COVID-19: Operational Guidance for Migrant & Displaced Children

TWG for Protecting M&D Children/MDI/Geneva Advocacy Office

Version 1 - April 2020

Contents

Save the Children

Executive Summary

- COVID-19's rapid spread poses particular challenges for vulnerable populations, notably migrants and displaced (M&D) children. Its impact will be felt disproportionately by M&D women and girls.
- Global pandemics have typically/historically been drivers of further displacement and migration.
- Certain characteristics of displaced populations: **higher risk of contagion, high mobility, difficult to access- present the perfect storm for a rapid and deadly outbreak of COVID-19.** The cost of not prioritising M&D populations is likely to be catastrophic.
- We recognise the complexity of the crisis and will work with Governments and partners to respond effectively. Yet, our foundational position is that child rights are universal to all children. Wherever we believe those rights are ignored or abrogated within the context of this crisis, we will speak out.
- **Health**: M&D populations face higher risk of infectious disease exposure due to over-crowding, limited or non-existent health infrastructure and poor WASH conditions, so social distancing, vigilant personal hygiene, and doctor visits are functionally impossible. M&D populations also face the risk of being deprioritized at a time when Governments struggle to support their national populations.
- **Protection**: M&D children face heightened protection risks (neglect, abandonment, violence and exploitation; vulnerability to contagion and to discrimination especially if unaccompanied or separated.
- Expedited recruitment to respond to C-19 risk lapses in proper **child safeguarding** good practice
- **Education**: Prior to Coronavirus, six million school-age children under UNHCR's mandate had no school to attend. Most displaced children that study do not have access to computers, or an internet connection. School closures will create huge barriers for M&D children's return to school.
- In displacement settings, schools also function as the focal point for vital services, such as school feeding programmes (WCS), child-friendly safe spaces, and formal and informal MHPSS support.
- M&D populations are often victims of **xenophobia** during major health emergencies leading to increased risk of tensions between host communities and displaced – and possible social unrest
- Governments could use the pretext of COVID-19-driven security or health concerns to enact, cement and/or legitimise draconian long-term anti-migrant and refugee policy
- It is probable that the COVID-19 pandemic will result in increased child poverty for refugee, displaced and migrant children, whose families already struggle to access **livelihood** opportunities.
- This document provides programme guidance across numerous M&D contexts and 'themes', including:
  - **Health**: Epidemiological surveillance and case management including: Early warning systems, community surveillance and adapted referral pathways
  - **Education**: e.g. Safe school and COVID-19, distance learning, Ed-Tech, etc.
  - **Livelihoods e.g.** A 'do no harm' approach in the provision of financial and material assistance
  - **Protection**: Family Tracing and Reunification, MHPSS, Children deprived of liberty (e.g. immigrant detention), Alternative Care, etc.:
  - **Context-specific responses**: e.g. urban settings, border areas, camp coordination, migrant shelters:
  - **Cross cutting issues**: such as gender, age and disability:
- **Strong advocacy** highlighting that M&D children are highly vulnerable to COVID-19 and must be prioritized; immediate actions include:
  - Calls for immediate and substantive scale-up to prevent (and test) outbreaks in camps/settlements
  - Ensure funding for M&D populations
  - Facilitate humanitarian access, e.g. to camps, to settlements.
  - Inclusion of M&D populations in national COVID-19 response plan. **Do not de-prioritise**

- o Consider temporary amnesties, to ensure M&D populations engage with response measures
- o Fundamental refugee/migrant rights must be upheld (asylum, non-refoulement)
- o Ensure that M&D populations are not **scapegoated or stigmatized**

Why this Guidance?

COVID-19's rapid spread poses particular challenges for vulnerable populations, especially migrants and displaced (M&D) children. Over 180 countries – and rising - have identified cases of COVID-19, and migration is often cited as the reason for its spread. It is apparent that certain characteristics of displaced populations such as higher risk of contagion, high mobility, and being difficult to reach, present suitable conditions for a rapid outbreak of COVID-19 – at huge risk to M&D children and to the surrounding communities. It is clear that the cost of not prioritising M&D populations is likely to be catastrophic.

Save the Children's Programme Framework explicitly recognises the acute vulnerability of migrant and displaced communities and suggests a number of possible programmatic interventions. This paper, developed by the TWG on Protecting the Rights of M&D Children, the MDI and Geneva Advocacy office, aims to provide further complementary analysis, suggested text for proposal and project design, and technical guidance to SC colleagues. It does this through three main sections.

- i) Highlight the main intersections of concern between M&D and COVID-19
- ii) Provide concrete and achievable M&D focused programmatic guidance
- iii) Provide top line M&D focused advocacy analysis and messages to be adapted to local context.

This document is a 'live' document and will be periodically updated. In the next draft, we intend to include *practical* examples of best practice emerging across the various thematic sectors at field level.

Introduction

84% of the world's 71 million globally displaced live in the developing world, in a context where States often lack the infrastructure or finances to provide sufficient support to their own population. In Sub-Saharan Africa, which hosts more than a quarter of the world's refugee population, cases are spreading rapidly. With just 0.2 doctors per 1000 people, it is the region with the fewest number of medical professionals per capita. It is clear that these States will require additional support to respond to the challenge faced by M&D populations.

It is also essential that we understand the scale and severity of the intersection of M&D and COVID-19. The global refugee population accounts for 13 million children – 57% originating from Syria, Afghanistan and South Sudan. There are an additional 17 million IDP children, and whilst undefined, the number of irregular child migrants is considerable. To provide a more localised example, at least 12 million refugees and IDPs live between Iraq, Syria, Lebanon, and Turkey –linked to Iran by frequent travel, irregular migration routes, shared borders, or all three. Iran itself hosts nearly one million refugees, mostly from neighbouring Afghanistan, and an estimated 1.5 to 2 million undocumented people.

As actors in the M&D space, we must be cognizant of the fundamental responsibility States and Governments have to protect their citizens. We must avoid being unnecessarily critical or oppositional while simultaneously recognising a) the legitimacy of this fundamental responsibility for ensuring safety and security and b) that Governments are facing extreme constraints from this complex, fluid and politically-tense situation. Nevertheless, and critically, we must never lose our rights-based focus. Consequently:

- We recognise the complexity of the challenge posed by COVID-19 and will work pro-actively with Governments and other partners at all levels to respond effectively to the crisis.

- Our foundational position is that child rights are universal to all children. Wherever we believe those rights are ignored or abrogated within the context of this crisis, we will speak out[1].

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[1] **E.g. The** plight of migrant children in camps and detention centres, who face increasing threats due to COVID-19

Section 1:   Risks impacting on migrant and displaced children

SURVIVE

- WHO's basic advice for protecting against the coronavirus focuses on social distancing, vigilant personal hygiene, and rapidly accessing medical attention when symptoms occur. This prevention advice is difficult to follow in most M&D contexts.

- Static populations in migrant/refugee/IDP camps and urban settlements, or asylum detention centres, often face higher risk of infectious disease exposure due to over-crowding, poor WASH conditions, and limited or non-existent health infrastructure (particularly important for COVID-19, which may require ventilators and high-capacity ICUs, etc.). These conditions equally apply to detention centres.

- General migration and displacement related levels of hygiene affecting children, combined with existing conditions in which children and their families have been accommodated or not whilst in transit and at destination, may aggravate the level of childhood illness like pneumonia and other transmittable diseases.

   o Many refugee/IDP camps and settlements are less physically isolated from the host communities than commonly assumed, with regular linkages to local markets, social spaces, and schools that may also foster greater and rapid spread of the pandemic (both in and out of M&D contexts). Urban refugees/IDPs likewise face cramped conditions. Most displaced actually live out of camps and amongst the host community.

   o M&D populations are often left out of disaster and epidemic preparedness planning at the best of times. At a moment when effective planning and communication is essential, this lack of participation could be detrimental to any effective response.

   o Contact tracing is the single most effective way of reducing transmission, and timely communication of public health information and advice is essential for controlling the virus – but reaching many refugees and migrants with information/support is often extremely difficult. . This is difficult in contexts like refugee camps in Cox's Bazar where access to mobile phone connection and internet have been severely curtailed limiting the health messages dissemination to refugees.

   o M&D children often don't have fixed places to live, or may take active steps to avoid exposing their contact information. As a result, authorities might not know how to contact them or have the capacity to coordinate a response. Many countries affected by war and/or instability have porous borders and M&D populations sometimes feel it necessary to hide from or avoid authorities. For example, in the US there are approximately 11 million undocumented migrants.

   o With large gatherings typically banned, and closing all education and non-essential facilities, the ability of actors to distribute awareness materials focused on good hygiene practices is severely compromised (at least without the use of mobile data and cell phone access, which are by no means universal amongst M&D populations).

- There is a risk that Governments may not prioritize healthcare (and other) services for displaced and migrants in the current context, especially when set against demands within their own national populations. This is particularly relevant in countries where there is strong **anti-refugee** (or migrant) sentiment among national authorities.

- Exclusion of displaced and migrant communities from national economic and income safety nets during COVID-19 lockdown periods may expose children to high vulnerability, particularly for those not benefiting from formal assistance and those living off informal economies.

EDUCATE

- Many countries hosting displaced and migrant children have suspended their formal education system, and similar suspensions are expected to increase in the coming days with 100 countries already affected by the pandemic, according to the WHO.

- Secondary impacts may also relate to the difficulty to re-join education or to the loss of opportunity for completion of secondary education. This can lead to onward unsafe migration[2] and risk-taking behaviour to hide from public authorities or lose refugee protection status.

- Six million school-age children under UNHCR's mandate already had no school to go to prior to COVID-19.

- In displacement settings, schools also function as the focal point for access to/referral pathways for other critical, child-focused social services, such as child-friendly safe spaces, school meals and formal and informal MHPSS support. As these activities are suspended, an increase in mental health problems, anxiety and tension can be expected in individual children, as well as families. Another challenge may also be posed to migrant and displaced children to whom access to school feeding programmes is essential for their wellbeing or nutritional capacity.

- In developed contexts, children are expected to continue learning and social interaction on-line (EdTech), yet access to computers, laptops and tablets is far from guaranteed for the many migrant and displaced children. Moreover, education technology may present risks for children without parental control as it exposes children to online trafficking and exploitation.

- M&D children that access education face reduced risk of forced recruitment into armed groups, hazardous labour, sexual exploitation and child marriage.

BE PROTECTED

Returns and asylum:

- In certain contexts, there are concerns that Government and public authorities may return migrants, refugees and IDPs by force on the basis of the threat caused by COVID-19 transmission.

- The impact of the closure of borders, refugee and migrant registration centres and movement restrictions on migrant and forced displaced populations may limit or prevent access to seek asylum, protection and services essential to their survival. It may also lead to the detention of children and their families.

General protection risks:

- COVID-19 heightens existing protection risks for M&D children and youth, those unaccompanied or separated from their family, especially children living in the street, including in relation to infection prevention and quarantine measures. These risks may particularly affect those crossing borders irregularly and in immigration detention or border facilities, as well as children hiding from public authorities.

- The current situation risks increasing family separation that is already common within M&D population, as caregivers or single parents may be taken into quarantine, or on-going / current repatriation and family reunification procedures are suspended.

- Camp settings and receptions centres are coming under increased securitization, with police / military taking control and access to reception centre/camps increasingly being denied. This compounds fears that essential and basic services will not be provided and NGOs will have no means of ensuring case management, social workers visit, monitoring the quality of protection and other services being provided.

- M&D children deprived of their liberty, including those held in detention or immigration facilities, face higher vulnerabilities as the virus can spread rapidly due to the high concentration of persons in confined spaces and to the restricted access to hygiene and health care.

- Reduced chances of identification of unaccompanied and separated migrant children due to restrictions on outreach work. This may prolong and increase vulnerability and abuse of migrant children in communities and families.

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[2] As outlined in SC's Why Children Stay Research: https://resourcecentre.savethechildren.net/library/why-children-stay

Child Rights

- While human rights apply to all people in normal situations, International Human Rights Law authorises the derogation or suspension of certain human rights (e.g. freedom of movement or public reunion in time of state of emergency) with the exception of the right to life and physical integrity. For many children and their families, concerns about their right to asylum and their immigration status will become exacerbated as they witness governments taking measures to secure borders and protect populations.

- For some M&D populations, residence and work permits may expire, asylum applications will be suspended, or children whose legal status in a country expires when they turn 18 may become illegal residents – all such cases risk not being handled as government offices close. Lack of legal documentation will prevent access to public services, and create heightened anxiety. This requires special considerations for M&D populations for inclusion in national and local COVID-19 readiness and response operations.

Gender:

- COVID-19's impact on refugees and IDPs will be felt disproportionately by women. Their access to services and ability to feed their families are often deeply constrained by stigma relating to their general socioeconomic situation, situation of trafficking or ties (real or alleged) to armed groups.

- There is a risk of domestic and gender-based violence being exacerbated amongst M&D families. Domestic Violence and GBV are known to increase during times of confinement, and given the poor and overcrowded conditions of many displaced, alongside heightened levels of anxiety, incidences of this nature are likely to increase. Displaced women and girls are likely to suffer increased exposure to sexual exploitation, trafficking or abuse in situations of lockdown. Women and girls may also be at risk while crossing borders or seeking shelter as they might be forced to negotiate protection.

- Displaced women and children are likely to be affected fast and first by the economic crises that will accompany the spread of the disease and are often deprioritized by Governments.

- Migrant adolescent males and boys may be also more exposed to epidemiological and protection risk are they constitute the higher population among migrants who are prone to take endangering behaviour.

MHPSS:

- M&D children and their parents or care givers can be exposed to distinct MHPSS challenges arising from COVID-19, such as marginalization and stigma from host communities.

- Children in camps or settlements are less likely to have any form of recreational material with which to fight boredom and depression during imposed periods of social distancing or lockdown.

- MHPSS support for M&D children is already under-resourced, despite their existing displacement related trauma. COVID-19 is likely to exacerbate M&D children's existing anxiety and stress.

- Their anxiety may be exacerbated by difficulties understanding and accessing messages about the disease and the ways to seek assistance, which may be communicated in a language they do not understand.

Child safeguarding:

- Many Global/National Actors are utilizing temporary health and social care surge-capacity staff to respond to the unprecedented scale of COVID-19. Expedited training/recruitment risk lapses in child safeguarding good practice, and the potential for children to be put at risk by improperly vetted individuals.

- Separated/unaccompanied M&D children already face comparatively high risks of exploitation, abuse and trafficking than host populations. It is essential that the expediency demanded by COVID-19 response not be used as an excuse to compromise on diligent safeguarding.

Digital safeguarding:

- M&D children already have some of the least ownership over their own data of any group, which is often used by border authorities to curtail their freedoms (See EU's use of migrant cellphones). The COVID-19

response may be used to justify abrupt and extraordinary intrusive measures into personal and group data under the justification of humanitarian necessity (for example, Israel's new health strategy policy around personal cell-phone data prior to COVID-19.

Elderly caregivers:

- Many children in displacement settings rely on elderly caregivers who are at most risk of severe impairment or mortality from COVID-19;

- Conversely, communities with high rates of outward migration often have a large number of households in which elderly caregivers are left behind to support children.

Xenophobia towards displaced and migrants:

- Throughout history, migrant and displaced populations have been targets for xenophobia during major health emergencies, where foreign and/or marginalized populations are associated with uncleanliness, and framed as hosts for 'foreign' illness. Migrants were linked to the spread of viruses associated with the SARS, Ebola, and Zika virus epidemics. We saw incidents of East Asian xenophobia in the early stages of COVID-19 and we are now witnessing this antagonism being directed towards M&D populations.

- Governments are potentially[3] using the pretext of COVID-19-driven security or health concerns to enact, cement and/or legitimise draconian long-term anti-migrant and refugee policy[4].

- The possibility of xenophobia within camps/settlements and between displaced or migrant communities, particularly of different ethnicities/nationalities should not be discounted. Displaced/migrant settlements can force people from traditionally warring tribes/nationalities to live next to other in difficult circumstances. Such inter-displacement tensions can potentially undermine camp security/stability and lead to a range of additional health and protection risks, with women and children particularly threatened.

- Risk of increased tensions between host communities and refugees/IDPs, including driving further movement. For example, in Cox's Bazar, Crisis Group highlighted that "should COVID-19 reach the camps, humanitarian agencies expect it to spread like wildfire, potentially triggering a backlash from Bangladeshis who live in the surrounding areas and are already unnerved by the refugees' prolonged stay.[5]"

Livelihoods

- Refugee or displaced populations unable to leave their camps may lose access to key sources of livelihoods. Certain refugee populations depend on daily informal jobs, movement and cross-border trade - border closure will seriously affect their livelihoods. It is very likely that the COVID-19 pandemic will result in increased child poverty for refugee, displaced and migrant children.

- Disruption of economic activities for Migrant and Displaced, including support from the diaspora, may prevent them from paying their bills, including those related to their housing, contracted loans or taxes.

- Children left behind by migrating parents and dependant on remittances for the survival, education and shelter may suffer the disruption of cash transfers.

- Exposure to COVID-19 may be high during cash and NFI distribution in refugee/IDP camps and settlements, which could limit the access to essential food and sources of nutrition and increase market price.

- Restriction of movement may also affect migrant and displaced children and their family's capacity to access banking and cash delivery services outside of confinement areas (e.g. camps, shelter, neighbourhoods).

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[3] We have to be careful not to assume that this is always the case. Clearly, confinement and travel control are essential parts of any effective response to the pandemic

[4] https://cmsny.org/xenophobia-coronavirus-thomas-031320/

[5] COVID-19 and conflict: seven trends to watch. Crisis Group, 24 March 2020

Section 2: M&D Programming in the context of COVID-19

Goal: The rights and best interests of refugee, internally displaced and migrant children are upheld during the COVID-19 pandemic and are an integral component of coordinated national and international responses to COVID-19.

- **Objective 1:** To contain the spread of the COVID-19 pandemic and to decrease morbidity and mortality amongst refugee, internally displaced and migrant children and to ensure that measures taken to address the COVID-19 crisis are inclusive towards refugees, asylum-seekers, internally displaced and migrant children as well as hosting communities

- **Objective 2:** To ensure that displacement-affected and migrant populations' rights are respected and safeguarded, including (but not limited to) the right to access asylum and refugee determination process, the principle of non-refoulement and a life in dignity.

- **Objective 3:** Secondary impacts of the pandemic on refugee, internally displaced and migrant children are mitigated.

PRIORITY NEEDS AND AREAS OF INTERVENTION

Save the Children Regional and Country Offices as well as members should promote integrated actions into all responses to the COVID-19, and should ensure compliance with Save the Children's COVID-19 Program Framework and Guidance. Complimentary guidance has or will be coming out on specific thematic responses and should be read in conjunction with this current guidance. It should be available here[6]. We will provide an updated draft of this report with hyperlinks to new guidance documents when available.

This is not an exhaustive list of activities and will be updated.

HEALTH

We're developing the health component of our programmatic guidance and will include guidance in subsequent versions of this document. We would again refer you to our programme framework and to the concept note "RACE: Rapid Action to Combat COVID-19's Effects on the World's Most Vulnerable Population" which should be available on SharePoint/Onenet. Where you're considering front-line health activities, it's obviously essential to be guided by relevant technical leads within your office.

Early warning systems and community surveillance:

- Where government recommendations on social distancing allow, include community engagement to support comprehensive surveillance systems for early detection of cases among migrant and displaced children, youth and their families, to reduce the spread of COVID-19 and ensure discrimination against M&D children is not preventing them from accessing emergency care.[7]

- Promote the use of mobile phones, internet and social media, including the establishment of a remote desk, as it can play an important role in disseminating COVID-19 related information and messaging to children, their family and youth, including with regards to available services. Keep in mind that digital technologies pose a range of ethical risks (including traditional risks exacerbated by the use of Information Communication Technologies [ICTs]) often insufficiently addressed by traditional safeguarding approaches.[8] Remain cognizant of language barriers in the dissemination of COVID-19 messaging and ensure translations are available. Monitor and follow the use of remote services by M&D population and adapt communication method in a timely fashion.

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[6] We'll update this document with new hyperlinks in mid-April

[7] WHO response Technical guidance for COVID-19 page 14.

[8] Displaced Children and Emerging Technologies page 22 and child safeguarding in emergency toolkit page 18

CHILD PROTECTION

Case management:

- SC and partners should aim to continue providing case management support to vulnerable migrant and displaced children (as well as all other vulnerable children); and new cases should still be taken on, as and when the need arises. Whilst adaptations will need to be made to the way case management is delivered, continuity of care to those in need of individual support is a priority for our programmes. For further, detailed guidance, see SC COVID-19 Case Management Guidance[9]. Some of the key adaptations that will need to be made are as follows:

Adapted referral pathways:

- Referral pathways should be revised to include **health and wash services** shared by Inter-Agency coordination structures in the event of a COVID-19 case.

- Referral pathways should also include agencies able to provide **remote psychosocial support and advice** to children whose caregivers or family members are admitted for COVID-19 or who find themselves unable to access medical service due to their status.

- Ensure all case and social workers, state agents and staff who are working in reception/transit/drop-in centres are up-to-date on the adapted referral pathways. Equally, ensure they actively promote the child protection referral pathways and safeguards in hospitals and health care centres when a caregiver or child is admitted (in the event of GBV, trafficking, child safeguarding or other identified / suspected concerns)

The case management process and case load:

- Map stakeholders and analyse current case management services provided to vulnerable M&D children to ensure continuity and adaptation, with a focus on prioritising those at high risk (e.g. unaccompanied children, trafficked children, undocumented children, those living on the streets and children with mental health needs). All existing caseloads should be reviewed to ensure risk level attribution is appropriate. See Child Protection Case Management Guidance during COVID-19.

- Depending on local government guidance / restrictions on contact and social distancing, and on whether there are indications of COVID-19 in the household, decide whether case management visits are carried out **by phone**, or **through a visit with appropriate precautions**. Medium and high-risk cases should ideally receive a daily check-in.

- **For new high risk cases:** Priority should be given to children who are separated from their caregivers, including those in alternative care, reception centres and shelters; children in households affected by restrictions on movement or lack of access to services; children who may be rejected by their families or communities; children with household members who have contracted the disease.

- Ensure case workers **understand basic facts about COVID-19**, including modes of transmission and risk of infection, so they can effectively combat myths that stigmatise child survivors.

- Case workers must take all the necessary precautions. For comprehensive list, see here[10]

- SC must ensure all case workers apply a 'do no harm' approach and continue home visits with the necessary protective equipment, sufficient phone credit and a copy of the updated referral pathways. Importantly, supervisors must regularly check in with caseworkers to monitor their well-being.

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[9] Still awaiting the final document. In the meantime, contact H.newth@savethechildren.org.uk for more information.
[10] http://www.socialserviceworkforce.org/system/files/resource/files/Child-Protection-Case-Management-Guidance-Covid19.pdf

Family Tracing and Reunification:

- Prioritise family tracing and reunification. Work with authorities to ensure that measures which restrict movement allow for reunification of parents/caregivers and children, and help families to remain together – even when this requires cross border movement.

- Where reunification is not possible, support the provision of information and regular communication between children and parents/caregivers who are separated because of treatment or confinement: ensure coordination with the International Federation of the Red Cross and Red Crescent Society, and promote the use of digital technology to support this action.

Alternative Care:

- Alternative Care should be established or strengthened through safe, family-based alternative care systems that are accessible to children who are refugees, migrants or displaced. As Governments consider their response to the alternative care needs of children who are separated from caregivers during COVID-19, SC staff should ensure that migrant and displaced children are included in all planning.

- If residential care is used, it should be planned as a temporary measure, for the shortest possible period of time, and with the objective of reintegrating the child with his/her family as soon as the situation allows. Any residential care setting must comply with minimum quality standards, as laid out in the **ACE** (Alternative Care in Emergencies) toolkit and SC's *Safe Programming in Interim Care Centres*[11].

- Where foster care is the chosen response, recruiting and training foster carers from within the M&D community should be considered. Foster carers from the host community, as well as staff in small group homes, should be trained on supporting M&D children, as they will have different cultural and psychosocial needs

Right to protection:

- Close monitoring is required to ensure that travel restrictions do not deny the right of individuals to access territory and seek asylum, or that there is no refoulement based on real or perceived fears of COVID-19 transmission.

MHPSS response and interventions:

- Usual MHPSS responses and interventions will need to be adapted during the COVID-19 outbreak. Most psychosocial support will be offered on an individual basis through Helplines and phone calls. Where M&D families have access to the internet, advice can be provided on sites offering educational and play activities

- The key principles of **Psychological First Aid** (Look, Listen, Link) are still possible over the phone, and case workers should be trained to provide PFA in this way, as well as provided with the appropriate means (phone credit etc) to make this work. For more information see here from IFRC.

- Parents and caregivers will require support to cope with stress, and to support the needs of their children, including those disabilities. One example of guidance on healthy parenting can be found **here** from WHO.

- Messages and activities for helping children deal with isolation or quarantine should be developed in the appropriate languages for the M&D population.

Children deprived of liberty:

To start, we refer you to the Inter-Agency Guidance on Children deprived of liberty, to be made available on the Covid-19 page of the Alliance for CP in Humanitarian Action website. This document aims to provide States with key information/practical steps to respond to COVID, and includes i) Instituting a moratorium on new children entering detention facilities, ii) Releasing all children who can be safely released and iii)I Protecting the health and well-being of any children who must remain in detention.

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[11] For a copy, please contact: L.Murray@savethechildren.org.uk or H.Newth@savethechildren.org.uk

- Work with state authorities to promote measures to reduce Covid-19 and other child protection risks for children while under restricted movement or deprivation of liberty, including in immigration detention facilities.

- Prioritise advocacy efforts towards authorities to institute a moratorium on new children entering immigration detention facilities; release all children who can be safely released; and protect the health & wellbeing of any children who must remain in detention.

- Provide training and guidelines on:

  o The clear distinction to be made between health-related restriction of movement and deprivation of liberty, such as detention, that is never in the best interests of children;

  o Promoting and providing solutions for the use of non-custodial alternatives to detention, such as alternative family based or community care;

  o Engaging with immigration, law enforcement, border management and other relevant agencies to recognise that restriction of liberty of migrant and displaced children must always be an exceptional measure of last resort and remain strictly legal.

  o Measures that restrict or deprive liberty for the purpose of managing risks to public health – such as quarantine - that are applied to people arriving from other countries, must be proportionate and subject to monitoring, prevent arbitrariness or discrimination and must be based on Best Interests Assessment (BIA)/Best Interests Determination (BID) of the child.

  o Children deprived of their liberty must have access to the same standard of health care as is available in the community, and applies to all persons regardless of citizenship, nationality or migration status. They must receive a medical examination upon admission[12], and adapted medical care & treatment, including of mental and psychological nature, whenever necessary.

EDUCATION

Whenever possible maintain or initiate educational support to migrant and displaced children, it is important to use a "do no harm" and adapt education policies and services:

- Plan continuity of learning for migrant and displaced children, including those in settlements, shelter or in hard to reach locations that must be adapted in migrant and displaced languages:

  - Whenever possible, use educational technology (EdTech): software and hardware designed specifically for use by children, teachers, parents or facilitators to provide education to hard-to-reach populations, including those that are displaced or on the move.

  - Assign reading and exercises for home study.

  - Disseminate radio, podcasts or television broadcasts with learning or home entertaining content.

  - Assign teachers or volunteers to conduct remote daily or weekly follow up with students or their caregivers.

  - Ongoing review and re-adaptation of education strategies and methodologies.

- Establish procedures and provide guidance to prevent sick students, teachers and other staff from going to school.

- Reinforce regular hand washing with safe water and soap, alcohol rub/hand sanitizer or chlorine solution and, at a minimum, daily disinfection and cleaning of school surfaces.

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[12] This point should not be seen as implicit acceptance of immigrant detention of children. Save the Children is always opposed to the detention of children. Nevertheless, in contexts where children are being detained, they should receive medical examinations.

- Schools should provide water, sanitation and waste management facilities and follow environmental cleaning and decontamination procedures.

- Schools should promote social distancing (a term applied to certain actions that are taken to slow down the spread of a highly contagious disease, including limiting large groups of people coming together).

- Monitor school attendance to identify possible cases of sick children or those who may face specific protection issues.

- Promote information sharing among teachers, students and their parents about the above.

- See SC Guidance on Safe Schools and COVID-19 and other guidance notes on educational provision during COVID-19, such as the IASC interim Guidance for COVID-19 Prevention and Control in Schools (jointly developed by IFRC, UNICEF, and WHO).

LIVELIHOODS:

- Ensure a 'do no harm' approach in the provision of financial and material assistance (cash or NFIs) to migrant and displaced children and their families whose income-generating opportunities have been affected by COVID-19 or in relation to their migratory and displacement situation:

  o Remote assistance instead of direct distribution of items should be privileged (CBT cash and/or voucher outlets).

  o In coordination with health authorities and inter-agency coordination fora, ensure dissemination of preventive guidance and tools that includes making awareness materials available in migrant and displaced children's own language at each distribution site, registration, CBT cash and/or voucher outlets (banks, cash out points, etc.).

  o Prevent biometric registration and collection whenever possible and make available handwashing stations and/or hand sanitiser to staff and beneficiaries on sites and ensure that service providers follow the advice. Ensure that Staff have access to masks when engaging with beneficiaries or delivering items.

  o Take measures to reduce the risk of crowding around distribution sites and ensure that migrant and displaced and their families are fully integrated in the scheme and are the principal beneficiary of remote livelihood assistance.

- Out-of camp refugees as well as migrants and internally displaced living outside of camp settings, renting accommodation may benefit from a waiver for rent payments and utility bills (electricity, water, etc) – it may be paid directly or negotiated with individual and legal entities.

- Payments should be frozen for refugees and migrants who have contracted mortgage, personal or business loans as part of (re)integration schemes.

- Migrant and refugee parents who lose income due to COVID-19 should get easier access to child benefits and simplified processes for child grants.

MULTI-SECTORIAL & CROSSCUTTING ISSUES

Urban settings and border areas:

- *If and when* outreach teams are employed to provide information about the virus and available health and protection services, ensure they are able to identify the most vulnerable children and youth, including M&D children, and refer them to service providers appropriately

- Establish a strong risk analysis and mitigation plan to keep Outreach team members safe - in terms of health, physical and psychological protection (notably when disrupting the activities of smugglers/traffickers, or when working in contexts of low acceptance of migrant communities).

- Support local partners and authorities to build their responsiveness capacities, equip them with relevant COVID-19 awareness messaging and strengthen their standard operating procedures to extend the reach to most of the city/border areas.

- Ensure that urban and border transit/community centres are safe and healthy spaces for M/D children, providing access to child-friendly WASH facilities and offering relevant information about COVID-19 prevention and responses. In addition, those centres must include support with legal assistance and referral mechanisms to health, shelter and protection services. Where possible, they will feature a girl-friendly space and provide tailored activities/messaging accordingly.

Camp Coordination and Management – and administration of migrant shelter:

- Provide migrant and displaced child-specific adaptations to the multi-sectorial approach to COVID-19 readiness and response measures implemented for the general population.

- Service delivery should be maintained to camps / collective settlements or shelters hosting migrants, thus recognising migrants' need for assistance, and informing them of their duty to respect confinement and their right to benefit from assistance:

    o Conduct a thorough risk analysis and identify mitigation measures. Develop a risk matrix integrating (see model):

        - COVID-19 related threats on children, their family and impact on staff and key interlocutors/stakeholders.

        - Protection risks for the children and their family and in relation to the context of intervention.

        - Evaluation of acceptable health and protection risks with regards to programme criticality.

        - Mitigation measures and the development of indicators to measure when to engage, extend/reduce operation and withdraw (e.g. evaluation of interventions as factors contributing to protection risk on children).

    o Develop remote coordination and establish online membership systems, procedures and communication that include Sites Integrated Monitoring Matrix (see: SIMM).

    o Identify and train focal points from traditional and non-traditional members (resident or service provider). The focal person should ideally be somebody benefiting from a good consensual reputation among the in-camp population. Their roles are not to respond to all needs in the camp, but rather to have oversight of the needs, referring and connecting with service providers, as required.

        - To the best extent possible, ensure that there is a general focal point and a sector specific focal point for each site.

        - For the activities such as food, education or health, designate a member of the community or service provider as the service focal points per camp cluster (a multitude of sites grouped together geographically). They have the responsibility of delivery oversight/coordination of the specific sector services per a specific area against needs/population, including reporting on the sick and deceased, as well as on burial arrangements.

    o Ensure partners set-up functional M&E systems and third-party monitoring:

        - Map and regularly update the service capacity (daily or weekly depending on the level of emergency).

        - Ensure weekly updates on the general camp situation.

        - Monitor and report weekly to ensure that confinement does not prevent refugees, IDPs and migrants from accessing emergency services (esp. lifesaving assistance) – respect gender and age specificity, and ensure that relief and child protection actors are able to maintain their essential activities.

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- o Re-adapt camp settings according to the level of risks:

  - Shelter and camp coordination, management and capacity should be strengthened in congested camp settings and immigration detention centres most at risk of COVID-19 outbreak and spread.

  - Establish a specific sector for medical containment, quarantine and keep social distancing with the population not presenting any COVID-19 symptoms.

  - Establish a specific area and remove those most at risk (elders, impregnated women, person with specific health condition) to allow for prevention of COVID-19 spread and care. For more see here.

  - Improve health and WASH systems and access to them according to the above.

  - Integrate child protection safeguards and conduct monitoring of the above activities.

- o Re-adapt food, NFI and Cash delivery and capacity so that they include using the procedures as described in the point 1 of the Livelihood section.

- o Ensure capacity building mechanisms exist and provide online training, information and guidance for partners and focal points when direct delivery of provision of capacity support not possible. Ensure that induction and coaching systems are available on child safeguards and Protection against Sexual Exploitation and Abuse (PSAE).

- For more information on CCCM and response to COVID-19, please see CCCM Cluster page and Sphere Standards in COVID-19.

Gender, age and disability:

- Providing services to combat domestic violence and SGBV will be essential during the pandemic, and are likely to be even more needed in M&D populations, where confinement in overcrowded living spaces, lack of access to services, and pre-existing poor mental health may be more common than in other communities – and lead to heightened levels of abuse.

- Ensure the continuity of support to survivors of SGBV and update referral pathways and service delivery for those most at risk. Ensure information is available in the community regarding available SGBV services and the eligibility criteria for support. The establishment or reinforcement of existing reporting mechanisms such as National Domestic Violence Hotline may be a solution together with the use of paramedical services such as pharmacies to serve as relay for survivors of domestic violence.

- SC and partner staff working with M&D communities must be aware of the potential to see increased levels of DV and SGBV at this time, and be trained to identify and refer cases appropriately. For further guidance on COVID-19 and SGBV, see the 'Further guidance section'.

- It is particularly important to engage with women, adolescent girls and the elders in the response as they are often the primary caregivers. Migrant women, children and elders must be informed about what to do to protect themselves and those in their care and include specific measures on how to care for a child in the family in quarantine and how to stay safe while taking care of dependents.

- Children with disabilities are too often overlooked, including within migrant and displaced populations. Depending on their disability, they may find themselves at increased risk of infection, or require special services that become very difficult to access during periods of lockdown/restricted movement. If a disabled child is not already receiving individual support and follow-up through the case management system, consider assessing his/her needs and developing a care plan for the child during this time – linking them to a case worker and whatever services are available to support.

Coordination and resources management:

- Ensure that all activities align with or support the national response, and support relations between local authorities and refugees/internally displaced populations and host communities to discuss preparedness and response to COVID-19.

- Map local organisations, committees and trusted individuals that represent different groups of people (e.g. community or religious leaders and representatives of migrants and refugees) and consult them to better understand medical, protection, economic and other impacts of the crisis on children and their families.

- Encourage children and their parents to participate in consultations related to the response and to establish channels for the effective transmission of information and support existing civil society organisations and migrant networks to engage with national governments on the development of COVID-19 preparedness and response plans.

- Engage through the Humanitarian Country Team (HCT), the Child Protection area of responsibility of the protection cluster and the Education Cluster (co-led by Save the Children) or with UN Resident Coordinator Office in the contexts where HCT are not activated in the revision of existing Humanitarian Response Plans and Refugees Response plans. Ensure permanent chain of communication (most likely virtually) with UNHCR and IOM representatives to share concerns, explore solutions and coordinate response and advocacy.

- Request UN Humanitarian Coordinator to ensure centrality of protection into the integrated response and to monitor access for migrant and displaced children, including those in settlements and to address any access denial with the relevant authorities.

- Through the provision of training and dissemination of material promote child sensitiveness and safeguards to staff, especially newly recruited or temporary health and social care surge-capacity, understand the rules of conduct as outlined in Save the Children Code of Conduct, which include Protection from Sexual Exploitation and Abuse.

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Section 3:   M&D advocacy messages

This section contains the main messages from the "Refugee, internally displaced and migrant children - impact of COVID-19, Advocacy Plan". The following key messages are generic. They will need to be tailored to each context/situation, which may vary from one country to another. Please refer to the plan itself for more detailed guidance.

KEY MESSAGES - What are we calling for?

Health: Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality amongst refugee, internally displaced and migrant children

- **Refugee, internally displaced and migrant population are highly vulnerable to the COVID-19 pandemic**. Stepping up preparedness and response to mitigate the impact of the epidemic on migrant, refugee and displaced children is urgently needed. The coronavirus will decimate refugee, displaced and migrant communities as well as host communities if we do not act now.

- **Governments must ensure that the most vulnerable populations (refugees, internally displaced and migrants) as well as host communities are included in preparedness and response plans to the COVID-19 health crisis.** This should include a continuation of basic services, including health, shelter, food. Specific preventative measures should be foreseen for those living in overcrowded camps/squats/urban centres/precarious housing. De-prioritising these vulnerable groups could have serious public health consequences.

- **Response efforts should include an analysis of the impact on refugee, internally displaced and migrant analysis** (disaggregated by age, gender and disability) to ensure that their rights are protected and that they receive appropriate support. This analysis should identify potential threats to their health, safety and other human rights, and mitigate these.

- **Preparedness and response plans should recognise the specific (including age, gender and disability specific) vulnerabilities to COVID-19 of refugees, internally displaced and migrant populations** and outline key age, gender and disability disaggregated measures that will be implemented to address these vulnerabilities

- **Provision of accurate information** about Covid19 and preventative measures is essential to prevent the virus from spreading. Government need to ensure that accurate and up-to-date information (including child-friendly and gender and disability sensitive information) about the virus, access to services, service disruptions, and other aspects of the response to the outbreak is readily available and accessible to all refugee, internally displaced and migrant populations as well as host communities. Messaging about the COVID-19 epidemic should be translated into the languages spoken by refugees, internally displaced and migrants. Messaging should also ensure the use of different forms of communication to ensure accessibility to all.

- National authorities should ensure that **surveillance and testing systems include refugee, internally displaced and migrant populations**

- **Government should ensure that all people regardless of documentation, status, gender, disability, ethnicity, religion or language can receive lifesaving testing and treatment in a timely manner**. Measures should be taken to ensure that no one is denied treatment for the lack of means

- Shelter and camp coordination and camp management and capacity should be strengthened in congested camp settings and immigration detention centres most at risk of COVID-19 outbreak and spread. Sufficient capacity and resources should be put in place for health promotion, identification, isolation and treatment of cases. **Authorities should also consider moving the most vulnerable**

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people from packed migrant camps to reception alternatives that allow for prevention of COVID-19 spread and care

- Governments should take steps to **create firewalls between healthcare providers and undocumented migrants** to reassure vulnerable populations that they do not risk reprisal or deportation if they access lifesaving care, especially in the context of seeking testing or treatment for COVID-19.

- Detention centres are often over- crowded and, in many cases, lack access to appropriate sanitation and health care. **Non -custodial alternatives to detention as a measure to mitigate these risks should be implemented.** Detention centres should apply strict standards to prevent the spread of the virus and respond appropriately. A moratorium to further immigration detention should be considered.

- Children not to be detained. **Long-term detention of children in migration should be avoided.** Children contained or detained as part of return procedures or arrival procedures (e.g. at the airport) that have been suspended should have immediate access to alternative accommodation/solutions.

- Governments should manage and mitigate the mental health and psychosocial impact on children and their communities (caregivers, teachers etc), including through MHPSS messages for caregivers of children affected by school closures and access to MHPSS support for all vulnerable children, including child survivors of gender-based violence.

Protection and rights: To ensure that displacement-affected and migrant populations' rights are respected and safeguarded, including (but not limited to) the right to access asylum, the principle of non-refoulement and a life in dignity

- **Travel restrictions cannot be used to deny the right to asylum**. If health risks are identified, screening arrangements must be put in place, together with testing, quarantine and other measures. These will enable authorities to manage the arrival of asylum seekers and refugees in a safe manner, while respecting international refugee protection standards designed to save lives.

- **There can be no forced returns based on real or perceived fears of COVID-19 transmission.** Any restrictions on freedom of movement, or other measures instituted by governments, should be applied to displaced people in a non-discriminatory way.

- **A moratorium on return should be established**, given the current circumstances and the expected lack of support to returnees

- **Returns should not take place** without an assessment of asylum claim and should include the protection of each individual from COVID-19 as part of the procedure.

- Adequate measures should be immediately implemented to ensure that **access to refugee and displaced camps as well as access to migrant and asylum seekers centres** remain possible throughout the pandemic. Physical distancing or any other COVID-19 preventive measures should not be used as a justification for limiting access to humanitarian interventions or basic social services.

- **Refugee, internally displaced and migrant children and their families should have full access to healthcare and other essential services irrespective of their migration status**. It is important that governments and civil society actors work together to address the barriers these communities are likely to encounter in accessing services, such as missing documentation or legal status and the related fear of deportation, movement restrictions and lack of financial means, as well as other barriers impacting children's access in particular, including age, gender, and disability status.

- Temporary **legal solutions** and temporary measures regarding visas and consular support should be identified and applied to facilitate access to medical care and other services for migrant, refugee and displaced families.

- Gender-sensitive protection mechanisms and social services, including cross-borders, should be strengthened to identify and support children in need of care or protection and refer them to

appropriate services; e.g. alternative care, emergency support or assistance, social services and response needs for child victims of gender-based violence. Funding to address the emergency should also be allocated to provide child protection services to all children irrespective of their immigration status

- Many refugees and migrants are currently living in camps or reception centres which are either on lockdown or have reduced access to services. Living in isolation, children are at higher risk of violence and abuse, especially if unaccompanied. **Strengthened child protection and gender-based violence prevention, mitigation, and response measures should immediately be put in place to address heightened child protection risks** (including the risks of children becoming separated from their parents/caregivers as a result of the pandemic).

- It is critical to engage refugee, internally displaced and migrant children as well as host communities in assessing how COVID-19 affects them differently to inform preparedness, response and recovery, particular efforts should be made to ensure that women and girls have access to decision-making spaces to ensure their needs and priorities are not invisible.

- **Xenophobia and discrimination**. Governments and local leaders should ensure that refugees, internally displaced people and migrant are not being stigmatised and that any alleged accusation that they spread the coronavirus should be denounced and dismissed publicly by the authorities. They should take prompt actions to respond to any xenophobic campaign. Particular attention should be paid to social media and the dissemination of hate and xenophobic messages targeting refugees, migrant and internally displaced populations.

Education: Education impacts of the pandemic on refugee, internally displaced and migrant children are mitigated

- Access to quality education is often limited at best of times for refugee, migrant and internally displaced children. National education authorities should ensure that measures are in place to mitigate the impact of school closure on migrant, refugee and displaced populations and ensure continuity of education.

- Governments should ensure continuity of learning / mitigation of loss of learning with teacher-led Inclusive Distance Learning Strategies, particularly Interactive Radio Instruction

- Schools with refugee, internally displaced and migrant students should adopt outreach measures to ensure these children return to school (once closure is lifted), including by working with refugee parent groups and community leaders, and with a particular focus on ensuring adolescent girls return to school. This strategy is critically important, as there is a significant risk that school closure means dropping out of school permanently, particularly for adolescent girls.

Livelihoods, Social Protection: Child poverty impacts of the pandemic on refugee, internally displaced children and mitigated

- As the closure of schools deprive many children of the school meals they were getting at schools, governments should explore alternative solutions to ensure food security and nutrition support

- Governments should take immediate steps to extend child-sensitive social welfare support and protection schemes to refugee, internally displaced and migrant children, targeting at risk households facing temporary loss of income

- Financial organizations and multilateral development banks should assess the impact of disruption of the on-going crisis on migrant and host communities in terms of their financial and socioeconomic well-being and development.

OTHER USEFUL GUIDANCE (not an exhaustive list)

Thematic	Link
Child Protection	Technical Note : Protection of Children During the Coronavirus Pandemic / Child Protection Minimum Standards Save the Children: COVID-19 and Child Protection Case Management (See OneNet C-19 site or email H.Newth@savethechildren.org.uk for details) Protection of Children during the COVID-19 Pandemic Children and Alternative Care: Alliance for CP in Humanitarian Action
Trafficking	Global Protection Cluster Anti-Trafficking Task Team: COVID-19 Pandemic Trafficking in Persons (TIP) considerations in internal displacement contexts
Gender	Gendered Implications of COVID-19 - Policy Paper Gender-Based Violence Area of Responsibility (GBV AoR) tools and resources on COVID-19 Gender-Based Violence Area of Responsibility (GBV AoR) advocacy resources on COVID-19
Disability	UNICEF COVID-19 Response Considerations for Children and Adults with Disabilities
Community engagement	COVID-19 - How to include marginalized and vulnerable people in risk communication and community engagement.pdf UNHCR Risk Communication and Community Engagement (RCCE) COVID-19
Digital technology	Displaced Children and Emerging Technologies / child safeguarding in emergency toolkit
Emergency response	Child Safeguarding: Safe and secure programmes for children COVID-19 guidance based on humanitarian standards
Education	Interim Guidance for COVID-19 Prevention and Control in Schools (jointly developed by IFRC, UNICEF, and WHO)
Health	Health WHO response Technical guidance for COVID-19 & WHO minimum requirements for infection prevention and control (IPC)
WASH	Global WASH Cluster COVID-19 Resources
MHPSS	IASC briefing note in addressing MHPSS in COVID-19-outbreak **IFRC Remote Psychological First Aid during a COVID-19 outbreak**
Camp Coordination and Management	Response Operations in Camps and Camp-like Settings on Scaling-up COVID-19 (IASC) Camp Coordination and Camp Management (CCCM) Cluster- COVID -19
Livelihood	Guidance for cash-based transfers in the context of the COVID-19 outbreak Social Protection and Jobs Responses to COVID-19: A Real-Time Review of Country Measures https://www.savethechildren.net/blog/coronavirus-devastating-blow-children-poverty CVA in COVID-19 contexts: guidance from the CaLP network
Food security & assistance	Standard Operating Procedures developed by WFP and partners on how to adjust food distributions in the context of the COVID-19 outbreak
Coordination	https://www.globalprotectioncluster.org/COVID-19/ Global Humanitarian Response Plan for COVID-19

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