



READY:
GLOBAL READINESS FOR
MAJOR DISEASE OUTBREAK RESPONSE



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Promoting Collaboration Between Child Protection and Health Sectors in the Context of Infectious Disease Outbreaks: Stakeholder Consultations

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1. BACKGROUND

In 2018, the United States Agency for International Development (USAID) Bureau of Humanitarian Assistance (BHA) funded Save the Children to lead a three-year global initiative to augment capacity for humanitarian response to major disease outbreaks. Through a consortium of partners, this initiative, known as READY, supplements existing efforts to build and retain capacity among operational consortium members, non-governmental organizations (NGOs), and other stakeholders to be able to respond to major outbreaks more quickly and effectively. It promotes an integrated and multi-sectoral approach to outbreak response to holistically meet the needs of affected communities, with community engagement and communications at the center. READY prioritizes diseases with major epidemic or pandemic potential, specifically water-borne, respiratory, and bodily fluid transmission pathways.

2. OBJECTIVES

Global evidence from past infectious disease outbreaks has repeatedly underscored an increased incidence of child protection issues¹ – specifically higher numbers of children facing abuse, violence, exploitation, and/or neglect. Children’s biological and behavioral susceptibility to certain infectious diseases can be compounded by the potential ways in which public health measures designed to contain and control virus transmission may disrupt daily lives during and after an outbreak.²

The unprecedented COVID-19 pandemic, its impact on children, and the lessons learned from it so far have led READY and its strategic partners to prioritize improved coordination and collaboration between Child Protection and Health actors. While previous responses to infectious disease outbreaks, such as Ebola and Diphtheria, highlighted the need for Child Protection and Health actors to work together – for example through ensuring safe alternative care options for unaccompanied or orphaned children, or child-friendly messaging – the COVID-19 response in humanitarian contexts spotlighted the necessity of and challenges related to integrated programming. Indeed, the pandemic has unequivocally demonstrated the need for increased attention and guidance to be provided on both the how and why of integrated programming.

In an effort to support evidence generation and development of guidance on integrated programming, READY undertook a series of stakeholder consultations to examine key challenges, best practices, and successes of integrated Child Protection and Health programming during the current pandemic and past epidemics and outbreaks. Specifically, these consultations aimed to:

- 1) Identify best practices and successes of integrated Child Protection and Health responses
- 2) Name and understand gaps and bottlenecks to designing and implementing an integrated response
- 3) Collate recommendations to ensure integrated programming in future

This work aims to uplift Standard 24 of the Minimum Standards for Child Protection in Humanitarian Action (CPMS)³ with the goal of better preparing both Health and Child Protection actors for future infectious disease outbreaks. This report documents key reflections and recommendations linked to inter-sectoral collaboration gleaned from consultations with key informants.

¹ UNICEF Innocenti (2020), Impacts of Pandemics and Epidemics on Child Protection: Lessons learned from a rapid review in the context of COVID-19, available at: <https://www.unicef-irc.org/publications/pdf/WP-2020-05-Working-Paper-Impacts-Pandemics-Child-Protection.pdf>.

² The Alliance for Child Protection in Humanitarian Action (2018), Guidance Note: Protection of children during infectious disease outbreaks, available at: <https://alliancecpa.org/en/child-protection-online-library/guidance-note-protection-children-during-infectious-disease>.

³ The 2019 edition of the Minimum Standards for Child Protection in Humanitarian Action (CPMS) is available at: https://alliancecpa.org/en/CPMS_home.

3. METHODOLOGY: STAKEHOLDER CONSULTATIONS

An overview of the methodology for the stakeholder consultations is provided below.

- A Steering Committee was established in May 2021 to bring together colleagues from the Child Protection Area of Responsibility (CP AoR), Global Health Cluster (GHC), Mental Health and Psychosocial Support (MHPSS) Reference Group, and the International Rescue Committee (IRC) to:
 - Serve as key contacts on behalf of their agency;
 - Provide regular technical oversight and direction to the consultation process;
 - Facilitate the collection of key documents for the desk review – particularly those that were not publicly available;
 - Jointly identify key informants for in-depth consultation as part of actor mapping and to facilitate scheduling and participant uptake;
 - Review and provide timely and consolidated feedback on draft deliverables, as well as validate final deliverables.
- Prior to beginning the consultation process, a light desk review was conducted to identify country-specific documents (including Standard Operating Procedures, guidance notes, job aids, etc.) created by colleagues to support collaboration and coordination between Child Protection and Health actors. This desk review initially included documents sourced from Steering Committee members and evolved to encompass further materials shared by key informants.
- With the support of the Steering Committee, READY utilized a purposive sampling approach to conduct a total of 32 key informant interviews (KIIs) between May and June 2021.
 - Key informants represented different sectors and technical areas including Child Protection (17 key informants), Health (13 key informants), and Education in Emergencies (2 key informants)
 - Key informants were sourced from a range of organizations and networks, including from the following groups: the Learning & Development Working Group of The Alliance for Child Protection in Humanitarian Action (Alliance), the Interagency Network for Education in Emergencies (INEE), the Child Protection Area of Responsibility (CP AoR), the MHPSS Reference Group, the Better Care Network, the Global Coalition to Protect Education from Attack (GCPEA), United Nations (UN) agencies including UNICEF, UNHCR, the World Health Organization (WHO), and the International Labor Organization (ILO), and international non-governmental organizations (INGOs) including: Save the Children, Plan International, IRC, Action Contre la Faim, World Vision, International Medical Corps, Humanity & Inclusion.
 - KIIs primarily sought to (1) understand informants experience in working on infectious disease outbreaks with varying degrees of sectoral integration vis-à-vis Child Protection and Health, (2) explore key gaps, identify opportunities, and document successes, and (3) understand informants' recommendations to ensure the integration of child protection considerations into preparedness and response efforts.
 - Informed consent was sought at the beginning of each key informant interview and responses from key informants were anonymized to uphold confidentiality.

4. KEY REFLECTIONS

In undertaking stakeholder consultations, a number of barriers and challenges to sectoral collaboration in the context of infectious disease outbreaks were collectively identified by Health and Child Protection practitioners. A high-level summary of these reflections has been grouped thematically below:

Constraints linked to time and rapidity of response:

- Some stakeholders felt that a combination of time constraints, personnel shortages, and work overload made intersectoral collaboration more difficult to achieve, especially in outbreaks that require a rapid response.
- These constraints were often exacerbated by a lack of preparedness or comprehensive scenario planning prior to an outbreak.

Disparities in sectoral norms, attitudes, and knowledge:

- The misperception that child protection is a ‘nice to have’ but not a necessity was highlighted as a potential attitudinal barrier to prioritizing the needs of children and caregivers, particularly in the early stages of response.
- Differences in academic background were also seen to influence ways of working. For example, clinical staff may be more inclined to be trained to be logical and procedural, following a linear series of steps, while Child Protection practitioners are trained to look at the holistic environment of a child beyond the clinical setting. Many stakeholders felt that Child Protection practitioners may therefore be more likely to identify and address concerns arising from the intersection between viral characteristics (mode of transmission etc.) and the (often unintended or corollary) effects of the infection prevention and control (IPC) measures/messages needed to control the outbreak.
- Stakeholders also indicated that a lack of knowledge of other sectors can limit the ability of individuals to identify points of convergence and ways of working together.

Individual, interpersonal, and institutional factors:

- A number of stakeholders noted that successful collaboration was often a function of individual personalities or a by-product of how long key personnel had been in their position.

The risk of silos due to the humanitarian cluster system:

- Several stakeholders felt that by its very nature, the humanitarian cluster system can perpetuate silos among sectors and that intentionality is required to overcome these silos by proactively pushing for an integrated response as a benchmark of quality.

Limitations linked to donors, funding mechanisms, and financing:

- While some donors are always multisectoral in nature (Pooled Fund, for example) and some can be champions for holistic programming, stakeholders reported that many donors can be more sector-specific, rendering the task of integrated response more difficult.

Cyclical versus novel outbreaks:

- In contexts where certain infectious diseases tend to be endemic and outbreaks are repeatedly managed, stakeholders felt that there may be more opportunities for consistent sectoral collaboration as the working relationships and outbreak response are iterative in nature.
- In Yemen, for example, the potential for cholera outbreak and its implications are highlighted within the Integrated Famine Risk Reduction Strategy,⁴ which looks at the disease from an intersectoral perspective (i.e., if a child is immunocompromised due to malnutrition, they will also be more susceptible to diseases like cholera).
- Stakeholders noted that, in comparison, the novelty of COVID-19 has meant that there was little information at the outset regarding its transmission patterns and how to protect against infection, particularly given the presence of asymptomatic, yet infectious, cases. The global scale of the pandemic also meant that everyone was affected to some degree, in contrast to other infectious disease outbreaks that are more likely to be geographically constrained and where outside intervention (from unaffected areas/individuals) is typically possible.

Infected versus affected individuals:

- Some infectious diseases primarily infect children, such as measles where the vast majority of patients are under age 2. In these cases, some stakeholders felt that the link between health and child protection might be clearer.
- With COVID-19, however, children constitute significantly fewer case numbers than adults (often with less severe symptoms). There has been correspondingly less of a focus on children from Health practitioners. The reality that children have been highly affected by the pandemic, even if infection rates amongst children were lower, may have received less attention as a result, according to some key informants.

⁴ Integrated Famine Risk Reduction Strategy: An Inter-Cluster Strategy to Prevent Famine in Yemen: A Case Study (July 2020), available at: <https://reliefweb.int/report/yemen/integrated-famine-risk-reduction-inter-cluster-strategy-prevent-famine-yemen-case-study>.

A Case Study in Sectoral Collaboration: Cox's Bazar, Bangladesh

At the onset of the COVID-19 pandemic, the child protection sub-sector in Cox's Bazar, Bangladesh was quick to integrate child protection considerations into the health-led response:

- At a time when health counterparts were overrun with requests from all sectors, the child protection sub-sector set up a small, time-bound and task-oriented ad hoc working group responsible for looking specifically at the question of child protection and health in the context of COVID-19 (another working group was set up for child protection and WASH).
- The Child Protection sub-sector took the initiative to proactively approach their sectoral colleagues and ask what kind of support would be most useful. They were responsive to identified needs by shouldering the bulk of the ensuing work (cognizant that Health counterparts were overloaded). Health colleagues, for their part, were open to cooperation and proactive in providing personnel for trainings and in reviewing key documents.
- The primary focus was critical scenarios in which children could be separated from caregivers. Additionally, the group focused on the need to provide MHPSS services if children or caregivers were admitted.
- An interim guidance note was drafted by Child Protection colleagues, reviewed by Health colleagues, and validated by both. In 2020, 137 health workers were subsequently trained in small, in-person batches by Child Protection leads to become 'child carers' to provide 24/7 support to children in treatment centers where Child Protection practitioners did not otherwise have access. Child Protection volunteers were able to secure entry in quarantine centers. Toys and books were made available for use in facilities as well.
- The interim guidance note has since been updated and a second cohort of health workers have been trained using virtual platforms in 2021.

5. RECOMMENDATIONS FOR WAYS FORWARD

During the course of stakeholder consultation, key informants identified a number of key recommendations to promote closer collaboration between Child Protection and Health sectors in future outbreak responses. Potential 'success' factors for effective communication, coordination, and collaboration between Child Protection and Health actors were largely based on past and current experience working in infectious disease outbreak preparedness and response. While recommendations will likely require contextualization depending on the type, scale, or location of an infectious disease outbreak, they are outlined below:

Develop a Theory of Change to explain the necessity of sectoral integration and clarify the roles and responsibilities of each sector:

- Present the integration of child protection considerations as an opportunity to meet the needs of a large cohort of the population (i.e., typically 40-50% of national demographic).
- Show how child protection can serve as an 'enabler' to the success of other sectoral objectives. Similarly, demonstrate how health practitioners/facilities can act as an important entry point for safe identification

and referrals of child protection risks and the prevention of sexual abuse and exploitation (PSEA), as well as for identifying risks and mitigating potential inadvertent harm that may arise from IPC measures such as family separation.

- Use measurement tools, evidence reviews, and stock-taking exercises to grow an evidence base for the benefits of integrated response, build ownership, and influence resource allocations.
- Ensure that actors understand the importance of integration to shift norms by making clear not just *how* to do integration but *why*.

Prioritize preparedness:

- Given the rapidity often required to respond to an infectious disease outbreak, greater emphasis must be placed on embedding child protection considerations during preparedness efforts so that the focus can be on the quality of response when an outbreak occurs.
- As a sector, health will typically have preparedness plans in place. Child protection actors need to be involved in the development of these plans to ensure child protection considerations and referral pathways are included as well as prepare their own sector-specific preparedness plans.

Maximize ‘low hanging fruit’ to make the case for integration:

- Risk Communication and Community Engagement (RCCE) and MHPSS are two areas of work that naturally lend themselves to intersectoral collaboration and provide relatively ‘quick wins’.
- RCCE strategies can often be adult-oriented and lack child-friendly messaging and imaging for different age brackets. Not only can child protection actors help fill this gap, tailoring interventions to children of varying ages, genders, and (dis)abilities, but they will also often have pre-existing links to communities and diverse platforms that can be leveraged during infectious disease outbreaks to increase understanding and uptake of recommended public health measures. Child protection actors can also lead on the development of a child-to-child methodology for raising awareness and adopting healthy behaviors.
- MHPSS interventions are cross-cutting and can support both child protection and health sectors. COVID-19 has put a spotlight on the importance of MHPSS for children and caregivers, and there is an opportunity to continue to strengthen this understanding to ensure a continuum of care during infectious disease outbreaks. The Social Service Workforce plays a key role at the frontlines given their engagement with families.

Make it easy to communicate, coordinate, and collaborate:

- Identify personnel in key cluster coordination positions and cultivate a positive working relationship (especially at key junctures, such as rotation of staff).
- Establish clear and succinct Standard Operating Procedures for referrals and counter-referrals.
- Avoid jargon and use accessible language.
- Provide cluster coordinators and other key personnel with three bullet points of priority actions they can do to support integration of child protection considerations.

Make sectoral integration a managerial priority and a mandatory part of work processes:

- Build it into job descriptions, annual objectives, and organograms.
- Structure workflows to require cross-sector review of key documents, strategies, messages, etc.
- Guidance and toolkits should emphasize integration in their wording, format, and branding.
- Budget allocations should reflect integration (for example, including a caseworker at hospitals).
- Develop joint outcome indicators, checklists, tip sheets, and training.

Promote thought leadership and formal collaboration by the Global Health Cluster and Global Protection Cluster, as well as CP AoR:

- Capitalize on the role of newly recruited Child Health Coordinator at the Global Health Cluster to advance intersectoral collaboration.
- Budget for personnel dedicated to integration.
- Advocate for the validation of child protection as a standalone pillar of infectious disease response, in addition to promoting child protection mainstreaming throughout other response pillars.

Synchronize efforts with other concurrent initiatives at integration:

- Leverage forward momentum and maximize impact by identifying points of convergence with other sectors, especially between health, nutrition, food security and/or WASH into job descriptions, annual objectives, and organograms.
- Ensure other sectors are actively involved in drafting, reviewing, branding, and dissemination processes for upcoming guidance/tools – so that they can also advocate on behalf of children.

Scale-up investments to promote sectoral integration vis-à-vis national governments:

- Because infectious disease outbreaks are often spearheaded and managed centrally, it can be important to sensitize national governments as to the benefits of an integrated response. This is especially relevant in contexts where inter-ministerial power dynamics may be at play, whereby the Ministry of Social Affairs (or equivalent entity responsible for child protection) may have less of a voice and/or lower budget than the Ministry of Health.

Undertake targeted donor liaison on the benefits of sectoral integration:

- Donors can play a powerful role in norm setting and aligning expectations around integrated preparedness and response efforts to infectious disease outbreaks.
- Donors can champion the cause by not only making integration a requirement for funding eligibility, but also sharing the message that integration is a hallmark of quality.