CHILD PROTECTION EMERGENCY PREPAREDNESS AND RESPONSE GUIDANCE TO THE COVID-19

Infectious diseases, such as COVID-19, can have a significant impact on children's and their caregivers' wellbeing beyond the disease itself. In terms of child protection, there are three main potential secondary impacts:

- Neglect and lack of parental care. Children may lose parental care when their caregivers die, are hospitalized, fall ill, or are quarantined. Children who are themselves hospitalized or quarantined may also be deprived of parental care. Measures put in place to control the disease e.g. school closure, may also leave children without parental care during the day (as their parents are at work). Given the concerns and fear around COVID-19, the traditional care support systems that would step in in the absence of parental care (extended family, community members) may be disrupted.
- Mental health and Psychosocial distress. Children affected by COVID-19 and their families face various stressors including social isolation, health related fears, and fears about contamination or spreading the disease. Persons suspected or confirmed of having COVID-19 have to face not only fear but also isolation in medical facilities. People who have been medically cleared as well as family members and care providers may also face social isolation, rumors, exclusion and even violence in their communities. Important rituals of grieving such funeral and burial practices may be disrupted. Front line staff are confronted with stressful working environments of witnessing considerable suffering and grief among children affected and their families. They have to battle their own fear and concerns about the disease.
- Increased exposure to violence, including sexual violence, physical and emotional abuse. This may result from caregivers and other adult family members becoming increasingly distressed, a sense of support and belonging to a community being disrupted and the use of dysfunctional coping mechanisms to cope with the challenging environment (i.e. alcohol, etc.).

Children with disabilities, marginalized children and other vulnerable groups are at higher risk of these secondary impacts.

UNICEF's Programme Guidance on COVID-19 identifies key Child Protection interventions for preparedness and response under Area 6 - *Prevent and address the **secondary impact** of the outbreak – minimize the human consequences of the outbreak*

- Child protection services for COVID-19 affected children: children quarantined, hospitalized, left without care provider, exposed to heightened protection threats.
- Support the continuity of health and social services
- Risk mitigation of Gender Based Violence and Violence Against Children
- Mental health and psychosocial support and stigma prevention for affected children and families, including groups who may be directly and indirectly affected by COVID-19.

PREPAREDNESS

The following are a list of actions to be undertaken in close collaboration and consultation of the lead/relevant Ministries and CSO partners.

Child Protection

- Identify vulnerable populations at-risk (marginalized, hard-to-reach, poor access to services, etc.) who would be adversely impacted. Understand the impact of COVID-19 on children and parents beyond health: what are some protection risks and safety concerns for children in the

case of an outbreak in the country? Would COVID-19 have different repercussions on boys and girls, children and adolescents, mothers and fathers, children and parents with disabilities?

- Assess the capacity of the social welfare system/child protection system to respond. This analysis includes also logistic considerations on operational capacity and geographical coverage of existing services (main cities, urban and rural areas, hard to reach locations, islands, etc.). Deliver dedicated training to relevant staff and volunteers on Psychological First Aid and MHPSS, case management and alternative care arrangement in emergency, parental support. Consider mobilizing and expanding the available cadre of trained volunteers, case workers, para-social workers, etc.
- Review and, if necessary, strengthen the existing case management system to respond to an outbreak/identified COVID-19 cases and raise awareness and knowledge on how to respond to such cases amongst frontline staff
- Review and, if necessary, strengthen or establish referral/coordination mechanisms between health and social welfare and ensure frontline staff are aware of these procedures. This may involve sensitization/briefing/training sessions to other sectoral teams to enable referral to protection services.
- Review and strengthen the availability and readiness of alternative care placements, preferring family-based arrangements.
- Develop and pre-test messages and materials for MHPSS, VAC and GBV prevention and identify dissemination channels (e.g. through remote learning mechanisms with Education, private partnerships, etc.) and integrated into broader COVOD-19 risk communication plan. In the interest of time and resource saving, check if resources made available by the Regional Office and/or other Countries can be easily readapted/translated to your context.
- Preposition masks and other necessary protective gear at the Ministry of Social Welfare, or equivalent Ministry, to ensure that protection and psychosocial teams managed by this Ministry can rely on needed protective equipment.
- Identify and prepare for creative and online measures to deliver services: social platforms, TV/radio channels, etc. If access to internet is considered key in the intervention, engage with internet providers to establish free access and expand coverage.
- Identify new partners, especially in locations where UNICEF is not supporting CP services, develop stand-by PCA with current/new partners that can be promptly activated if scale-up of services is required.

Mental Health and Psychosocial Support

- Mapping of resources (in terms of current availability and human resources): both mental health care resources and resources for community psychosocial interventions (e.g. women's groups, child welfare committees, children's programs, survivor networks, social services, etc.);
- A comprehensive list of MHPSS practitioners trained and locally available to offer appropriate advice and to participate in a response to an infectious disease outbreak, such as COVID-19. The list should ideally cover competencies and areas of expertise, as well as identify gaps in MHPSS human resources;
- A vulnerability analysis (to identify potential scenarios, weaknesses in public mental health and social support systems during a crisis, needs and capability, and resources needed to respond);
- A strengths inventory (to identify community and system strengths across care delivery systems);
- Identify local community advisory groups that can be rapidly contacted and are included in decision-making from the very beginning
- Assuming the availability of volunteer/non-volunteer community workers, organize outreach and non-intrusive emotional support in the community by providing, when necessary, PFA and referral.

RESPONSE

With the lead/relevant Ministry/department and CSO partners:

- Advocate for the safe delivery and continuation of essential services including child protection. If child protection gets deprioritized within the national response plan or funding appeals, ensure that decision makers are aware ad take full responsibility of the risks entailed in not addressing imminent protection and psychosocial needs.
- Identify and deliver protection services for children left without a care provider, due to the hospitalization or death of the parent or care provider (working with health and social services at the national and sub-national level) and children at risk or suffering from harm/violence. Work closely with other sectors, especially health, to make sure frontline teams are familiar and use existing referral pathways. Consider activating a child-help line. Ensure adequate monitoring of identified and supported cases takes place.
- Consider conducting a rapid assessment to understand the impact of the epidemic on the protection and psychosocial wellbeing of children and families. Findings from the assessment will be useful to guide an evidence-based response and advocate for dedicated resources.
- Support age and sex-sensitive psychosocial support services for affected children, caregivers and communities according to context. Experience from other countries or previous health emergencies can inspire creative interventions in a situation where traditional MHPSS services may not be appropriate.
- Engage communities to assess and address any potential stigmatization of populations related to COVID-19.
- Promote the safety, self-care and psychosocial wellbeing of the frontline teams. Ensure that the protection and psychosocial teams have all needed logistics to safely perform their tasks. Depending on the weather conditions, working time and specificity of the context, logistics may include organizing smooth transportations for the mobile teams, providing them with the protective gear (masks, hand sanitizer and other items), communication equipment (radio, phone, credit, etc.) a field-kit (e.g. umbrellas, boots, hats, radios, drinking water, packet-lunch, medicines, first aid kits, etc.), DSA if appropriate, etc. Moreover, the frontline teams should be adequately briefed on preventive measures and practices to keep themselves protected from the virus and should be provided with regular supervision, technical guidance and emotional debriefing.

Important: To access specific guiding tools on designing and implementing relevant actions mentioned in the practical framework below, please refer to 'Overview of MHPSS-CP resources and links' and the Child Protection folder in the EAPRO COVID-19-dedicated share drive.

RISK IDENTIFIED (as actual or expected)	ACTION (some possible options)	KEY CONSIDERATIONS
CARE AND SAFE ALTERNATIVE CARE		
▪ Children whose caregivers fall ill, are quarantined, hospitalized or die are at high risk of being left without protection and care. ▪ Young children whose caregivers are hospitalized may remain go with the caregiver and be exposed to the virus. ▪ Children under quarantine and treatment may be deprived of parental care. ▪ Children with disabilities, marginalized children and other	▪ Establish a system for tracking vulnerable individuals (e.g. unaccompanied children, persons with disabilities and the elderly). ▪ **Review, strengthen or establish a system** for ensuring that children without appropriate parental care, including unaccompanied/separated children and orphans, due to COVID-19, have safe alternative care, preferably **through extended families or family-based alternative care systems.** ▪ Establish or ensure that a **referral network between health and social welfare** is in place and prepared to deal with emergency situations, such as quarantine and hospitalization, and an efficient family tracing mechanism in case of family separation or loss of primary caregivers. ▪ **Train** or raise awareness amongst social workers/child protection staff /community volunteers/committees on alternative care system in the event of the spread of COVID-19.	While it can be expected that traditional support systems will provide care where children are deprived of parental care because of COVID-19, there may be instances where children are left without emergency, temporary or longer term-care, including because of the **fear and stigma associated with the virus**. **Extended families may also need additional support**. ▪ Are emergency and temporary alternative care placements available and sufficient in *a)* high risk areas *b)* all areas, including remote, low populated and hard-to-access areas ▪ Are there sufficient numbers of social workers/community-based actors to manage and supervise these placements? ▪ Is there are robust referral mechanism between health and social welfare already in place? ▪ **Screening and training a wide network of reliable carers/foster-families** (ready to accept children on short notice for limited periods of time) would allow for timely provision of alternative family-based care at times of emergencies. (It is noted that this is challenging if these systems are not already in place) ▪ Where not already approved to provide care for children, potential caregivers should undergo a pre-screening process, child protection

vulnerable groups and minorities are at higher risk of being negatively impacted by the outbreak, as they have less opportunities to access information and services. ▪ Children in institutions can be a particular risk during infectious disease outbreaks.	▪ Develop **contingency plans** for care of children in existing alternative care and in justice **institutions**.	training, and agree to adhere to a child safeguarding policy and monitoring visits. ▪ Existing 'foster carers' would need to be equipped with **accurate knowledge about the COVID-19.** ▪ Close follow up and support to children in alternative care systems and foster families is critical to ensure quality and mitigate protection risks. **Where movement is restricted, consider the availability and use of remote systems for regular contact (phone/ video-calls, etc.) with carers.**
▪ Children are left unattended at home.	▪ Enhance and mobilise the social workforce and trained community volunteers and other key community committees, as appropriate, to **identify children left unattended/at risk and provide support**. ▪ Advocate for the application of **flexible working arrangements or other feasible strategies** for working parents with young children.	▪ Recognize the safety and protection risks of children being left unattended during the day, due to closure of school, day care other recreational centres, CFSs etc. and identify with key decision makers solutions to mitigate these risks. Consider using mobile teams, reliable community networks or other arrangements that are still feasible under the restrictions likely in place. A tailored solution may be needed in each geographical location depending on specific resources and constraints.
PROTECTION FROM VIOLENCE AND ABUSE		
▪ As tension in the households rises, domestic violence, corporal punishment and other forms of	▪ **Support case management systems** to *(i)* identify and address vulnerabilities, *(ii)* deliver integrated and coordinated services and conduct regular follow-up; and *(iii)* **address pre-existing protection concerns and those aggravated by COVID-19.**	▪ Also linked with the provision of safe alternative care, to consider – what is the **capacity** of governmental institutions, Ministries, departments to prevent and **respond to CP issues** if the case of a COVID-19 outbreak? What's the capacity of the social workforce? Is social welfare working closely with the Health system? What is the role of

abuse against children and negative coping mechanisms (such as alcohol consumption) are likely to intensify. (see below considerations also on MHPSS) ▪ If the traditional protective networks are disrupted, children are increasingly exposed to violence, abuse, violations and exploitation. ▪ Children who fall ill, or whose family members are sick are likely to be stigmatized, socially excluded and discriminated against. ▪ Families may lose their income as factories close.	▪ Identify children at higher protection risks and **establish support and monitoring mechanisms.** This can be done through home visits by social workers and other trained personnel, or with remote regular contact (phone/ video-calls, etc.) with vulnerable families. ▪ Train CP partners, social workers and para-social on case management and alternative care in emergency. ▪ Where appropriate, consider putting in place a stand-by PCA to provide additional support on case management, alternative care, and any other emergency CP service required. ▪ Coordinate with other sectors and link vulnerable households with actors providing **cash-based assistance and delivering survival kits.**	UNICEF and how can UNICEF help bridge identified gaps (i.e. service delivery, coordination, partnership, technical guidance, operational support, HR, etc.)? ▪ **Priority should be given to** children who are separated from their caregivers, including those in observation centres, treatment centres, or alternative care; children in households affected by restrictions on movement or lack of access to services; children with disabilities, chronic illnesses or other vulnerabilities; excluded children, child survivors of the disease, and children with family or household members who have contracted the disease. ▪ If not already in place, consider conducting a **service mapping** of child protection and MHPSS actors.

▪ Children may be sent to work to support families.		
MENTAL HEALTH AND PSICHOSOCIAL SUPPORT (MHPSS) FOR CHILDREN, ADOLESCENTS AND CAREGIVERS		
▪ Children may be scared and experience unsettling, disturbing emotions. ▪ Children may be sad and isolated and have limited peer and community interaction and support. ▪ Parents can feel overwhelmed, scared, worried, powerless, frustrated and their caring capacity may be jeopardized. (see above on protection from violence and abuse). ▪ Intensified negative emotions can lead to psychosocial distress. ▪ If distress is prolonged can	▪ **Provide support to children** to cope with fear, isolation, worries, intensified emotions, disrupted routine and bereavement. ▪ **Support parents and other community members** to better care for themselves and support children. This involves providing key messages about care of children, and engaging parents and community members in face-to-face dialogue, if the situation allows (for instance running sessions at the workplace) about how they can better support their children. ▪ Alternative means that don't involve in-person contact can be used (set-up a hotline to ask for support, online videos, messaging, etc.). ▪ Conduct a service mapping of MHPSS actors and establish referral mechanism for children and families. ▪ **IASC and UNICEF MHPSS guidelines/standards of practice** adapted to the context (including for people with severe mental disorders infected by the virus and admitted quarantine, and psychosocial support for the discharge and follow-up of patients). ▪ **Identify and train partners** at the national, provincial/district and local levels	▪ Mental health and psychosocial support services should be designed to be culturally, gender and age-appropriate, safe and stimulating. ▪ **Psychological First Aid messages** should be prepared and ready to be integrated in risk communication messages and be delivered to different groups through multiple modalities. ▪ Orient responders to PFA (including PFA for children). Ensure that responders know the limits of their capacity based on a very brief orientation, and are aware of referral mechanisms (including for mental health clinical care). ▪ **If conditions allow, community-based support should be prioritized**. This can be done building on existing networks (e.g. women's associations, religious groups, para/social workers, etc.) if are still functioning, and systems (empowering teachers and nurses to provide psychosocial support, for instance). ▪ **Inter-agency and inter-sectoral coordination and integration of services is essential**, especially with CP, Education and Health. Representatives from the MHPSS coordination group should also attend sectoral coordination groups (health, protection, education) to ensure the integration of MHPSS activities into different sectors. ▪ If group-activities are not appropriate or safe, other **creative options can be identified, including in collaboration with Health and Education**. Alternative options can include: *(i)* home visits by social workers, nurses, teachers and trained community-volunteers/youth, religious groups, etc. *(ii)* conducting activities with children within the

undermine the capacity to positively cope with adversity. Prolonged distress may result in severe mental conditions and long-term repercussions on the functioning and coping capacity of the individual.	▪ Work closely with the Education team to **integrate mental health and psychosocial support and messaging within online formal/ informal education programmes.** ▪ **Avoid that children and adolescents are exposed to excessive/continued exposure to threatening news and images (such as from the media).** ▪ **Train relevant personnel in MHPSS interventions (including awareness-raising on the relevance of such interventions for non-MHPSS workers)** ▪ **Advocate, contribute to ensuring that affected communities have free and regular access to services available online and through the phone network** (e.g. social platforms and others offering psychosocial support and remote schooling, child-helpline, etc.).	extended family or households (for instance in situation where children can't go out but live with other children), *(iii)* delivering emotional support online through messaging apps and other online platforms*, (iv)* offering support at the health centres for hospitalized/quarantined children, integrate MHPSS in other activities (e.g. immunization campaigns, non-formal/formal education, etc.). ▪ Advocate and ensure that social workers, psychosocial workers, community volunteers and other protection personnel conducting outreach/door-to-door activities are **equipped with the necessary protective equipment** (i.e. masks, other protective gear and hand-sanitizer) **and receive training/instructions on how to mitigate the risk of contracting the disease.** In fact, it may occur that masks are distributed to frontline teams with prioritization of the health personnel only, with the consequence that protection and psychosocial activities are hampered, and protection/psychosocial teams are put at risk**.** Instructions concerning the correct use of the protective gear and other safe behaviors (such as frequent handwashing and avoiding touching eyes, mouth, nose, among others) are critical mitigation measures complementing the protective equipment. ▪ Include a mental health and psychosocial awareness component – including communication skills – in the training of teams going door-to-door in communities to avoid the under-reporting of symptoms amongst people with mental health problems.
▪ Children and parents receive confusing, stressful and incorrect messages concerning COVID-19	▪ **Develop preventive and support messages for children and adults.** Such messages can cover: risks related to COVID-19 and how to keep oneself safe from the disease, how to keep children protected from injuries, abuses and violations, possible physical and psychological reactions of different-age-children and	▪ Work closely with C4D, Education and other key sectors and agencies to develop an **integrated package of psychosocial support messages** offering parental guidance to caregivers and emotional support to children and adolescents, with attention to supporting children who have experienced loss or grief.

and how to prevent the disease. ▪ Children and family may not be able to access needed information to keep themselves protected against the disease.	adults in a situation of distress, positive coping mechanisms to overcome a challenging environment, positive messages for caregivers to deal with distressed children and provide them with needed comfort.	▪ **Psychosocial messages should always integrate and complement prevention messages** informing on the risks and on recommended health and hygiene practices. Support messages and risk communication should be designed to be accessible by children of different age-groups of both sexes, in a manner that is culturally sensitive. ▪ Where possible, develop and pre-test messages in advance of an outbreak. ▪ Review messages already developed in the region and, if appropriate, readapt or translate them to your countries. ▪ Explore private partnerships in advance to identify multiple channels to disseminate messages. ▪ Ensure that messages are available in multiple formats to be accessed by children and caregivers with disabilities.