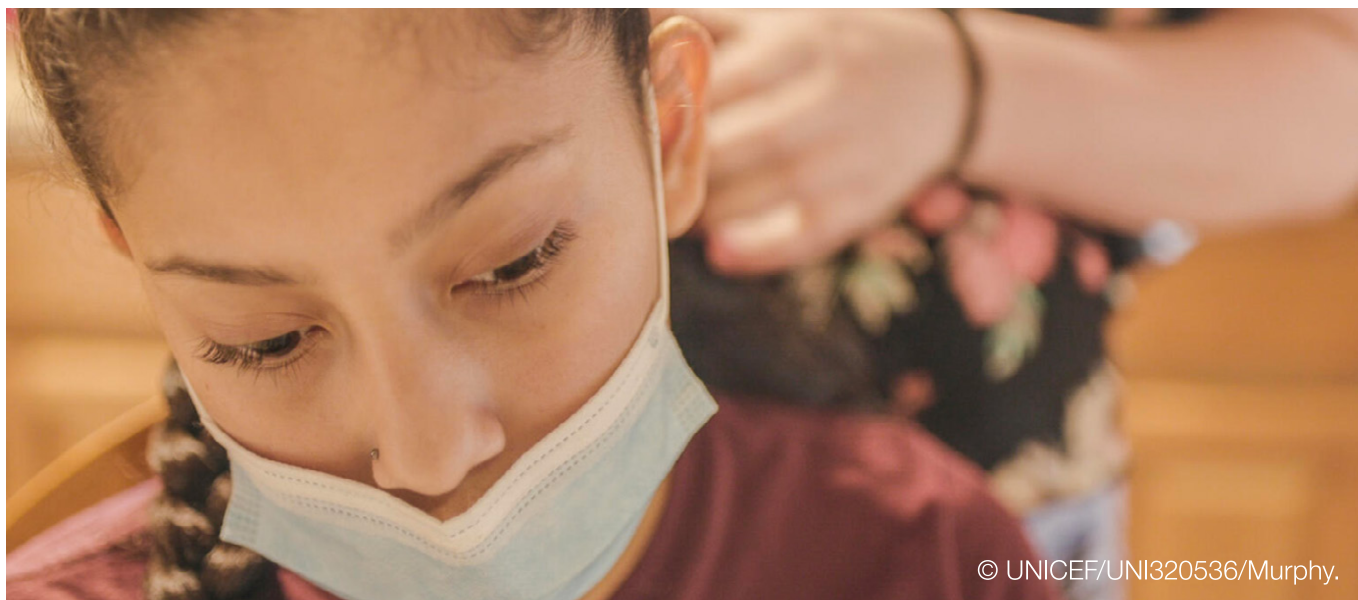
Key considerations

Family Tracing and Reunification (FTR) for Unaccompanied and Separated Children (UASC) in relation to the COVID-19 pandemic, and other potential infectious disease outbreaks

A. Introduction

This document builds on existing Unaccompanied and Separated Children (UASC) programming guidance and incorporates recent field experience from the child protection sector in the context of the COVID-19 pandemic.

It should therefore be read in conjunction with *thematic recommendations* already available. It is designed to help adapt and/or initiate Family Tracing and *Reunification* (FTR) programs in the COVID-19 pandemic, and during any *infectious disease outbreak* more generally. It outlines how key principles should be applied and describes priority actions to consider at each stage of the programming in view of supporting the identification, the tracing and family reunification of Unaccompanied and Separated Children (UASC) in need of such services.



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B. Consequences of the pandemic for UASC and impact on FTR programs

Children, UASC in particular, have been impacted in a unique way by the *COVID-19 pandemic.* UASC have been exposed to the virus as a result of their specific vulnerability, while the programs catering for their needs, Family Tracing and Reunification, as well as the provision of *alternative care,* have been hampered. Moreover, some of the containment, control and mitigation measures designed to control the spread of the pandemic have created or exacerbated child protection risks. The consequences of the pandemic for UASC can be classified as follows:

- **UASC direct exposure to the pandemic**
  - Health promotion messages, and basic protective kits such as masks and sanitizers are most often targeted at and distributed to adults. These are less likely to reach UASC living on the margins of their communities, e.g., children on the move, children living in the streets, or in *detention* for instance.
  - Children, whether UASC or not, may be less likely to adhere to some behavioural and hygienic practices such as routine hand washing or social distancing that prevent, or reduce the risk of infection, unless awareness raising material and approaches are adapted to their age, maturity, and evolving capacities.
  - The adoption of such preventative practices might be particularly challenging for UASC involved in child labour or in other livelihood activities or who live in environments with limited access to water (IDP/*refugee camps,* places of detention etc).
  - UASC in informal care might not be prioritized by carers when protective kits, masks and sanitizers are scarce.

- **Pandemic impact on FTR programs**
  - FTR services not regarded as essential services during COVID-19: Governments

have taken a range of measures restricting movements, as well as imposed lockdowns, requested physical distancing and re-prioritized health and social protection programs. Against this backdrop of activities targeting large populations or specific geographical areas, child protection activities, and FTR in particular, are not necessarily seen as essential.

- COVID-19 related factors hindering the provision of temporary alternative care to UASC: Lockdown, curfews, physical distancing, restrictions of movement measures can hinder Child Protection/Family Tracing and Reunification (FTR) personnel delivering services towards UASC living in all forms of care (residential, community-based, family-based, independent living, temporary facilities), in camps or living alone.
- COVID-19 related factors hindering the tracing of UASC's families: Containment, control and mitigation measures, the fear of infection, the competing priorities - stakeholders being absorbed by the implementation of unprecedented large scale public health response - also hamper child protection/FTR personnel ability to undertake Family Tracing and Reunification activities per say. These are indeed particularly constrained given their nature, requiring mobility across different communities, regions and States, engagement with, availability and trust from multiple actors in different places over periods of time.
- Limited referrals: Equally, community actors, authorities and other sectors, instrumental in identifying and referring UASC or in helping trace a child and or their family have a limited ability to reach out to child protection/FTR personnel if they can no longer meet them physically or regularly.
- Children themselves face restricted access to services: UASC themselves can be prevented from or unable to access international protection or reach out for assistance. It is particularly true of children on the move, including refugee and asylum-seeking children and children in mixed movement situations, who cannot cross borders and or whose families may be prevented from joining them due to border closures.

- **Measures that can exacerbate protection risks**
  - In addition to the pre-existing caseload of UASC, child protection/FTR personnel have to cater for new children becoming or at risk of being separated or unaccompanied as a result of the pandemic e.g., infection of the *caregiver being isolated/quarantined,* caregiver being deceased, *child being infected and subsequently isolated/quarantined* without sufficient mitigation measures to prevent separation.
  - Beyond the increased risk of separation, mandatory containment, control and mitigation measures applied to UASC being transferred within the country, across regions and or borders, can exacerbate protection risks – e.g., violence including Gender-Based Violence, abuse, neglect, trafficking – if authorities in charge do not enforce minimum safeguarding measures.
  - Concurrently, containment measures applied to communities, regions or States can prevent children from being reunified with their families. This can include a lack of access to testing for UASC and or their caregivers or accompaniers to be able to travel.
  - The lack of advocacy on behalf of UASC for consideration, prioritisation and registration for testing and vaccination could result in UASC not being registered, being overlooked, or have limited access to testing and vaccination schemes. This might in turn prolong separation and prevent them from being cleared to travel from one region or State to another.
  - The *social stigma* attached to the child, to her/his family/community if or when falling ill, when there is uncertainty regarding child's health status, can delay or prevent family reunification.
  - Households' (biological, kinship, foster, independent living, child-headed households) reduced economic opportunities, loss of employment and income as a result of the COVID-19 pandemic exacerbate the risk of family separation.
  - The reduced opportunities for the households also may increase the expectation and the pressure on the child to breach control and mitigation measures and to get involved in *child labour,* thus exposing her/him to the virus.

C. Principles

All the principles applying to child protection/FTR work remain valid during the COVID-19 pandemic. They apply to all steps of the FTR process, and to the care modalities envisaged at the different stages, while the specificities of the pandemic and its unique challenges call for contextualization. This section outlines how they can be adapted to FTR programming in the context of a infectious disease outbreak:

Family unity

- All efforts need to be made and all options considered to ensure that decisions made to *isolate or quarantine a primary caregiver and or a child* do not result in separation. Family unity and contact need to be maintained, while following recommended clinical care and infection prevention and control measures.

Best interests

- The principle needs to be given primary consideration in all decisions that affect children in general, and individual children in particular, including decisions regarding isolation, quarantine, family tracing and reunification.
- Similar to non-COVID-19 contexts, the best interests of the child with regards to tracing on the one hand and reunification on the other hand will need to be assessed independently, with her/his consent or assent depending on her/his age. As part of the process and when relevant, risks of further harm will be given due consideration (i.e. in the case of children who may have fled due to violence in the family, including Gender-Based Violence, risk of marriage, *recruitment*, etc). For refugees, a *Best Interests Assessment* will be required, and in specific situations a *Best Interests Determination* may be required.

Participation

- *Children need to be engaged in child protection and FTR processes,* to receive appropriate information and to be listened to. Information shared at all stages of the FTR process needs to be child-friendly, culturally and developmentally appropriate, so as to reach younger children, those who are illiterate and children with disabilities. Information is to be made available in the languages or format commonly used and understood by the children.
- The child's consent or assent to be enrolled in a FTR program is the preferred option. It is important that when asked to provide consent, she/he can fully consider the risks and benefits of the processing operation in the context of the pandemic.
- Children should be encouraged to express their concerns and ideas. It is important to build on their strengths and to prioritise the children and their caregivers' views in decision making. An understanding of the family context and the family environment, of the risks and opportunities that a reunification would entail is crucial in decision making.

Confidentiality

- While the principle of sharing information on a "need-to-know" basis remains, the COVID-19 pandemic has brought additional actors into discussions that they were not necessarily part of before, e.g., health actors. All actors need to be briefed on how confidential information should only be made available to authorized individuals, and that any sharing is guided by the best interests of the child.
- The implementation of a *case management approach* in the context of the COVID-19 pandemic might require the inclusion of health information into individual files, e.g., current or past exposure to COVID-19 , the status of caregivers, communities of origin or destination, or previous quarantine or isolation measures. Such decisions will have to be guided by an assessment of the child's best interests.
- *Information sharing protocols* amongst concerned actors and internal procedures within organisations are to be adapted accordingly.

Do no harm

- The principle consists in ensuring decisions regarding the child, the practices around her/him do not impact negatively on her/his health, her/his exposure to the COVID-19, her/his degree of separation and or her/his likelihood of reunification and reintegration. Its application also requires an appreciation of the situation and the risks that resulted in the child's separation in the first place.
- Given the contagious nature of COVID-19 , the principle applies to decisions regarding all personnel in contact with children, child protection/FTR, health and beyond. It also pertains to other children potentially brought into contact with the UASC that receives FTR services.
- *Strict and adequate protocols* to reduce risk of infection and propagation must be developed and rolled-out.

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D. General considerations applying to all stages of FTR programming

This section highlights key generic considerations valid throughout the implementation of a FTR program. It adds to *existing guidance,* and articulates COVID-19 specific measures regarding advocacy, coordination, planning, prevention, communication, and transportation.

- ***Advocacy***
    - Engage with responsible authorities/health actors/donors regarding the essential nature of child protection/FTR work, including family-based care, community-based care, tracing, and reunification.
    - Promote access to *social protection* for households caring for UASC, for UASC themselves where relevant, with competent actors.
    - Advocate with responsible authorities/health actors to ensure restrictions on movement and across borders do not contribute to family separation and to facilitate reunification.
    - Advocate with responsible authorities to ensure restrictions on movement and across borders do not deny children and their families their right to seek asylum and their right not to be forced to return to country of origin, and to receive information about the right to asylum and the asylum procedure.
    - Review and respond to context specific, authorities' requirements to FTR e.g., child/child protection personnel testing, vaccination, access to Personal Protection Equipment (PPE).
    - Engage with responsible authorities/health actors/donors for suitable access to testing, to vaccination for vulnerable children/UASC/child protection personnel, for safe and child friendly isolation or quarantine options, as per the *sector's guidance.*
- **Coordination and planning**
    - FTR programming in the COVID-19 pandemic requires a *cross-sectoral approach,* bringing together national and local authorities, child protection, health, education, WASH, camp management, MHPSS, prevention and response to GBV, law enforcement, civil society organisations and other relevant actors.
    - Design cross-sectoral plans e.g., material, financial, technical support, supplies that support all dimensions of FTR programming, from identification to transportation and reunification and monitoring, including all forms of care: temporary/interim care, families in quarantine/isolation, families caring for a child whose parents are in quarantine/isolation, independent living.
    - Provisions need to be made to cover additional costs of transportation, accommodation, communication, as well as testing and vaccines for adults, as requested by some States.
    - Ensure FTR coordination is linked to any existing child protection coordination forum e.g., *cluster* or refugee settings, with adequate participation and alignment with government structures to ensure UASC are considered in any new measures.
    - Together with relevant actors, set up cross-sectoral coordination mechanisms, appoint focal persons, and design simple and functional *Standard Operating Procedures (SOPs) and Referral Pathways* for the identification and referral of UASC and children at risk of separation, their care, and their reunification.
    - Where regional or national border crossing is involved, promote bilateral participation of national and local authorities in coordination mechanisms.
    - Together with health and other relevant actors, assess risks of infection and of separation at all stages of the FTR process, and design mitigation measures accordingly.

Case Study 1. An inter-agency, cross-sectoral approach to UASC programming in Afghanistan

In 2020, in the context of the COVID-19 pandemic, UNICEF in Afghanistan assisted 5,916 unaccompanied and separated children (UASC) on the move returning mainly from Iran, but also from Pakistan, Turkey and Europe. A cross border inter-agency inter-governmental approach was agreed upon from the onset to facilitate their registration, the provision of temporary care, the family tracing, the transportation, the reunification and the reintegration.

Amongst the many challenges faced at the Iran-Afghanistan border, UASC were confronted to the social stigma resulting from the uncertainty around their health status and to the logistical constraints in terms of safe temporary accommodation and transportation.

These concerns were gradually addressed through a set of mutually reinforcing interventions. Standard Operating Procedures (SOPs) were developed, articulating the roles and responsibilities amongst UN agencies, international and national NGOs and government actors. The frontline personnel (government and civil society) received adequate supplies and protective equipment to reduce risks of infection for themselves and their families, and safe transportation protocols allowing for physical distancing were financed and put in place. They were also trained on protecting themselves and others from the virus, on awareness raising with communities and children, identification of the symptoms, and referrals to appropriate services, which contributed to addressing the social stigma around COVID-19. Finally, their knowledge and skills on case management and on the vulnerabilities of children on the move more generally were further strengthened.

Such measures, combined with the regular health checks and screening performed at the border, were found to have addressed some of the initial hesitancy of frontline workers to engage with the returning children. Moreover, the rollout of a case management approach and individualised assessments, allowed for the identification of the UASC who could benefit cash transfers and or livelihoods activities to reintegrate into their communities. Please see this *link* for more information on our work in the country.

- **Prevention of and response to infection**
  - Ensure child *protection/FTR personnel are supported*, trained, equipped with required COVID-19 prevention and management knowledge and equipment.
  - Include contingency and mitigation measures in plans, to prevent and mitigate for the risk of infection of child protection/FTR personnel e.g., promote, establish network of alternates for key FTR functions within same organization, especially for identification, care, tracing, and reunification.
  - Equip UASC, families, *communities* involved in the FTR process with knowledge and practices on COVID-19 to protect themselves and others.
- **Prevention of separation and related child protection risks**
  - Raise health, law enforcement and other *relevant actors' awareness on child protection risks*, including separation, violence, trafficking, gender-based violence affecting girls, boys and non-binary children, when in *interim care* e.g., *isolation, quarantine facilities*..., and during transportation. Ensure the specific needs of unaccompanied and separated children, and vulnerabilities are understood by health personnel.
  - Plan to include contingency and mitigation measures to prevent family separation when isolation/quarantine measures are taken e.g., explore all options to keep child with caregiver, identify alternative options e.g., kinship care, relatives, trusted adults.

- Build and support networks of temporary foster families as a preparedness measure, ensuring adherence to strict safeguarding policies, advocate with authorities/health actors/ donors against establishment of new long-term residential care facilities.

- **Communication**
  - Plan to support and promote safe and confidential use of Information Communication Technology (ICT) (phone, emails, WhatsApp, videoconference, help/hotlines…) wherever feasible, at all stages of the FTR process, by authorities, child protection/FTR personnel, by UASC, by families and communities.
  - Use of ICT during the FTR process is particularly relevant in ensuring that children and their family members can maintain contact during the (possibly prolonged) period of separation, isolation or quarantine.
  - During lockdowns, when physical distancing measures are in place, use of ICT facilitates interaction and exchange of information and documentation with national and local authorities, law enforcement, and transportation personnel… It also facilitates cross-border communication between different government entities.
  - Consider the need for ICT platforms to have adequate security safeguards to cater for _online risks_ and to respect sharing of sensitive and confidential information and documents where needed e.g., asylum claims. ICT platforms should allow for three-way calls or videos for context where interpretation is needed to support with communication.

- **Transportation**
  - Plans to include measures to mitigate risks of separation and infection during transportation of the child from one place to another, within country, cross border, by road, by air, including access to PPE.
  - Transportation, context specific protocols to be developed, in consultation with public/ private transportation actors.

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E. Considerations specific to FTR stages

This section is organized around the customary stages of a FTR program. Complementing available *sectoral guidance*, it outlines key COVID-19 related considerations for each stage of the process.

- ***Identification* of UASC**
  - Monitor child's health/COVID-19 status in line with *WHO guidance* upon identification.
  - Assess, plan and arrange for child's immediate needs re. temporary care and protection, preferably in family settings.
  - Assess, plan for and address child's potential protection risks through a coordinated case management approach, that includes MHPSS support where relevant.
  - Initiate documentation and tracing as soon as a child is identified and or placed in quarantine or isolation and or an adult carer is placed in similar facilities, in view of preserving family unity and preventing separation.
  - Child and carers need to be informed of each other's location and health/COVID-19 status and communication needs to be maintained.
  - Information on child's next of kin needs to be collected from the outset, and always kept in the child's individual file.
  - Child protection/FTR actors to apply physical distancing measures to interaction with UASC, with key informants on UASC, use of Personal Protection Equipment (PPE) as appropriate.
  - Consider remote inter-action, use of ICT (phone, emails, WhatsApp, videoconference, help/hotlines…) where possible and relevant, by child protection/FTR actors, by UASC, by key informants on UASC.
- ***Documentation* and filing**
  - Where an UASC is identified in an isolation/quarantine facility, coordinate/harmonize documentation with health actors (age, sex, next of kin, disability, address…) in view of facilitating case management and FTR.
  - Documentation needs to include health related available information on UASC, the current carers, the host community, the family to be reunified with, the community to be reintegrated into.
  - Record child and caregivers' health history, measures already taken, prospects re. current or future carers' health and risks (elderly carers, carers with chronic diseases…), over time (see confidentiality principle).
  - In addition to health information, in cases of forced displacement, UASC individual files need to include reasons for flight, including child's understanding of prevailing risks in country (for refugee, migrant children) or community/region (for Internally Displaced Child) of origin.
  - Document the child's current migration status (refugee, asylum seeker, current status of asylum claim, IDP, undocumented…).
  - Consider use of main information management system (CP IMS or proGres, government unique identifier number, NGO, multi-agency…) where available, to record UASC health information and support FTR, as per information sharing protocols.

Case Study 2. Use of ICT to document and case manage UASC in Libya

While embassies shut their doors and borders closed, UNHCR Libya's Family Reunification (FR) Program adapted and was able to continue with its FR interviews, sharing of case updates and counselling sessions with the exceptional use of end-to-end encrypted messaging and voice-over-internet-protocol (VOIP) services.

In the case of Libya, available and commonly used communication tool were surveyed, and Whatsapp was identified to be the most common application used persons of concern in Libya as well as by their families in the FR destination countries, allowing for the FR Expert to maintain contact during the lockdown periods in Libya and Tunisia.

Through messaging/VOIP service, UNHCR FR Expert was able to carry out three-way calling, accommodating the different locations of the interview participants (the FR Expert, the interpreter, and the child) in the FR process. The camera feature enables the FR Expert to verify the child's identity prior to the start of any FR interview and documents supporting the FR application can be shared. It also allowed for the FR Expert and interpreter to connect easily with the family members in the destination countries for FR interviews and related communication. Please see this *link* for more information on our work in the country.

- **Caring for the child while in *temporary care***
  - If the child is in a family environment (foster families, kinship care…):
    - Disseminate knowledge on preventing the spread of the virus within the household.
    - Make contingency plans for who will care for the child if primary caregiver falls ill.
    - Promote use of technology to provide support and contact with family members or other caregivers, support workers or CP staff who are elsewhere.
    - Identify and address potential barriers for families to access child- and other *social benefits.*
    - Combat stigma against those who are ill and the virus in general (symptoms, mode of transmission…).
  - If the child is already in alternative care or just placed in alternative care due to the pandemic:
    - Promote family-/community-based care over residential, as well as independent living where appropriate.
    - Adjust admission/monitoring/assessment/ referrals procedures to allow on-line and telephone channels of communication and to cater for prevention measures; procedures need to cater from the increased risk of isolation in community-based care, especially when schools and community centres are closed, including through the provision of additional ICT tools.
    - Develop guidance to address need for interim care of infected/contact cases of children.
    - Where in use, facilities should not be closed rapidly without effective support and plans for every child.
    - Ensure sustained provision of supplies and support to facilities.
    - Strengthen capacity of *hotlines or helplines* to allow children and parents to report issues or concerns of neglect, abuse, trafficking, violence, including Gender-Based Violence.
    - Additional support to *children with disabilities* in care.
  - All actions must appropriately *safeguard children*, including against the risk of sexual exploitation, violence including Gender-Based Violence, abuse and trafficking.
  - Continue to prioritize family tracing and reunification to reduce time children spend in transit or interim care centres.

Case Study 3. Foster Home for Unaccompanied Children, Villa de Rosario, Norte de Santander, Colombia

The Foster Home for Unaccompanied Children in Villa del Rosario, Norte de Santander, Colombia, is managed by World Vision and is funded by IOM. The Foster Home responds to the high number of migrant unaccompanied children, in transit within Colombia, or returning from Chile, Ecuador and Brazil. Indeed, the health emergency caused by COVID-19, and the subsequent measures adopted by the governments of each of these countries, led many of the children to return to their country of origin as access to basic resources such as food, health and housing became more and more difficult.

In the municipality of Villa del Rosario, World Vision's gender and protection teams, in collaboration with IOM, UNICEF and UNHCR, identify unaccompanied children within the migrant population at the Family Station (Comisaría de Familia, the public institution in charge of, among other functions, ensuring the rights of girls, boys and adolescents). Those requiring temporary care and reunification are referred to the Foster Home which has adapted its procedures to the restrictions imposed by COVID-19, in coordination with the responsible authorities at local, regional and national level. After a 4-day quarantine period and the completion of a COVID-19 test, newly arrived children join the other residents.

In parallel, withing the first 24 hours, girls and boys are registered and documented, provided with food, psychosocial, pedagogical support, and legal advice. An individual intervention plan is designed by professionals to identify immediate protection needs and to trace families and or caregivers in communities of origin. Once reunification is assessed to be in the child's best interests, the family is traced, the links verified, and steps are taken with the competent local authorities to reunite the child. These include transportation adhering to biosafety protocols as well as safeguarding measures. Please see this *link* for more information on our work in the country.

- ***Tracing***
  - As part of the case management approach, confirm whether tracing is in the child's best interests at this stage. Weigh up opportunities towards re-establishing contact the separated child against risks for children who may have fled due to family violence, Gender-Based Violence, child marriage, *recruitment*, etc. For refugees, this should be part of a formal Best Interests Assessment.
  - Engage children and families to assess whether tracing will be undertaken for reunification purposes or to restore family links prior to actual reunification, based on the child's best interest.
  - Promote electronic matching vs. physical tracing, use of ICT where feasible. Involve the health personnel from isolation/quarantine facilities in electronic matching.
  - Assess risks of the child contracting the virus compared to the benefits of reunification with family at each stage.
  - Assess ability and willingness of the family/adult carer to receive the child from a health viewpoint and socio-economic viewpoint.
  - Assess weight of the potential stigma against a child who has been ill, who is coming from a high prevalence region/*community*.
  - Similarly, assess family/community reluctance to receive child previously institutionalized, in *detention* facilities or involved in other groups discriminated against e.g., boys and girls living in the street, engaged in survival sex or victims of Gender-Based Violence.

Case Study 4. Restoring family links in Central African Republic

Across the world, the International Red Cross and Red Crescent Movement (the Movement) restores contact between families separated by conflict and disasters, including between refugees from the Central African Republic (CAR) in the Republic of the Congo and their families back home.

In early 2020, when the COVID-19 pandemic led the government to declare lockdowns, border closures, and to limit travels, dozens of unaccompanied and separated children about to be reunified were stranded. For scores of children separated from their families by war and aching to go home, this meant months of further uncertainty and anguish, compounding the trauma of the initial separation and the violence they had lived through. Moreover, in CAR, people returning from abroad were seen with increasing suspicion as a potential vector of the disease.

Throughout this period, the Movement carried out work to address the potential risk of stigmatization within the communities of the returnees, disseminating information on the disease and ways to protect oneself. The Movement ensured UASC had access to adequate health care and continued to be provided with alternative care where they were, in line with national standards whilst the children awaited reunification. In compliance with evolving restrictions and hygiene protocols, field staff and volunteers maintained their efforts, to carry out tracing, restore contacts with relatives, to verify whether reunification was possible and in the best interest of the child and to reunify children with their families. Please see this *link* for more information on our work in the country.

- **Verification, *reunification***
  - As part of the case management approach, and engaging children in the process, confirm whether reunification is in the child's best interests or possible at this stage.
  - Anticipate the potential additional need for temporary/transit care during the reunification process.
  - Anticipate additional needs when reunifying across borders, including travel documents/ laissez-passer/residency permits, *isolation or quarantine requirements,* UASC care and protection during isolation/quarantine; plan for alternatives for UASC isolation or quarantine (e.g., hotels…).
  - Review and address authorities'/communities' requests regarding children's medical testing and or vaccination prior to reunification.
  - Review and address authorities'/communities' requests regarding child protection/FTR actors' tests and or vaccination prior to intervening.
  - Assess availability, modus operandi of national and local authorities, including border authorities, asylum services, embassies, consular services during the COVID-19 pandemic, including through online modalities.
  - Address *potential stigma* against children who have been ill, who are coming from a high prevalence region/community, from a potentially discriminated group.
  - Provide households/communities receiving the child with simple guidance on prevention, signs and symptoms, modes of transmission, prevention, and emergency numbers; consider distribution of masks and hands sanitizer.
  - Encourage and support where necessary households to develop their own contingency plans in case care givers fall ill, that make provision for the child to continue to be cared for by the family, by a relative or by another trusted adult.
  - On-going monitoring of public health situation in regions where UASC are located as well as being reunified.

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Useful resources

On UASC programming:

Field Handbook on Unaccompanied and Separated Children | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Toolkit on Unaccompanied and Separated Children | Resource Centre (savethechildren.net)

Inter-Agency Guiding Principles on Unaccompanied and Separated Children | International Committee of the Red Cross (icrc.org)

Interagency Working Group on Unaccompanied and Separated Children (2013) Alternative Care in Emergencies Toolkit | Resource Centre (savethechildren.net)

Child Safe Programming and Safeguarding in Interim Care Centres | Resource Centre (savethechildren.net)

On Child Protection in the context of the COVID-19 pandemic, or any other Infectious Disease Outbreak:

cp_during_ido_guide_0.pdf (alliancecpha.org)

Technical Note: Protection of Children during the Coronavirus Pandemic v.2 (alliancecpha.org)

Technical Note: Adaptation of Child Protection Case Management to the COVID-19 Pandemic - Version 3 | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Guidance for Alternative Care Provision During COVID-19 | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

children_isolation_and_quarantine_-_cp_considerations_during_covid-19_-_final_-_2020.10-english_0.pdf (alliancecpha.org)

Social-Service-Workforce-Safety-and-Wellbeing-during-COVID19-Response.pdf

Working with Communities to Keep Children Safe, v.1.1 | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Key Messages and Considerations for Programming for Children Associated with Armed Forces or Armed Groups During the COVID-19 Pandemic, v.1 | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Document. Protecting Forcibly Displaced Children during the COVID-19 Pandemic (unhcr.org)

Technical Note: COVID-19 and Children Deprived of their Liberty | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Advocacy Messages for Child Protection Actors: Prioritizing Child Protection in COVID-19 Response Plans | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Social Service Workforce Safety and Wellness during the COVID-19 Response: Recommended Actions | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Technical Note: Child Helplines and the Protection of Children during the Covid-19 Pandemic | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

Policy Paper | Social Protection & Child Protection: Working Together to Protect Children from the Impact of COVID-19 and Beyond | The Alliance for Child Protection in Humanitarian Action (alliancecpha.org)

ida_recommendations_for_disability-inclusive_covid19_response_final.pdf (alliancecpha.org)