at least 75% of the planned sessions). Complete pre- and post-session evaluations (if available) to measure progress in knowledge, skills, or behaviors related to positive parenting. Show evidence of learning or behavioral change, as indicated by session assessments or follow-up evaluations (where feasible). These criteria ensure that the participation is meaningful and contributes to the desired outcome of improving parenting skills and relationships. also the purpose is to promote caregivers' wellbeing and strengthen their capacity to support children
Number of safe, inclusive group activity locations established and maintained for child well-being	Counts the number of safe, accessible spaces for children that are fully functional, meeting minimum standards for protection and psychosocial well-being. A space providing group activities will be counted if it meets the following criteria: Established and Designed to Standards: The space is designed to adhere to guidelines, ensuring safety, accessibility, and inclusivity for all children, including children with disabilities. The space is equipped with age-appropriate materials and resources to support children's psychosocial, recreational, and developmental needs. Operational and Maintained: The space is fully operational with trained staff and facilitators who are trained in child protection and psychosocial support. Regular maintenance ensures the safety and functionality of the space, including appropriate lighting, sanitation, and security measures. Program Delivery: Structured activities are conducted regularly within the space, including educational, recreational, and psychosocial programs tailored to meet the needs of children in the community. Activities are inclusive, gender-sensitive, and culturally appropriate.

	Child well-being refers to a child's experience of being physically safe, emotionally supported, and meaningfully engaged in activities that promote their development and resilience. In the context of group activity locations, child well-being is supported when spaces are: Physically safe and protective, meeting minimum standards for safety, hygiene, and accessibility for all children, including those with disabilities; Psychosocially supportive, offering structured group activities that strengthen children's psychosocial wellbeing Inclusive and child-centered, designed in consultation with children and tailored to their age, gender, and cultural background. Avoiding Double Counting: Each location is only counted once in a specific reporting period, regardless of the number of times it is used or assessed. Structured MHPSS Definition: Structured MHPSS refers to evidence-based programs designed to achieve specific psychosocial outcomes, delivered through organized, sequential activities tailored to the needs of children and aligned with their developmental stages. These programs should have clear objectives, follow an established curriculum, and be conducted by trained and supervised personnel.

Number of operational mobile group activity teams reaching children with structured, inclusive group sessions	Tracks the number of mobile setups delivering group activities and psychosocial support services in areas where static spaces are unavailable or impractical. Mobile activities ensure access to essential protection and recreational services, particularly in remote, displaced, or transit settings. These setups often include temporary installations, such as tents, buses, or portable kits, designed to meet minimum child protection standards while adapting to the mobility and accessibility needs of the community. **Data Collection Guidance:** Collect data on the number of operational mobile setups actively delivering services, validated by program activity reports or on-site observations. Ensure activities meet child protection and psychosocial well-being standards for mobile services. Avoiding Double Counting: Track the number of sessions and attendance records separately, ensuring that repeated visits to the same mobile setup are not counted as new operational setups.
Number of communities with functioning, intersectoral referral systems for children identified during group activities	Tracks the number of targeted communities where a referral system is operational and accessible for children and caregivers requiring MHPSS services. A functional referral system ensures: Clear Pathways: Documented protocols and steps for referring individuals to appropriate MHPSS services. Trained Personnel: Community members and service providers are adequately trained to identify needs, provide initial support, and facilitate referrals. Accessible Services: Services are physically and culturally accessible, with no significant barriers to use, including language and stigma-related obstacles. Community Awareness: Community members are informed of the existence of the referral system and how to access it. Coordination: Coordination between various sectors and service providers to avoid duplication and ensure efficient referral management. Communities with referral systems meeting at least 80% of quality benchmarks (as defined by program standards) can be considered functional. These benchmarks should assess clarity of pathways, training adequacy, and service accessibility.

	Integrated across sectors: Integration across sectors ensures that MHPSS referral systems are collaborative and holistic, linking services across health, education, Shelter, Wash etc.... This involves shared referral pathways, joint service mapping, and intersectoral protocols to define roles and workflows clearly. It emphasizes cross-sectoral training for service providers to recognize psychosocial distress and facilitate referrals effectively. Integration also promotes data-sharing mechanisms, community engagement, and regular joint assessments to ensure that referrals address the full spectrum of children's and caregivers' needs comprehensively.
Case Management (CPMS Standard 18)	
Number of new child protection case management cases opened and receiving case management services tailored to their needs.	Monitors the number of children identified as at-risk and provided with full case management services through trained caseworkers. To be counted under this indicator, a child must receive the full scope of case management services, including all six steps, and not just identification and referral. The six steps are as follows: **Assessment:** Conduct a comprehensive assessment to understand the child's specific needs, risks, and protective factors. **Case Planning:** Develop an individualized case plan outlining clear goals, necessary services, and timeframes to address the child's needs and mitigate risks. I**mplementation and Direct Support:** Provide or facilitate access to services, including psychosocial support, health, legal, education, or other relevant interventions. **Referral:** Ensure referrals are made to appropriate service providers, following up to confirm services are delivered effectively. **Follow-Up and Review:** Conduct regular follow-ups to monitor progress, evaluate the effectiveness of the interventions, and revise the case plan as needed. **Case Closure:** Conclude the case once objectives are achieved, risks are mitigated, and the child no longer requires support. Trained Caseworkers: The services must be delivered by caseworkers trained in child protection standards and guidelines. Documentation: The process must be documented using standardized tools and systems, ensuring accountability and quality control. **Minimum Standards:** The child must be identified with a clear child protection case based on established criteria to distinguish protection needs (e.g., abuse, neglect, exploitation, separation) from other welfare or development cases. The child must receive all six steps of case management as described above. The services must be delivered by trained caseworkers who adhere to child protection standards and guidelines.

	Documentation must demonstrate that the intervention was necessary, appropriate, and complete.
Number of children and caregivers receiving legal assistance related to child protection issues.	Measures the number of children and caregivers receiving professional legal support related to child protection issues. This support may include: **Documentation Assistance**: Help in obtaining vital legal documents, such as birth registration, custody papers, or legal identity documentation. **Legal Representation**: Advocacy or representation in legal proceedings, such as custody hearings, protection orders, or criminal cases involving child abuse or exploitation. **Rights Awareness and Counseling:** Education on legal rights and obligations, ensuring informed decision-making and access to justice. **Case-Specific Advocacy:** Support to navigate legal processes tied to specific child protection concerns, such as guardianship, adoption, or family reunification. Context-Specific Adaptation: This indicator can be split into separate categories if the context requires differentiating between children receiving civil documentation support and children with other legal needs (e.g., representation in abuse/exploitation cases). Country teams can disaggregate data by type of legal service provided to meet their reporting needs. **Eligibility Criteria:** Only children or caregivers directly involved in child protection cases (e.g., abuse, neglect, exploitation, custody disputes) are included. Support must be provided by trained legal professionals or organizations specializing in child protection-related legal aid.

	Minimum Standards for Counting: The legal assistance must address specific child protection issues (e.g., abuse, neglect, or family separation). Services must include at least one of the specified types of legal support (e.g., representation, documentation, counselingl). Support must be provided by professionals adhering to legal and ethical standards. Cases must be documented and tracked in a centralized system or case management database (e.g., CPIMS+).
Number of child protection case management cases closed during [reporting period].	This indicator tracks the number of cases that were formally closed during the reporting period. A case is considered closed when case management services are no longer required, as determined through a final case review with the child and/or caregiver, and based on the best interests of the child. Closure occurs when: The child's protection needs identified in the case plan have been adequately addressed, and further case management is no longer necessary. The child and/or caregiver agree to the closure based on their informed consent. The case is transferred to another service provider or case management agency for continued support. The case is closed due to exceptional circumstances (e.g., child relocates, family reunification, loss to follow-up).
Number of children benefiting from emergency case management funds (e.g., cash assistance, direct service payments).	This indicator measures the number of children benefiting from emergency case management funds, which may be provided in the form of direct cash assistance to the child or caregiver, or indirect payments covering essential services to meet urgent protection needs. Types of Support Covered: Direct Cash Assistance – Cash transfers given to the child/caregiver to meet urgent child protection needs. Service Payments – Funds used by case management actors to directly pay for: Emergency accommodation (e.g., safe shelter, temporary housing). Transport costs for reunification or accessing services.

	Medical expenses for treatment related to child protection risks. Legal fees or administrative costs (e.g., birth registration, legal documentation). Disaggregation: By type of support provided (direct cash vs. service payments) By age and sex of the child By type of emergency protection need addressed
Family Reunification and Alternative Care (CPMS Standard 13)	
Number of unaccompanied and separated children (UASC) identified and documented through case management systems.	This indicator tracks the number of children identified as unaccompanied or separated (UASC) from their families due to emergency situations or other vulnerabilities and whose information is formally documented in a child protection case management system (e.g., CPIMS+ or other approved systems). Key Components: Identification: The process of recognizing children as UASC using child protection criteria (as defined in CPMS Standard 13). Identification may be conducted by trained caseworkers or, in some contexts, other protection actors who refer cases to case management agencies. Documentation (Case Management-Specific): Documentation refers to the formal recording of UASC cases within a structured child protection case management system (e.g., CPIMS+). This includes essential child protection details: Child's personal information (age, sex, disability status, etc.). Circumstances of separation. Immediate protection needs. Initial case actions (family tracing, interim care, etc.). This does NOT include general lists, registration by non-CP actors, or referral records that are not linked to case management. Link to Case Management (CPMS Standard 13): This indicator is aligned with CPMS Standard 13 (Family Reunification and Alternative Care), ensuring that UASC are documented for appropriate follow-up, tracing, and care arrangements. It is distinct from general identification efforts that do not involve case management.
Number of girls and boys reunified with their caregivers.	This indicator measures the number of unaccompanied or separated children who are successfully reintegrated with their families or primary caregivers. Reunification is completed when the child is physically placed back with their family and the process adheres to international best practices for family reunification, including assessments and preparation for reintegration. Key Components: The reunification process should include verification of the caregiver's identity and capacity to care for the child.

	Social workers must ensure that the reunification process is in the best interest of the child, addressing potential risks and challenges. Pre- and post-reunification support should be provided, including psychosocial assistance or material support if necessary. Quality Assurance: Confirmation of reunification status through documented case files. Post-reunification follow-up visits to monitor child well-being..
Number of girls and boys placed in alternative family-based care arrangements.	Measures the number of children placed in family-based care settings such as foster care, kinship care, or other alternative family arrangements. These care settings are designed to provide children with a safe, stable, and nurturing environment when they are unable to live with their biological parents or customary caregivers. Key Elements: Alternative Family-Based Care: Refers to arrangements such as foster care (formal or informal), kinship care (with extended family), or other legal guardianship arrangements recognized under customary or statutory law. Criteria for Counting: A child is counted when: They have been formally placed through a child protection mechanism or authority. The placement meets minimum standards for child protection and care, including safety, stability, and well-being. A clear case management process has been followed, including assessments, placement agreements, and ongoing monitoring. Exclusions: Does not include institutional care, such as orphanages, or situations where children are informally living with friends or neighbors without oversight.
Community-Level Approaches (CPMS Standard 17)	
Number of community-based child protection structures or groups established to ensure community participation in child protection.	Tracks the number of community groups formed, revitalized, or supported to actively engage in child protection initiatives. These structures aim to strengthen community ownership and participation in preventing and responding to child protection risks. Key Elements: Community-Based Child Protection Structures : Includes groups, committees, or networks established at the community level to address child protection concerns, such as violence, neglect, exploitation, and abuse. These structures are often composed of community members, including parents, teachers, religious leaders, and youth. Activities and Responsibilities: Identifying and responding to child protection concerns. Raising awareness about child protection risks and services. Strengthening referral pathways and liaising with formal protection systems. Supporting the reintegration of children in need of care and protection. Criteria for Counting: The group must be functional, with clear roles, responsibilities, and regular activities.

	The group should either be newly established or receive formal support, such as training, capacity building, or funding, during the reporting period. Evidence of engagement in protection-related activities must be documented.
Number of members of community-based child protection structures trained on child protection approaches and referral mechanisms.	Measures the number of group members trained to understand child protection risks, services, and referral pathways. The quality of training is assessed against established benchmarks, including the use of standardized curricula, participatory facilitation methods, pre- and post-training evaluations to measure knowledge improvement, and adherence to CPMS guidance. Trainings also emphasize practical application, ensuring participants are equipped with the skills to implement safe and effective referral mechanisms and engage meaningfully with their communities. If a person participates in multiple trainings on different child protection topics, each instance can be counted separately, as long as: The training topics are distinct (e.g., child protection case management, referral pathways, or MHPSS approaches). Each training is tracked as part of its specific program or indicator. If the training program has multiple modules or sessions (e.g., a 3-part child protection training series), participants should only be counted after completing the entire program (all required modules).
Sexual and gender based violence (CPMS standard 9)	
Number of individuals benefiting from awareness-raising sessions to prevent and respond to Sexual and Gender-Based Violence	This indicator measures the number of individuals who actively participated in structured awareness-raising sessions aimed at preventing and responding to Sexual and Gender-Based Violence (SGBV). These sessions should be planned and conducted with clear learning objectives to ensure participants gain relevant knowledge and skills. Core Topics Covered (Minimum Standard): Sessions should address at least one of the following key topics: Prevention of SGBV: Understanding risk factors, fostering safe environments, and addressing harmful gender norms. Prevention of child marriage, sexual violence, and exploitation. Engaging men and boys in SGBV prevention efforts. Protection Risks & Response: Identifying and mitigating risks for child survivors of SGBV, children associated with armed groups (CAAG), and child labor victims. Survivor-centered approaches and safe referral pathways for SGBV survivors. Accessing available psychosocial, legal, and medical services.

	Legal & Policy Frameworks: National and international legal protections against SGBV. Child safeguarding principles in prevention and response efforts.
% of girls, boys, women, and men aware of the ways to report SGBV , including PSEA allegations and child safeguarding.	Monitors the proportion of individuals (disaggregated by age and gender) who demonstrate knowledge of safe and accessible mechanisms for reporting Sexual and Gender-Based Violence (SGBV), including allegations of Protection from Sexual Exploitation and Abuse (PSEA). This indicator measures general awareness of available reporting pathways to ensure individuals affected by SGBV or PSEA can seek appropriate assistance and protection. Key Components of Awareness: Knowledge of Reporting Mechanisms: Includes any formal or informal systems where individuals can report SGBV incidents. Examples: Helplines or hotlines. Local community-based mechanisms. Police stations or legal aid centers. Child protection or gender-based violence service providers. Awareness efforts should clarify the process for filing complaints, who to contact, and what happens post-reporting. Inclusion of PSEA Allegations: Refers to reporting mechanisms for addressing cases of exploitation and abuse, whether perpetrated by community members, family, or service providers. Awareness includes confidentiality assurances and survivor-centered principles.
Number of survivors of SGBV referred to appropriate and accessible services by CBCPM through established referral systems.	Tracks the number of survivors of sexual and gender-based violence (SGBV) referred to appropriate and accessible specialized services by Community-Based Child Protection Mechanisms (CBCPM). Specialized services may include healthcare, psychosocial support, legal aid, shelter, or livelihoods assistance. Referrals must be facilitated through functional and established referral pathways, ensuring the confidentiality and dignity of the survivor. Key Elements of the Indicator: Appropriate Services: Referrals must align with the needs of the survivor, such as access to trauma care, mental health services, or legal assistance. Accessible Services: Services must be reachable geographically, culturally sensitive, and inclusive for diverse survivors, including those with disabilities. Community-Based Mechanisms: Referrals should originate from trained community-based actors who understand the referral pathways and confidentiality protocols. Referral System: The system must include documented Standard Operating Procedures (SOPs), defined roles, and clear referral pathways that meet inter-agency standards.

Number of SGBV child survivors currently part of the case management caseload and receiving appropriate case management services	This indicator tracks the number of child survivors of sexual and gender-based violence who are actively enrolled in case management services, receiving tailored and survivor-centered support to address their individual protection needs. Appropriate case management ensures adherence to established standards, it is essential that caseworkers are trained specifically in SGBV case management and that a dedicated, systematic framework for managing SGBV cases is in place. Key quality benchmarks fo rthe specific case management of SGBV cases: Specialized SGBV Case Management System: To qualify as part of this indicator: A dedicated SGBV case management system must be operational, with standardized forms, protocols, and referral mechanisms. The system should incorporate a confidential and secure data management platform (e.g., CPIMS+). SGBV-Specific Training for Caseworkers: Caseworkers must have undergone specialized training on handling SGBV cases, focusing on trauma-informed approaches, confidentiality, and survivor-centered support. Training should also cover legal and cultural considerations specific to SGBV, as well as referral pathways and service coordination.
Child protection monitoring (CPMS standard 6)	
Number of individuals trained in Monitoring and Reporting Mechanism (MRM) on grave violations.	Measures the number of individuals trained on the MRM framework, which is used to document and report grave violations against children in conflict settings. Training includes key competencies such as documentation protocols, confidentiality practices, and understanding of the six grave violations as per international standards, Compliance with the MRM country Field Manual ensures that monitoring and reporting are conducted ethically, accurately, and securely while respecting confidentiality and the safety of all involved parties. MRM Framework Understanding: Overview of the six grave violations: recruitment and use of children, killing and maiming, sexual violence, abduction, attacks on schools and hospitals, and denial of humanitarian access. Understanding of the roles and mandates of the United Nations, country task forces, and local actors in MRM. Technical Skills Covered: Documentation protocols: Accurate recording of violations using standardized tools. Confidentiality practices: Ensuring the safety and privacy of survivors, witnesses, and data collectors. Verification processes: Triangulating information to confirm accuracy before reporting. Context-Specific Focus: Safe detection and referral mechanisms based on the country context.

	Knowledge of mandated agencies and local referral pathways to ensure survivors access appropriate support services.
Number of detected grave violations against children documented and reported in compliance with the MRM Field Manual.	.Tracks the number of grave violations against children that are formally documented and reported using the standardized processes outlined in the MRM Field Manual. Compliance ensures that monitoring and reporting are conducted ethically, securely, and in alignment with international best practices.
Number of child protection monitoring systems established at national and subnational levels.	Measures the number of formal child protection monitoring systems developed and operationalized at national and subnational levels. These systems are designed to systematically monitor, document, and report child protection concerns, ensuring data-driven planning, advocacy, and response. Use of Findings: Monitoring findings should align with CPMS Standard 6 on child protection monitoring, which emphasizes that monitoring systems are used not only to document child protection risks and violations but also to inform and improve programmatic responses. Findings may include specific data points on child protection risks, incidents, service coverage, or gaps, as well as recommendations for action. Integration into Plans: Plans and documents must explicitly reference child protection monitoring findings as a source of evidence for the development of strategies, prioritization of actions, or resource allocation.
Children associated with armed forces or armed groups (CPMS atandard 11)	
Number of children demobilised from armed forces or armed groups who were placed in a family environment (biological or alternative).	Definition: Tracks the number of children separated from armed forces or armed groups who are successfully placed into family-based care. Family environments include biological families, kinship care, foster care, or other forms of alternative care that prioritize the child's well-being, security, and stability. Placement must comply with international child protection standards, ensuring proper assessment, preparation, and follow-up of the child and family environment. Alternative care must align with guidelines for safety and suitability. Eligibility Criteria for Beneficiaries: Only children demobilized from armed forces or armed groups who have been successfully placed in family-based care are counted. demobilisation can be both as part of DDR process or spontaneous Family-based care includes biological families, kinship care, foster care, or other safe alternative care arrangements.

	The placement must be aligned with international child protection standards, involving: Assessment of the child and family. Preparation of the child and caregivers. Structured follow-up visits. Frequency of Reporting: Reporting should align with placement milestones, such as initial placement and confirmed follow-up within the first month.
Number of children demobilized from armed forces or armed groups who received basic recovery services (e.g., healthcare, MHPSS, education)	Definition: Measures the number of children accessing essential recovery services, such as medical care, mental health and psychosocial support (MHPSS), and educational services, after demobilization from armed forces or groups. Basic recovery services aim to address the immediate and long-term physical, psychological, and social needs of children. Services should be delivered by trained professionals and be contextually appropriate. Demobilization Context: DDR programs: Children officially released through organized disarmament, demobilization, and reintegration initiatives. Spontaneous demobilization: Children who self-demobilize from armed forces or groups, often seeking assistance directly or through community or protection actors. Service Access: Only children who receive at least one recovery service are counted, such as: Medical care: For physical injuries, illnesses, or disabilities. MHPSS: Counseling, support groups, or structured mental health interventions. Education or vocational training: Enrollment in formal/non-formal schooling, skill-building programs, or apprenticeship opportunities. Recovery services are often part of an integrated case management plan, meaning multiple services (e.g., MHPSS, education, medical care) are bundled together to address the child's overall needs. In such cases, the child is still counted as one unique beneficiary. Each agency reports the total number of beneficiaries served since the start of the program or activity and updates this cumulative count against the relevant indicators.
Number of children Demobilised from armed forces or armed groups who were provided livelihoods services (e.g., vocational training, income-generating	child is counted as a beneficiary if they: Enroll and actively participate in the livelihood program. Complete a minimum threshold of activities defined by the program (e.g., attending 80% of training sessions). Receive documented support, such as tools, start-up funds, or mentorship. Beneficiaries should only be counted once per type of livelihood service to avoid duplication. Service Quality Standards:

activities) to support their recovery.	Livelihood programs must adhere to child protection and labor standards, ensuring activities are age-appropriate and safe. Programs must integrate psychosocial support to address emotional needs alongside skills development. Frequency of Reporting: Report progress at regular intervals (e.g., quarterly) to track engagement and completion rates.
Number of school-age children formerly associated with armed forces or armed groups supported to enroll or re-enroll in formal or non-formal educational opportunities.	Definition: Tracks the number of children associated with armed forces or armed groups who have been provided with support to access education programs. Support includes activities such as school enrollment assistance, provision of school materials, remedial education, or referrals to alternative education pathways. Key Components: Formal Education: Refers to traditional schooling systems, such as government-run or private schools. Non-Formal Education: Encompasses community learning centers, accelerated learning programs, or other flexible approaches designed to cater to out-of-school children or children needing alternative pathways. Counting Rules: A child is counted once they are formally enrolled or re-enrolled and regularly attend a minimum threshold (e.g., 75% of classes in the first month). Avoid double counting by maintaining unique identifiers for children across different agencies or programs.
Working across sectors	
Number of humanitarian workers across sectors trained on child protection principles and standards.	Definition: Tracks the number of humanitarian personnel across different sectors (e.g., health, education, WASH) trained on comprehensive child protection principles, focusing on: Best Interest of the Child: Ensuring that all decisions prioritize the safety, dignity, and welfare of children. Confidentiality: Protecting sensitive information about children and their families to avoid harm. Child Protection Minimum Standards (CPMS): Promoting global standards for safeguarding children in emergencies. Additional Training Components: Definition of Child Protection: Clear understanding of child protection, its objectives, and its scope within humanitarian contexts. Well-being of the Child: Concepts of physical, emotional, social, and cognitive well-being.

	Risk Factors and Vulnerabilities: Identification of risks to children's safety and development at individual, family, community, and societal levels. Ecological Model: Framework for understanding the child's environment and its influence on risks and protective factors. Safe Referrals: Steps and procedures for referring at-risk children to appropriate services, ensuring confidentiality and child-friendly practices. Practical Application: Scenarios and case studies to help participants understand how to apply principles in real-world situations. Key Considerations: Ensure training includes cross-sectoral elements to promote collaboration and integrated responses. Utilize interactive training methods such as role-plays, group discussions, and case studies to enhance understanding and practical skills. Data Collection: Attendance sheets, pre- and post-training evaluations, and training completion records. CP AoR working across sectors training package is a module that could cover such training
Number of children identified through integrated services who are referred for specialized child protection support.	Measures the number of children identified via integrated programs (e.g., health, education, and WASH) as requiring specialized protection interventions, such as: Case management. Legal assistance. Mental health and psychosocial support (MHPSS). Referrals should follow documented pathways and standards to ensure timely and appropriate care. Children referred must meet eligibility criteria for child protection cases, ensuring differentiation from other support needs. A child should meet all the following criteria to be counted: Identified through integrated services, such as school health programs, nutrition screenings, WASH interventions, or community-based initiatives. Assessed and determined to require specialized child protection services, such as case management, legal assistance, psychosocial support. Successfully referred to a specialized service using a formal referral pathway. A child is counted once per reporting period per service type, even if multiple referrals occur. (Example: If a child is referred for both medical and psychosocial support, count them once, unless the services are reported under distinct categories.)

Number of functional referral pathways established at national and subnational levels across sectors for child protection concerns.	This indicator measures the number of formal, functional, and harmonized referral pathways established at national and subnational levels to ensure that children in need of protection receive timely and coordinated support across sectors. Referral pathways should be developed in a collaborative and standardized manner, ideally facilitated by the Child Protection AoR (or equivalent coordination mechanism), in alignment with GBV and General Protection sectors where applicable. Criteria for a Functional Referral Pathway: A referral mechanism is counted only if it meets all of the following criteria: Documented Process: A clear, written referral system exists, outlining roles, responsibilities, referral steps, and timelines across sectors. The system is agreed upon by key actors at the coordination level. Standardized Tools & Procedures: Includes standard referral forms, contact lists, SOPs (Standard Operating Procedures), and data-sharing protocols. Aligns with national child protection case management guidelines. Service Mapping & Accessibility: Referral pathways must be linked to mapped and accessible services (e.g., medical, psychosocial, legal, alternative care). Service providers must regularly update availability and capacity. Trained Focal Points Across Sectors: Key personnel (e.g., health workers, teachers, social workers, GBV caseworkers) are trained in: Referral procedures. Child protection principles and safe referrals. Confidentiality and survivor-centered approaches.
Number of integrated child protection service delivery points established in affected communities.	This indicator measures the number of service delivery points integrated within other sectors (e.g., health, education, WASH) that provide child protection services alongside their primary sectoral services. These points serve as entry points for child protection activities, leveraging existing sectoral infrastructure and resources to deliver essential protection services in a coordinated manner. Core Elements of Integration: Service Provision: Delivery of at least one specific child protection service (e.g., psychosocial support, safe referrals) within the sectoral facility. Staff Training: Staff in the sectoral facility (e.g., teachers, healthcare providers) are trained on child protection principles, identification, and referral mechanisms. Referral Pathways: Clear and functional pathways for referring children identified within the sector to specialized child protection services (e.g., legal aid, case management).

	Accessibility: Services are co-located within sector-specific facilities, ensuring accessibility for children and caregivers who engage with that sector (e.g., patients in health centers, students in schools). Alignment with CPMS: The services provided at these points are designed and delivered in line with Child Protection Minimum Standards (CPMS), emphasizing the best interest of the child, safety, and confidentiality.