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# BEYOND THE VISIBLE

The Overlooked Linkages between Public Health Emergencies and Child Protection in Eastern and Southern Africa

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UNICEF Eastern and Southern Africa Regional Office
P. O Box 44145. Nairobi · Kenya ·
Telephone: +25420 762 1234

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# Contents

# Key Messages

## 1 Public Health Emergencies Exacerbate Child Protection Risks

PHEs disrupt the environments where children live, learn, and grow—undermining community and family structures as well as education, health care, and other essential social services. These disruptions increase risks such as neglect, abuse, exploitation, family separation, and psychosocial distress, especially for children already in vulnerable situations.

## 2 Child Protection Interventions are Essentials Not Only to Address the Impact of Public Health Emergencies but Also to Improve the Quality of the Health Response

A robust child protection response is not only critical for protecting children but also contributes to controlling disease transmission and improving health outcomes. Involving social workers in case management or psychosocial support can reduce the long-term impact of the epidemic and even improve medical processes, as patients become more familiar with and therefore more open to treatment protocols.

## 3 Child Protection Core Responses Remain Consistent Across Different Types of PHEs

While the nature, intensity, and protection impact of public health emergencies may vary, the core child protection interventions largely remain the same. These include community engagement, individual case management, family tracing and reunification, provision of alternative care arrangements, mental health and psychosocial support, and gender-based violence risk mitigation, prevention, and response. These interventions can be provided across various settings—whether children being in isolation or treatment facilities, being discharged, or living in vulnerable environments, including children living or working on the street or in detention.

## 4 Girls Face Heightened Protection Risks During Public Health Emergencies

Public health emergencies disproportionately affect girls, exposing them to increased risks of sexual violence, early marriage, exploitation, and harmful coping strategies such as transactional sex. These risks are often exacerbated by school closures, loss of caregivers, economic hardship, and the breakdown of protective services. Girls frequently take on additional caregiving responsibilities, which can further limit their access to education and essential services. Responses to public health emergencies must be gender-sensitive, ensuring that girls are seen, heard, and supported through tailored interventions that address both their immediate safety and long-term well-being.

## 5 The Long-Term Impacts of Public Health Emergencies on Children and Families Must Be Addressed

Beyond the immediate health crisis, PHEs often result in prolonged economic hardship, psychosocial distress, and social disruption for children and their families. These impacts can lead to school dropouts, child labour, early marriage, and exploitation. Effective responses must therefore go beyond containment and control to include long-term support—such as inclusive social safety nets, in-kind assistance, and cash transfers—to promote recovery, resilience, and the sustained well-being of children.

## 6 Balancing Child Protection Mainstreaming and Specialized Child Protection Interventions Remains Critical

While mainstreaming child protection across sectors—such as health, education, and WASH—is essential, it must be complemented by targeted, specialized child protection interventions. These include interventions such as deploying trained social workers and psychologists, integrating protection indicators into health surveillance systems, support family tracing and reunification or alternative care arrangements. A balanced approach ensures that protection is embedded in all aspects of the response while also addressing the specific needs of the most vulnerable children through dedicated services.

# Introduction

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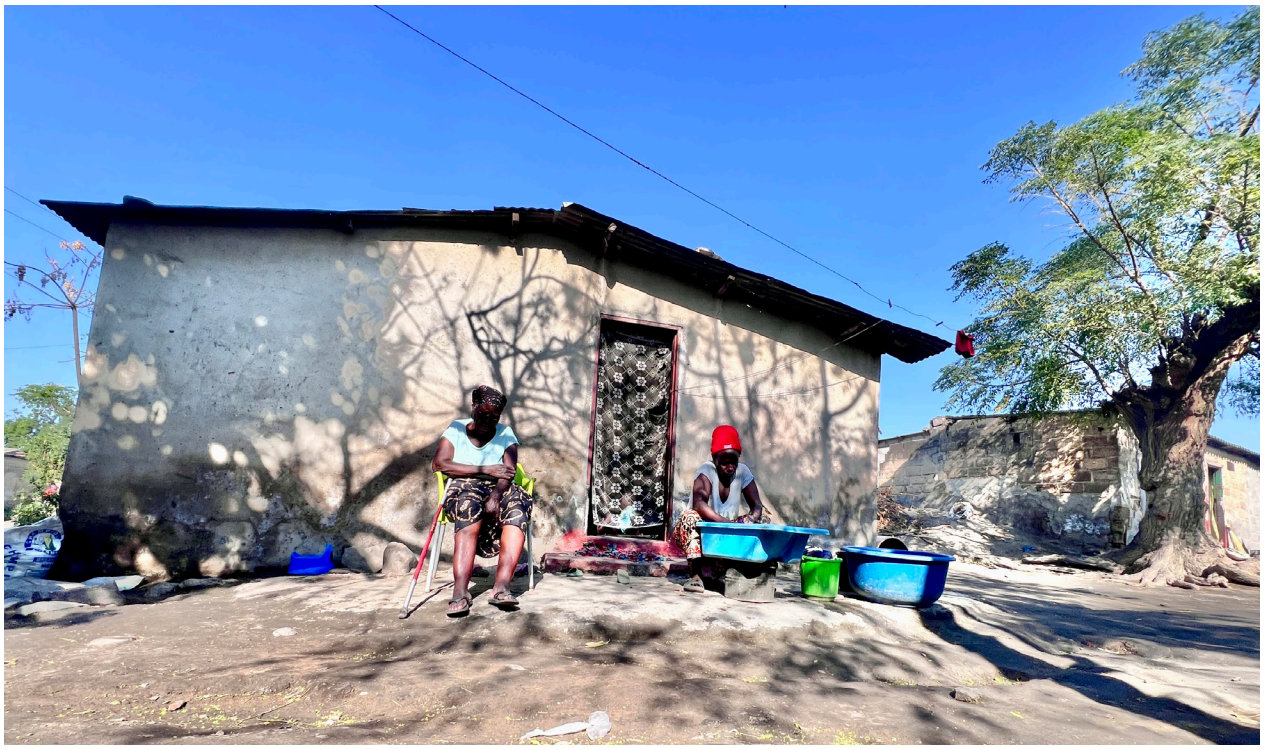


The alarming frequency of public health emergencies and disease outbreaks in the region is disrupting vital safety nets for children and stripping away their right to a safe and nurturing environment. Global and regional stakeholders must come together to fortify protection systems offered by families, communities and state services to ensure every child can thrive even in the face of multiple challenges.

UNICEF Regional Director for Eastern and Southern Africa, Etleva Kadilli.

**This technical brief explores the linkages between public health emergencies[1] and the protection of children in the Eastern and Southern Africa Region (ESAR)[2]. It highlights key effects on children, strategies used by countries to enhance protection, and recommendations for future action.** Despite the lessons learned over the last decade on the significant impact of public health emergencies (PHEs) on the safety of children, with COVID-19 being a notable example, protection concerns too often continue to be overlooked or brought in late, after interventions have been set up and as an afterthought. At the same time, when

1 Although not all the public health threats cited in this paper were officially declared public health emergencies, they are still included as they raise many of the same issues and concerns. According to UNICEF's Operational Response Framework for PHEs, a PHE is defined as *"the occurrence or imminent threat of an infectious disease outbreak or other threat whose scale, timing or unpredictability threatens to overwhelm routine capacities to respond and poses a substantial risk to the public's health including excess deaths and/or disabilities."* In this note, PHEs are used as a generic term to designate any type of public health event characterized by a significant impact on populations and requiring resources beyond the country's capacity.

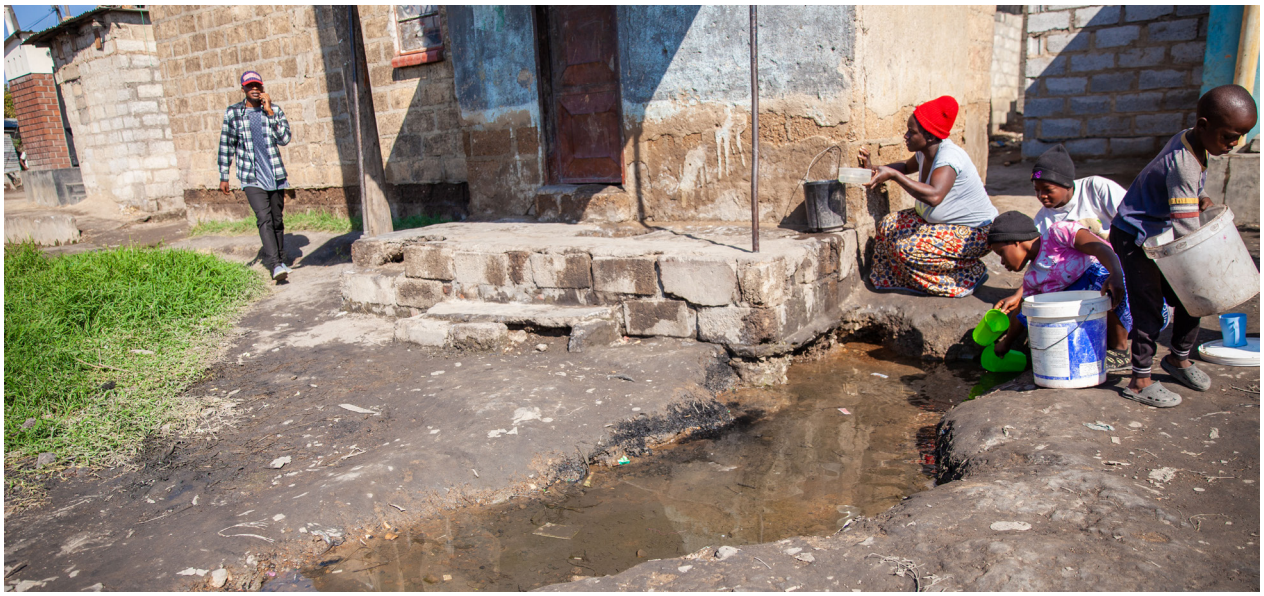
2 For UNICEF, the Eastern and Southern Africa region refers to 21 countries, namely Angola, Botswana, Burundi, Comoros, Eritrea, Eswatini, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

protection stakeholders become involved, they are often called upon to support interventions for which they may not have the appropriate expertise or which should fall under a broader cross-sectoral mandate such as community mobilization, risk mitigation or the prevention of sexual abuse and exploitation. Drawing from country experiences across the region, this technical brief consolidates good practices and lessons learned to support stronger and more responsive child protection systems during future crises. These efforts are critical not only for immediate response but also for building the long-term resilience of national child protection systems to withstand future shocks.

**In the first months of 2025 alone, more than 80 per cent of countries across eastern and southern Africa have faced public health crises.** While the majority of PHEs are driven by outbreaks of vaccine-preventable diseases such as polio and measles, the region is also regularly battling deadly viral haemorrhagic fevers such as Ebola and Marburg and, more recently, mpox outbreaks. Cholera also remains a serious threat with more than 178,000 cases confirmed in 15 countries between January 2024 and March 2025[3] with the region recording the highest number of cholera and acute watery diarrhoea-related deaths globally.

**While several often-overlapping factors were already contributing to the high number of public health emergencies, climate and environment change is becoming an increasingly significant trigger.** For decades, conflict, sociopolitical instability, poor sanitation, high levels of malnutrition, forced displacement and weak public health systems have been identified as critical drivers of infectious disease outbreaks and PHEs. This is further compounded by rising social and behavioural factors including declining trust in health systems, stigma, cultural practices and lack of countermeasures such as vaccines and therapeutics. With 16 out of 21 countries in the region classified as at risk and high risk on the Children's Climate Risk Index (CCRI)[4] climate change is now emerging as a major driver. Shifts in weather patterns and rising temperatures lead to more frequent and severe floods, droughts and disease outbreaks while altering the habitats of disease-carrying vectors and zoonotic reservoirs. These dynamics compound existing vulnerabilities and increase the likelihood of complex health crises. It is estimated that the 2015–2016 El Niño event, associated with severe drought in southern Africa, led to a fourfold increase in diarrhea and a threefold increase in cholera among children in affected countries.[5]





3 UNICEF, Eastern and Southern Africa Records Over 178,000 Cholera Cases Over 15 Months, March 24, 2025, https://www.unicef.org/esa/press-releases/esa-records-over-178000-cholera-cases-over-15-months.

4 The Climate Crisis is a Child Rights Crisis: Introducing the Children's Climate Risk Index. New York: United Nations Children's Fund (UNICEF), 2021. https://www.unicef.org/media/105376/file/UNICEF-climate-crisis-child-rights-crisis.pdf

5 Godfrey, S. and Tunhuma, F.A., The Climate Crisis: Climate Change Impacts, Trends and Vulnerabilities of Children in Sub Sahara Africa, UNICEF, Nairobi, 2020.

## **BOX 1:** The Environmental Determinants of Public Health Emergencies in a Changing Climate

Climate change crises in ESAR such as heatwaves, cyclones, droughts and floods contribute to the spread of diseases and cause food and water shortages. The crises disrupt essential environmental conditions such as clean air, safe water, sanitation and access to nutritious food and place additional pressure on already fragile social services (health, education or protection), making it harder for countries and communities to protect children.

Water-borne illnesses such as cholera and diarrhea become more common during droughts and floods. Vector-borne diseases such as malaria and dengue are also spreading as warming temperatures and changing ecosystems allow disease-carrying insects to thrive in new regions. While risks are increasing, services as well as individuals' capacities to recover are also negatively impacted. Rising temperatures and extreme weather reduce crop yields and food quality making nutritious food less accessible and therefore less affordable. This can hinder children's physical and mental development, push them into forced labour or expose them to greater protection risks such as domestic violence.

**Because children are often more susceptible to diseases outbreaks and disproportionately affected by their social consequences —as well as the related prevention and control measures—the negative impact on their safety and well-being is especially severe.** In response, UNICEF works with regional institutions, governments, the World Health Organization, civil society, and communities to strengthen child-focused emergency response. Guided by its Core Commitments for Children[6] and its Operational Response Framework for PHEs,[7] UNICEF supports three key objectives in PHEs: contain, control, and mitigate. This includes ensuring that water, sanitation and hygiene (WASH) is safe and available; supporting infection prevention and control measures; delivering mental health and psychosocial support (MHPSS) to affected children and families; reduce exposure to gender-based violence (GBV) risks; support frontline health and social workforce; and maintain continuity in education, child protection, and essential health services.

**As the evidence base on the impacts of PHEs on the safety of children has grown,[8] child protection actors have become increasingly engaged in PHE preparedness and response.** While challenges may persist at country level, protection services are now globally recognized as essential with interventions including: family tracing and reunification services; providing alternative care for children left behind when caregivers are hospitalized or whenever they are being isolated from their family for treatment; psychosocial support for children grieving the loss of a family member; and measures to prevent violence and exploitation such as forced labour, sexual exploitation or domestic violence when income loss increases household risk. Preparedness and response also includes prevention of and response to GBV and efforts to strengthen the prevention of sexual exploitation and abuse (PSEA) across all aspects of the response.

**These experiences have yielded valuable case studies and important lessons that can continue informing more effective and coordinated responses that place the protection of children as one as the key outcomes of PHE preparedness and response.** In highlighting these lessons, this technical brief emphasizes the importance of context-specific cross-sectoral strategies that recognize child protection as essential-not secondary-to saving lives and supporting physical, social and emotional recovery.

6 UNICEF, *The Core Commitments for Children in Humanitarian Action*, UNICEF, New York, 2020. https://www.unicef.org/media/130411/file/CCS (English, full).pdf

7 UNICEF, *Operational Response Framework for Public Health Emergencies,* UNICEF, New York, 2024. https://www.unicef.org/reports/operational-response-framework

8 The Alliance for Child Protection in Humanitarian Action, Guidance Note: Protection of Children during Infectious Disease Outbreaks, 2018. https://alliancecpha.org/en/child-protection-online-library/guidance-note-protection-children-during-infectious-disease

# The Linkages between Public Health Emergencies and Child Protection

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**PHEs dramatically alter the environments in which children live, learn and grow.**[9] While the impact of PHEs on the safety of children has been long overlooked, the growing prominence of haemorrhagic fever outbreaks and, more recently, the COVID-19 pandemic has brought renewed attention to the urgent need for child-focused preparedness and response strategies. It has revealed how such crises– both the outbreaks themselves and the public health measures taken in response to them-can severely undermine protective social structures including families, education, health care, social services or community systems, all of which are essential to children's safety, stability and development.

**While protection risks increase, the components of a functioning child protection system face unique challenges and the sector is often not regarded as critical as it is considered in other crises such as conflicts.** Mobility restrictions, lack of recognition for social workers as frontline workers, weakened community networks or diverted funding all hinder effective child protection systems. Ministries responsible for child protection are often excluded from emergency coordination and planning and must frequently advocate for their engagement.

9 The Alliance for Child Protection in Humanitarian Action, Technical Note: Protection of Children during the Coronavirus Pandemic, Version 2, May 2020. https://alliancecpha.org/sites/default/files/technical/attachments/the_alliance_covid_19_tn_version_2_05.27.20_final_2.pdf

## **BOX 2:** Diverse Health Emergencies, Consistent Interventions: Child Protection Across Contexts

Public health emergencies (PHEs) in eastern and southern Africa can differ significantly due to distinct regional challenges. In eastern Africa, countries like Kenya, Uganda and Burundi frequently face outbreaks of vaccine-preventable diseases (e.g., polio, measles, diphtheria) compounded by viral haemorrhagic fevers such as Ebola and Marburg. In contrast, southern African countries, such as South Africa and Mozambique, more commonly experience cholera outbreaks.

These regional variations have implications for child protection. For example, during cholera outbreaks, isolation and treatment are often swift reducing the time a child is left alone. However, the widespread impact of cholera often results in fewer resources and lower ability of social workers to identify and support the most vulnerable. Resources may be limited even when the number of fatalities is significant. While more resources may be mobilized during or in Ebola or Marburg outbreaks, children may face extended isolation and separation from caregivers, disruption of education, stronger community stigma and psychological distress.

Regardless of the type of PHE, the nature of child protection risks (such as family separation, domestic violence or sexual abuse) and the interventions to address them (community engagement, individual case management, family tracing and reunification, mental health or psychosocial support etc.) remain largely consistent. What varies is the intensity of these risks which will influence the priorities and focus interventions for the response.

**Experience shows that well-functioning child protection system can be critical during PHEs.** Involving social workers in case management or psychosocial support can reduce the long-term impact of the epidemic and even improve medical processes as patients become more familiar with and therefore more open to treatment protocols. Taking advantage of child protection information systems (using insights gained from family visits or from child help lines) can also be critical to informing and improving the overall quality and coverage of the response.

**Pre-existing child protection concerns also hinder efforts to contain the spread of outbreaks.** Displacement, family separation or overcrowded living conditions significantly elevate health risks. Children experiencing neglect, domestic violence or living in street situations often lack essential protection making them more vulnerable to illness and more likely to become carriers of disease. Strengthening child protection systems is therefore not only crucial for safeguarding children but also instrumental in preventing and controlling the spread of disease outbreaks.

**Disruption of Family and Social Structures.** PHEs can severely disrupt family systems. Caregivers may be taken to treatment centres with little notice leaving children without adequate supervision. Children may experience the trauma of losing loved ones, the anxiety of sudden separation or the distress of being left alone during quarantine or isolation. Children themselves may be taken to treatment centres put in isolation or quarantine without sufficient access to a caregiver or other support. Isolation, whether in treatment centres or at home, can intensify fear and loneliness with long-term effects on children's physical and mental well being. Inadequate or fragmented social support for children is a known risk factor for child mental health distress and, in worst cases, longer term mental health difficulties.

**Increased Vulnerability to Abuse and Exploitation.** Children left without care when a parent falls ill are more vulnerable to abuse and exploitation. Girls face heightened risks as they often take on increased caregiving responsibilities (for the ill or for family members who are left behind) and are more vulnerable to sexual violence especially when they are separated from their families, experience economic hardship or lack access to essential services such as education and health care. Increased stress and the potential absence of protective caregivers can also increase all forms of abuse and mistreatment of children in the home. The breakdown of protective services and school closures eliminates many of the safe spaces where children are

seen and supported. In desperate situations, some girls may resort to transactional sex and children may be driven to engage in multiple forms of dangerous and exploitative labour to help their families survive amid loss of income and rising hardship.



## **BOX 3:** The Syndemic of Gender-Based Violence and Public Health Emergencies

Emerging research shows that responses to infectious disease outbreaks-the policies, measures and interventions put in place to interrupt transmission-can lead to an increase in GBV. Even outside such crises, the magnitude of GBV globally is staggering; 1 in 3 women will experience some form of physical, sexual, emotional or psychological violence in their lifetime; 1 in 5 young women (aged 20-24) were married before age 18; and nearly a quarter of partnered/married adolescent girls have experienced sexual or physical abuse in their lifetime. PHEs amplify these risks due to both the consequences of the outbreak and the control measures implemented such as movement restrictions, closures of schools and essential services (including GBV case management and MHPSS), lack of appropriate sanitation facilities in isolation or treatment centres, increased caretaking responsibilities or income loss. Across the ESA region, promising practices have emerged to mitigate GBV during PHEs. For example, safety audits, an observation tool used to identify and reduce GBV risks, have enabled different sectors such as health, WASH, nutrition and protection to act on key safety concerns. In Uganda and Burundi, safety audits have been instrumental in improving safety for women and girls during PHEs. Lessons from recent outbreaks have led to a core set of recommendations aimed at ensuring that GBV is neither overlooked nor exacerbated during any future PHE including:

1. Train frontline workers on GBV risk mitigation including safe handling of GBV incident disclosures and linking survivors with specialized services.
2. Conduct regular GBV risk and safety audits through consultations with women and children to ensure services and facilities are safe and accessible.
3. Integrate GBV and PHE-related risks into public messaging including information on available GBV services for survivors and women and girls at risk of GBV/SEA.
4. Identify where and how survivors can access available services in their communities in a safe and non-stigmatizing manner.
5. Maintain essential services such as health, safety, case management and MHPSS and ensure that they remain open and accessible throughout the outbreak.

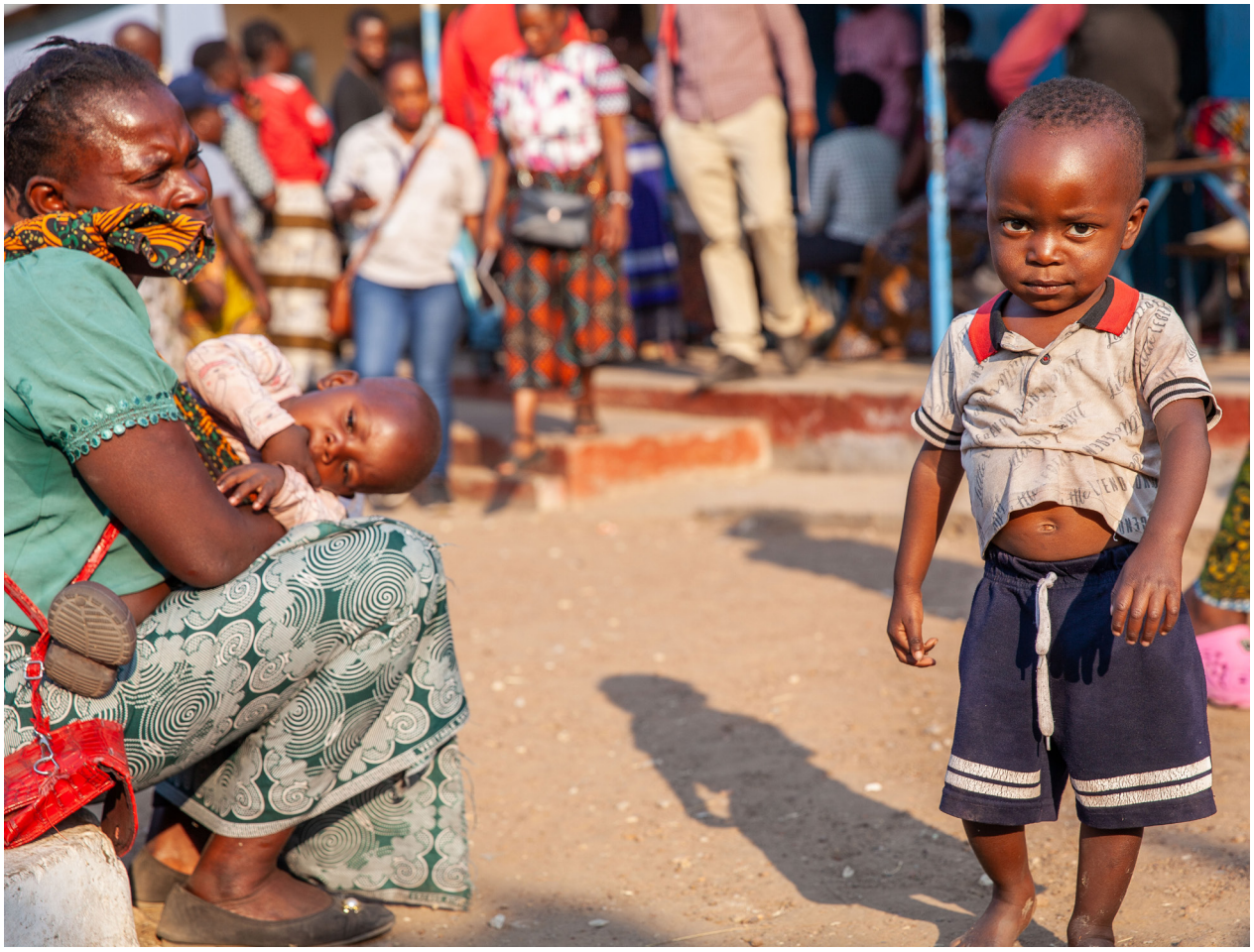
**Barriers to Services and Support:** as medical systems focus on the outbreak, other essential services become less accessible. Health facilities and personnel are often diverted to emergency response reducing access to routine health care for children including victims of physical and sexual violence. Other services such as education or social work may be reduced, fail to be designated as essential or impeded by movement restrictions. Isolation measures and the stigma surrounding illness can further reduce access to essential care and protection.

**Economic Hardship and Harmful Coping:** loss of income due to illness, death or public health measures (e.g. movement restrictions and quarantine) can devastate families that often already lack economical resilience. Economic stress may lead to negative coping strategies that put children at risk. Children may be separated from caregivers, placed in institutions, forced into early marriage, withdrawn from school or forced into hazardous labour.

**Psychosocial Distress and Mental Health Risks:** the fear, uncertainty, and stigma surrounding a disease outbreak can cause serious distress in children particularly when paired with isolation or the death of a loved one. Disruption to social and educational opportunities can compound distress by removing natural sources of support and routine. Children and caregivers with pre-existing mental health conditions or with other special needs, like children with disabilities, often lose access to support. Without clear information, reassurance and adequate support, children may experience fear, anxiety, or panic affecting their development and long-term mental health.

**Social Exclusion and Discrimination:** misinformation, fear and stigma around disease can lead to the marginalization of certain children and families. Those who are or are suspected of being infected or who belong to already disadvantaged groups may be excluded from services or be discriminated against further isolating them at a





time when support is most needed. Children living or working on the streets, in refugee or displacement settings, in detention, in residential care, from marginalized groups or living with disabilities (particularly those who depend on caregivers for daily support such as transportation to school or health services) face even greater challenges in accessing essential services and support when those caregiving arrangements are disrupted. Pre-existing disparities are often worsened during PHEs placing already vulnerable children at even greater risk.

**Gendered Impacts of Public Health Crises:** Women and girls face heightened risks during public health emergencies as existing gender inequalities are often exacerbated in times of crisis. Disruptions to essential services—such as sexual, reproductive and maternal health care as well as protection services—can leave them more vulnerable to exploitation, abuse and neglect. Increased caregiving responsibilities (for the ill or for family members who are left behind), economic insecurity and mobility restrictions further limit their access to support and resources. At the same time, GBV rates often rise while support services such as safe shelters, legal aid and psychosocial care become harder to access. Adolescent girls may also be at greater risk of early marriage, exploitation or being pulled out of school.

## CASE STUDY 1: Bridging the Gap: Integrating Child Protection into Uganda's Public Health Emergency Response to Ebola and Mpox

Uganda has experienced multiple PHEs in recent years including its eighth Ebola outbreak in early 2025 and an mpox outbreak in late 2024. Drawing on decades of experience, the country has developed robust, government-led systems for preparedness and response. This foundation enabled a swift response to the 2025 Ebola outbreak, which was declared over by April 2025.

Thanks to its longstanding collaboration with the Ugandan Government during previous outbreaks, UNICEF in partnership with the Ministry of Health's Division of Mental Health, Butabika National Mental Health Referral Hospital and the Ministry of Gender, Labour and Social Development, rapidly trained MHPSS focal points to address child protection needs, GBV and PSEA. These focal points played a critical role in supporting children inside Ebola Treatment and Isolation Units and children left behind when caregivers were hospitalized. However, as the outbreak waned, new challenges emerged; stigma, discrimination and economic hardship became significant barriers to reintegration affecting both Ebola survivors, their children and families and stressing the need for more community work. UNICEF's response included supporting the training of Community Development Officers, para-social workers, Village Health Teams and Community Health Assistants on child protection, MHPSS, GBV and PSEA. These community frontline workers, part of the government social workforce, carried out home visits, provided psychosocial support, and linked families to essential services and livelihood opportunities. UNICEF also supported Uganda's national SAUTI 116 Helpline to respond to emerging child protection needs and has been supporting longer term solutions by contributing to the Government's Ebola Survivor Program, which supports survivors and their families for 24 months including access to child protection services.

Despite its recurrent exposure to PHEs, Uganda's recent experience dealing with Ebola stresses the continuous challenge of integrating child protection into PHE response systems. PHE response plans are typically organized around health-related containing pillars, where child protection services often lack clear entry points. UNICEF managed to leverage a strategic opening through the case management pillar (focused on clinical case management) and its MHPSS sub-pillar. By positioning child protection case management as a critical complement to clinical care, UNICEF's experience demonstrated the importance of addressing the social and economic factors that heighten children's vulnerability, contribute to disease transmission and worsen health outcomes.

# Promoting a Harmonized Approach to Child Protection Interventions during Public Health Emergencies

**While different PHEs may have different effects on children, the core interventions to protect children remain the same.** These interventions aim to prevent and reduce children's vulnerability and exposure to all forms of violence and exploitation including GBV. While the nature and magnitude of an infectious disease outbreak can vary, a child protection response generally focuses on community engagement, strengthening existing individual case management capacity,[10] family tracing and reunification, mental health and psychosocial support, GBV risk mitigation, alternative care arrangements and social workforce strengthening. These can be provided across different settings, ranging from communities to isolation/treatment centres as well as contexts where children may be more at risks of violence including children living or working on the street, in residential care, in refugee or internal displacement camps, in detention or even when they become orphans due to the outbreak. When embedded within a resilient child protection system, such interventions help ensure continuity of care and protection even amid significant disruption.

**This section focuses on five key areas of intervention for child protection in PHEs: community protection systems; children and caregivers in isolation or treatment facilities; safe discharge and reintegration of children and caregivers; children living in vulnerable environments; and children without parental care.** It highlights how UNICEF in ESAR has developed a set of common interventions in response to the increasing number of PHEs and how these have been tackled across the five key areas of interventions.

## Key area 1: Community protection systems

**In eastern and southern Africa, families and communities are at the forefront of PHE preparedness and response given the often-limited geographical coverage or capacities of public health and social care services.** They are the first to be mobilized to accelerate awareness campaigns and identify cases playing a critical role in containment and control of an epidemic. Communities also play a crucial role in shaping public health messages and deepening understanding of epidemic dynamics.

**When it comes to the protection of children, communities often serve as a key safeguard mechanism for children.** Community-based mechanisms, such as community child protection committees or volunteer networks[11] can play a vital role in quickly identifying the most vulnerable children and ensuring they receive immediate support. During a PHE, family members can be abruptly referred to isolation or treatment centres leaving children behind with minimal care or oversight. When properly

10 To address potential risks to children such as discrimination, forced labour, transactional sex, provide alternative care or assess children specific needs.

11 Child protection committees are community-based groups responsible for promoting child-friendly environments and ensuring the well-being, safety and rights of children as well as monitoring, reporting and responding to child protection issues. They can include representatives of service providers (teachers, social workers and health personnel), administrative and traditional leaders or community leaders.

equipped, communities can help fill this gap by providing temporary care and ensuring that children remain safe from harm. Community child protection systems can also support children and/or parents following their discharge by identifying ongoing needs, addressing stigma and discrimination and facilitating safe reintegration into the community.

Strong community-based child protection systems are well-positioned to address the non-medical aspects of discharge (e.g., challenges around loss of income, stigma and absence of caregivers) that are so often overlooked and can provide holistic support to families as they recover and rebuild after isolation or treatment.

## CASE STUDY 2: Burundi: Strengthening Community Systems for Sustained Protection Services during Mpox

In July 2024, Burundi declared a mpox outbreak, which, in its first six months, brought more than 3,300 confirmed cases,[12] nearly half of whom were women and children. This public health emergency significantly impacted children, particularly in situations where caregivers were isolated for treatment (which could last from 2 to 4 weeks) and in areas with limited social services including access to social and medical workers. In response, UNICEF's child protection efforts prioritized strengthening mental health and psychosocial support (MHPSS) in treatment centres and support to decentralized social workers and community-based child protection committees. Composed of local community members, child protection committees have been instrumental in identifying at-risk children and providing immediate assistance.

From the onset of the emergency, these commitees has proven to be a pivotal, cost-effective and sustainable child protection strategy especially amid shortages of social workers and funding. Established under a national legal framework, child protection committees have been formed across the country with support from the Ministry of Social Affairs and partners including UNICEF. Just before the outbreak, UNICEF supported a national mapping of the committees highlighting capacity strengths and gaps as well as geographical disparities. Based on this mapping, a national strategy to strengthen the committees was adopted in April 2024 just two months before the mpox outbreak.

The committees proved to be indispensable. They identified affected families, conducted home visits during and after family members' hospitalization and supported the temporary placement of children whose parents were in treatment centres. The committees provided psychological first aid and helped maintain family contact. Working with communal social workers, they ensured that vulnerable children were not overlooked and identified the most vulnerable households for livelihood support, including cash transfers, thus reducing the risks of children experiencing economic or sexual exploitation as a result of household income loss.

UNICEF also supported NGOs to deploy teams of social workers and psychologists to treatment centres and affected communities and advocating for these teams to work with and through communal social workers and child protection committees. Teams were encouraged to support communal social workers to organize case conferences for particularly vulnerable children. Three months after the start of the outbreak, UNICEF also supported a review of existing tools and training modules for child protection committees. This provided an opportunity to ensure that lessons learned during the first phase of the response (and the particular competencies which had proven important) were integrated into the revised tools and training modules thus setting the stage for a better prepared community child protection system in future PHEs.

This experience shows that investing in community protection mechanisms enhances resilience, ensures sustainability and safeguards children when formal systems are overstretched offering a compelling example for other countries seeking to strengthen child protection during PHEs.

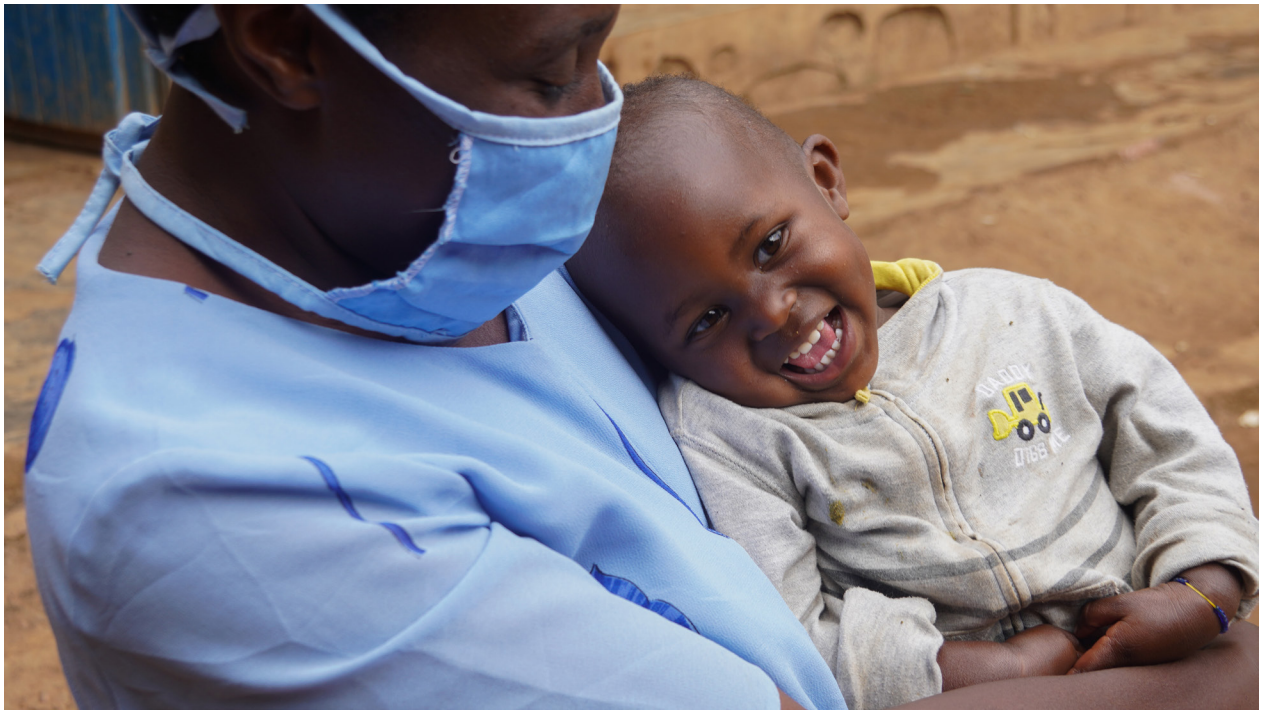
12 During the same period, there were also more than 6,700 suspected cases due to lack of treatment and testing.

## Key area 2: Children and caregivers in isolation & treatment facilities

**In PHEs, anyone suspected of infection, including children and their caregivers, is often quickly relocated to isolation or treatment centres frequently under conditions that are both stressful and unsafe.** Children may be transferred alone, separated from their caregivers upon arrival, expected to support a sick parent or even left behind with little attention paid to their well-being. In several contexts, children have been placed in facilities that lack basic child protection safeguards such as gender-separated spaces or clear boundaries between children and unrelated adults. The absence of an adequate registration mechanism, whereby the admission of any child entails the correct recording of his or her biographical data, can also have a negative impact on future reunification. This exposes them to heightened risks of abuse, neglect and severe psychological distress. During their stay in isolation and treatment facilities, children also often witness the death of loved ones and other patients. The unfamiliar and often challenging environment of these centres and the lack of attention to children's specific needs and capacities (lack of adapted tools to explain to children what is happening, limited qualified personnel including MHPSS staff that have been trained in supporting children including MHPSS, lack of adapted and safe recreative materials, etc.) can generate high levels of anxiety in children sometimes leading to behavioural issues.

**During certain public health emergencies, children may be confined at home, increasing their exposure to domestic violence or psychological stress.** This typically occurs when the scale of an outbreak exceeds the capacity of treatment centres, and children in isolation are cared for by overwhelmed, unavailable, or inadequately housed caregivers. The absence of regular interaction with teachers, social workers and peers further heightens the risk, as signs of abuse or distress may go unnoticed, delaying critical support and intervention.





### Integrating the Prevention of Sexual Exploitation and Abuse in Public Health Emergencies

In crisis settings, the power imbalance between aid providers and vulnerable populations intensifies particularly where systems are strained, recruitment is rapid and oversight mechanisms are weak. PHEs are no exception. Overburdened health and social service systems can lead to gaps in safeguarding mechanisms increasing the risk of exploitation. The urgent need for frontline personnel can result in insufficient vetting and training heightening the risk of sexual exploitation and abuse (SEA). At the same time, functional complaint and reporting mechanisms may be scarce or overwhelmed preventing survivors from seeking help. Several countries in ESAR have scaled up interventions to integrate PSEA and safeguarding into their PHE responses in 2024 and 2025. Their experiences have generated some promising practices and key recommendations, which are summarized below.

Promising Practices in ESAR:

- **Dedicated Funding:** the Emergency Programme Funds (EPF) enabled early prioritization of PSEA by allocating resources for awareness, training and integration across sectors.
- **Cross-Sector Collaboration:** including PSEA focal points in internal PHE coordination meetings and external interagency platforms helped ensure consistent messaging and action.
- **Engaging Frontline Workers:** community-facing responders in high-risk zones were trained on the PSEA Code of Conduct and referral pathways, enabling them to serve as channelsfor reporting SEA and are equipped for safe referral.
- **Leveraging Existing Reporting Systems:** rather than creating new channels, existing child protection systems (e.g., child helplines) were strengthened and adapted to handle SEA reports effectively in Uganda and Burundi.
- **Government Engagement:** ministries of health in Rwanda and Uganda integrated PSEA into national emergency plans, appointing focal points and including it under high-level coordination structures.
- **Innovative Community Engagement:** the use of digital tools and radio messages to share PSEA and GBV information with youth piloted in Uganda provides an example of how to innovatively and efficiently engage the community especially young people.

More examples of PSEA programming and recommendations for the integration of PSEA in PHEs are available here: Lesson learned and promising practices - PSEA in PHEs and in The PSEA in Public Health Emergencies Toolkit.

**Protecting children and their caregivers in these settings requires a multi-faceted approach. First and foremost, physical and emotional safety must be ensured. Innovative approaches such as cross-sectoral safety audits[13] have proven to be critical.** Safety audits can help in identifying and addressing risks within treatment and isolation centres. In Burundi, safety audits highlighted unsafe washroom infrastructure and prompted the adaptation of protocols to the age and sex of children (e.g., by ensuring that female medical staff were assigned to care for girls or that staff were trained on how to share relevant information with children). Safety audits also helped to ensure that mechanisms such as intake protocols,[14] group discussions, peer support, and referral systems were in place to identify and support the most vulnerable. Embedding safeguarding protocols and training frontline staff such as medical

13 A safety audit is a systematic process used to assess and mitigate risks of GBV in a specific area or setting. It involves identifying observable risks and barriers to accessing services, and, in response, implementing actions to improve safety and access to support for survivors.

14 Intake protocols also play a critical role in preventing and responding to family separation, particularly when registration processes capture the necessary information to support future tracing and reunification.

personnel, social workforce and community health workers on child protection standards, GBV and PSEA is also essential. Staff and service providers must be equipped to recognize signs of distress or abuse and respond with the requisite sensitivity and care.

**Equally important is the provision of individual MHPSS.** Tailored MHPSS interventions help children to process their experiences, reduce anxiety and build resilience and healthy coping mechanisms. For caregivers, such support enhances their capacity to provide nurturing care and ensure their own well-being. In some instances, more specialized mental health services can help support patients with grief and fears around illness and dying. In Rwanda, Uganda and Burundi, the inclusion of psychologists in treatment centres has also supported medical treatment by improving patient adherence to medical protocols as some patients initially reported the process to be frustrating and confusing. Helping patients understand why they need to stay in an isolation centre, manage their fears, communicate effectively with family members, anticipate potential long-term impacts and access available support can assist in coping with this challenging experience.

**Interventions must be underpinned by a robust child protection case management system which can address the other impacts that a PHE may have on the safety of children such as community discrimination, child labour, school exclusion, etc.**

Using psychologically informed approaches such as psychological first aid (i.e., immediate emotional and practical support) is critical. Yet, children, especially those in isolation or treatment centres, must also be individually assessed to identify specific protection, mental health and psychosocial concerns that either predate or result from the PHE. While protection concerns may be similar they may also be distinct; in many contexts, a child's distress may stem not only from illness or family separation but also from stigma, prolonged disruption of education, loss of family income, or preexisting challenges such as domestic violence or neglect, which can be exacerbated by a PHE. Economic hardship can also increase pressure on children to contribute to their own and their family's survival, heightening their vulnerability to economic exploitation such as child labour or even transactional sex. Social workers play a crucial role in identifying these specific vulnerabilities. Their presence enables timely and appropriate responses, including family tracing and reunification when children are separated from their families, and can facilitate referral to more specialized MHPSS services and other important services such as legal aid and livelihoods when needed. In Zambia, social workers joined efforts with communities to identify the most vulnerable during the cholera outbreak ensuring that children were reintegrated into schools and that families received in-kind support to facilitate quick recovery.




*MHPSS Chatbot consultative meeting with adolescent girls in Uganda.*

## CASE STUDY 2: Rwanda: Provision of MHPSS services in Isolation and Treatment Centres during the Marburg Outbreak

When a Marburg outbreak was declared in Rwanda in September 2024, providing MHPSS services to children and adults in isolation and treatment centres emerged as a critical component of the child protection response. This rapid prioritization of MHPSS built on lessons learned from the COVID-19 response and Rwanda's extensive investments in preparedness for the Ebola Virus Disease –a frequent threat along its borders with the Democratic Republic of Congo, Uganda and Tanzania.

At the onset of the outbreak, frontline workers including clinical nurses and psychologists were rapidly mobilized to deliver child-adapted MHPSS services using simplified guidelines. Prior investments in preparedness for COVID-19 and Ebola and the application of lessons learned from prior outbreaks enabled their swift deployment. The community child protection workforce had already been trained on responding to PHEs between 2021 and 2023 poising them for a quick response to Marburg. While it was necessary to update training materials to reflect the specific dynamics of Marburg, with a strong foundation already in place, there were no interruptions to child protection and MHPSS services during the PHE. Existing guides and tools were updated and supplemented to address gaps that had not been fully anticipated such as the lengthy period of isolation, which resulted in children spending extended periods without adult care, and the need for consistent, reliable communication between separated family members. At the community level, volunteers and social workers were trained to support early identification of high-risk communities and ensure that contact tracing, home self-isolation support and other health measures were child-sensitive thus fostering a more protective and supportive environment during outbreaks.

Providing MHPSS services to children and adults in isolation and treatment centres required a well-resourced and effectively coordinated team. A system was put in place to respond to specific needs expressed by patients and caregivers and ensure that regular communication between patients and their family was maintained. Specific standard operating procedures and guidance were also developed to support personnel and family members to communicate about the disease including situations in which a patient had died. To ensure smooth service delivery, the MHPSS team was provided with dedicated transport, phone airtime for client follow-ups and coordination, which served as additional office space or child-friendly areas near isolation centres. Personal protective equipment including masks, gloves, raincoats and hand sanitizers, were also provided to safeguard team members during service delivery. To maintain staff well-being, structured shifts were implemented to allow for rest with regular check-ins to identify and address burnout or stress.

As part of institutionalizing this progress, UNICEF has also been supporting the Government of Rwanda in establishing a permanent unit for MHPSS coordination, developing national guidelines on MHPSS during public health emergencies and training personnel in district hospitals and health centres across the country. This unit will ensure structured and consistent emergency responses, which will serve as an entry point for child protection actors in future PHEs.

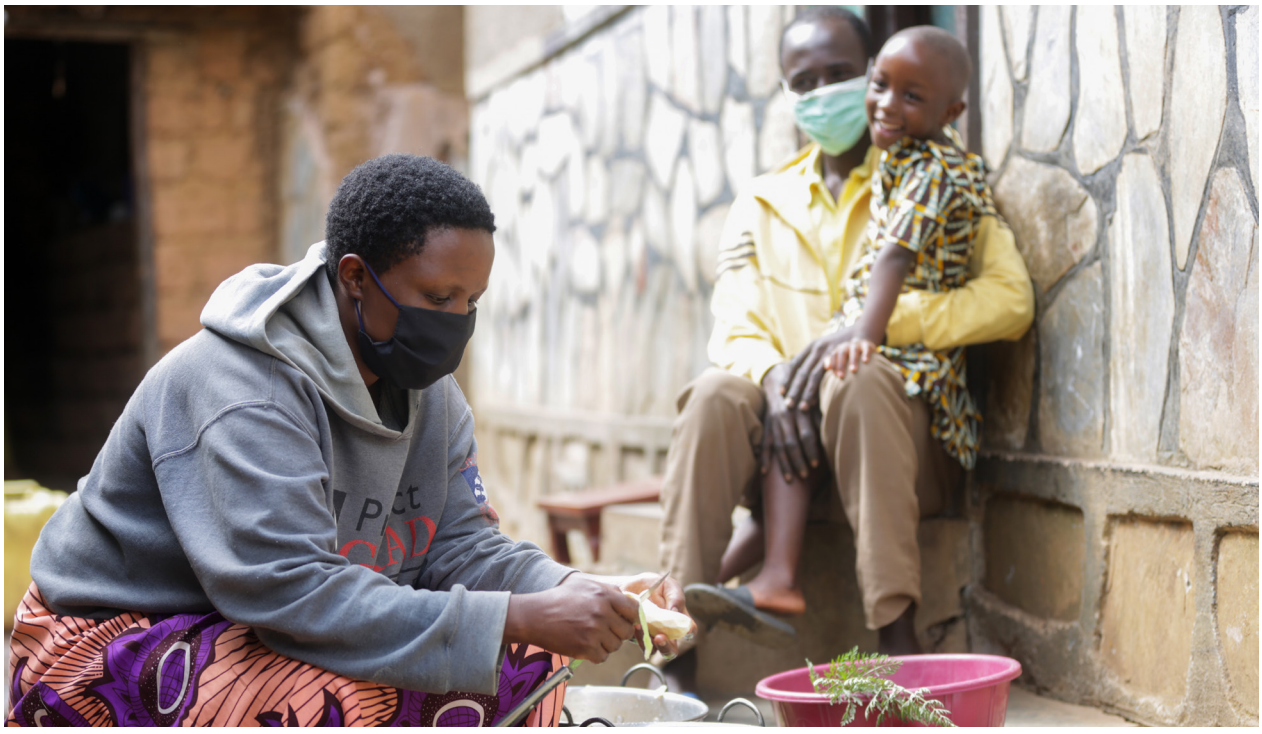
## Key area 3: Safe discharge and reintegration of children and caregivers

**When children and caregivers are discharged from treatment and isolation centres, they are vulnerable to several protection risks which must be addressed to ensure safe reintegration into the community.** Discharge processes often focus solely on medical recovery overlooking the broader social and economic challenges that families face when leaving treatment and isolation. Many require financial support, access to services and help overcoming community stigma that can severely impact their livelihoods and well-being.

**Reintegration should be viewed as a process that begins as soon as a child or caregiver is referred to a treatment centre with social workers maintaining links with families, identifying potential reintegration challenges and beginning early support planning.** A continuum of services from treatment centres to the communities is critical. These include home visits to identify possible barriers to future reintegration, the provision of alternative care services if the child cannot be reunified and, later, to assess the well-being of each discharged child and caregiver. Where needed, individual child protection case management should be implemented offering psychosocial support and referring families to essential services such as health and nutrition, distributions of non-food items, livelihoods schemes and education.

Child-friendly discharge standard operating procedures (SoPs) should guide the discharge process ensuring the child is not discharged alone, that the process is rigorously recorded including with contact details or information on the caregivers, and that their needs are met in a safe and supportive manner. Additionally, children and their caregivers often face reintegration stigma, discrimination or isolation upon returning to their communities. Addressing this stigma requires targeted interventions to promote acceptance and a protective environment for children.





## CASE STUDY 3: Zambia: In-Kind Support for Vulnerable Children and their Families during the Cholera Outbreak

Between October 2023 and June 2024, Zambia experienced one of its worst cholera outbreaks with more than 17,000 cases identified and almost 800 registered deaths. While healthcare professionals focused on containing the epidemic, social workers, who provided welfare services in affected communities, began to highlight the lasting economic impacts of the outbreak, which were often more severe yet less visible than the immediate health effects.

During PHEs, families often face severe financial strain both during illness and before and after treatment. A UNICEF rapid assessment conducted in Zambia revealed the substantial economic burden borne by households affected by cholera. This included prevention-related costs such as accessing clean and safe water, purchasing chlorine or charcoal to boil drinking water and buying soap for handwashing; treatment-related costs such as oral rehydration salts, transportation to health facilities, food for children while parents were ill and communication or travel support for accompanying family members; and post-treatment costs such as replacing clothing and bedding destroyed as a result of cholera or reorganizing caretaking arrangements especially for children of affected families. Even after recovering from illness, many individuals discharged from cholera treatment centres were lacking the resources to return home or face mounting debts, which severely weakened their household's long-term resilience.

To reduce stigma and promote the reintegration of those who have been discharged, UNICEF, in collaboration with the Government of Zambia, helped strengthen the Public Welfare Assistance Scheme (PWAS), a social protection mechanism that provides support to affected families. This support includes food, hygiene kits and sanitation supplies and, in some cases, cash for transportation, for immediate needs and for supplies and interventions to curb the risk of further disease transmission. Through this initiative, 1,285 children and 3,322 families were assisted. In cholera-affected areas, emergency foster families, households undergoing treatment and families who had lost a breadwinner or caregiver were prioritized. Depending on need, beneficiaries received either in-kind assistance or a one-off cash transfer of up to 1,200 kwacha (approximately USD 50).

By integrating social protection into the emergency response, UNICEF and the Government of Zambia not only helped families manage the immediate fallout of the outbreak but also laid the groundwork for greater household resilience in future PHEs. Continued investment in these integrated approaches is essential to mitigate the long-term consequences of disease outbreaks on children and their caregivers.




*A grandmother and caregiver of 6 children survivors of cholera benefited from Public Welfare Assistance Scheme support in Zambia.*

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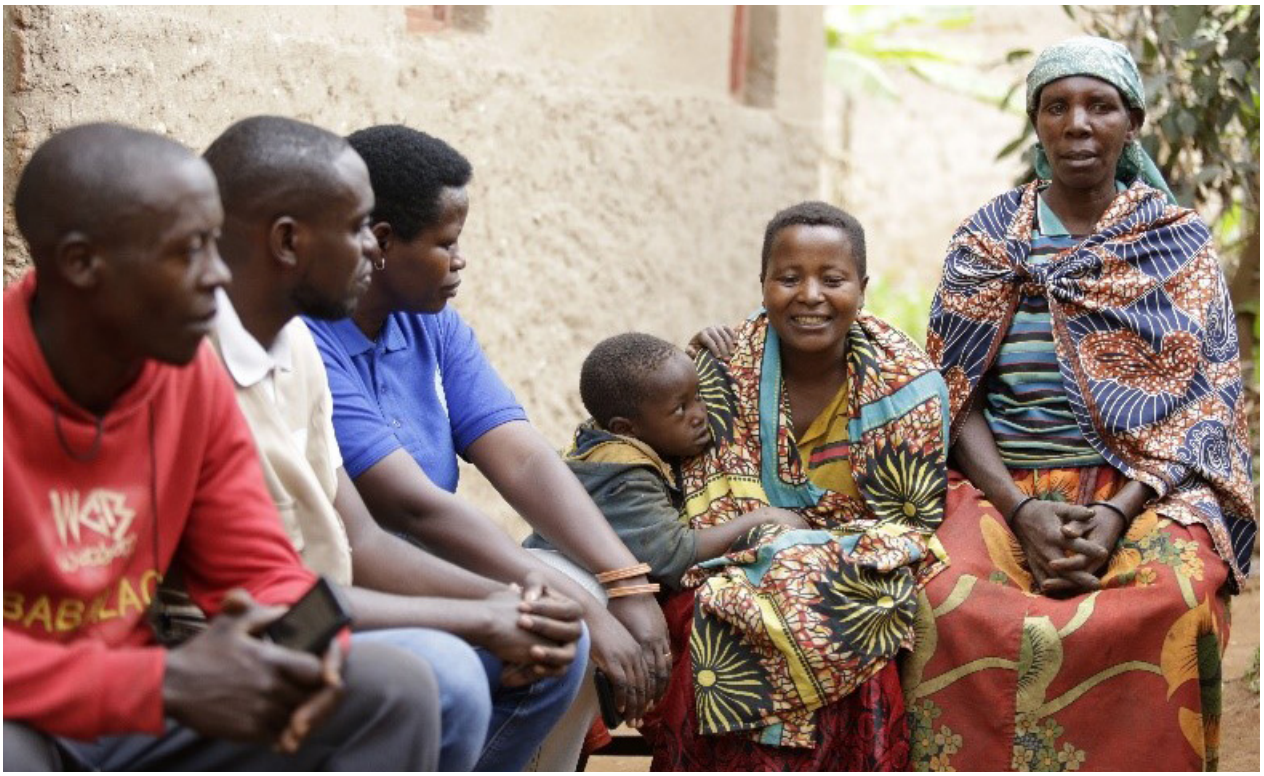


*Home visit and MHPSS to two women discharged from Mpox in Kayanza province, Burundi by PPSM social workers.*

### MHPSS: An Essential Element of a Child Protection Response to PHEs

The MHPSS response to PHEs is grounded in the 2022 Inter-Agency Standing Committee (IASC), Minimum Services Package (MSP) and the UNICEF Operational Response Framework for Public Health Emergencies. These resources emphasize integrating MHPSS across all sectors in emergencies through a coordinated multi-sectoral approach. The MSP outlines key actions for sectors, including Child Protection and GBV, and includes specific guidance for MHPSS in PHEs. Key activities for protection actors in the MSP include:

- Coordinate within and between sectors ensuring that protection actors are included in the MHPSS response pillar and vice versa (and if different that these 'talk' to each other)
- Contribute to holistic MHPSS needs assessments and mapping to inform the overall response
- Advocate for MHPSS at all response levels ensuring a strong child protection lens
- Contribute to the development of risk communication and community engagement (RCCE) approaches and disseminate child- and family-friendly key messages to promote mental health and psychosocial well-being
- Build the capacity of frontline workers and community leaders in basic psychosocial support skills
- Support new and existing community well-being initiatives that activate naturally occurring and inherent community support structures
- Maintain MHPSS integration into CP and GBV programming including case management
- Ensure staff and volunteer care systems that protect the physical and emotional well-being of frontline responders as an essential element of responding organizations' duty of care.

*For more information: Integrating MHPSS Into the MPOX Response: A Field Brief (2024)*

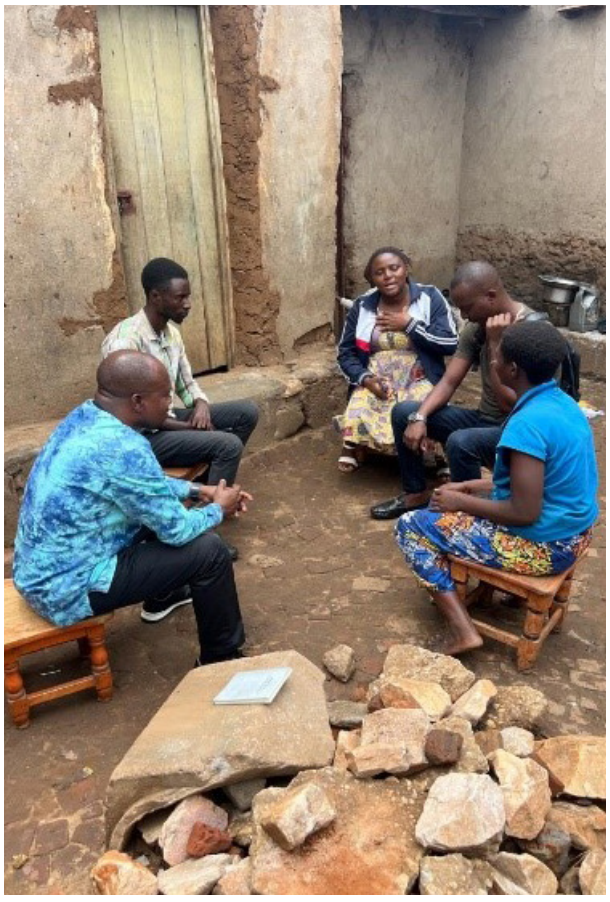
# Key area 4: Children living in vulnerable environments

**During PHEs, children living in vulnerable environments such as those in street situations, detention centres, residential facilities, refugee camps or informal settlements are at a significantly higher risk of exposure to infection and its consequences.** These children often face pre-existing vulnerabilities including limited access to healthcare, poor hygiene conditions, and lack of adult supervision or protection. As a result, they are not only more susceptible to direct health impacts but also to risks such as neglect, exploitation and abuse. During outbreaks, these children are often stigmatized and may be perceived as threats associated with the rapid spread of disease. In the most severe cases, they may face violence, arbitrary arrest, or discrimination further depriving them of the support and protection they direly need.

**Identifying and mapping at-risk children in these settings is a critical first step in ensuring their protection.** This requires coordinated action with social welfare services, civil society organizations, and community networks to reach children who may otherwise be overlooked. Once identified, tailored support should follow including the distribution of essential WASH supplies such as handwashing stations, soap, sanitizers and clean water to help reduce the risk of infection. Equally important are targeted awareness-raising campaigns that use age-appropriate communication to help children understand how to protect themselves through better hygiene practices, recognize symptoms of infection and know when and how to seek help. These campaigns should also address stigma and discrimination, debunk myths and challenge negative perceptions within communities.

**PHEs can also present unique opportunities to advance the protection and well-being of the most vulnerable children.** During outbreaks, increased attention is often directed towards marginalized children, who, if well-supported, can receive the care they deserve. Agreements can be made with governments to release some children from detention facilities or to find long-term care arrangements for those living in the street. Additionally, heightened scrutiny of alternative care centres, such as orphanages may lead to a revision of norms and standards for care arrangements or trigger broader reforms that promote family- and community-based care over institutions. This can also ensure that vulnerable children receive their birth certificates, which are crucial for accessing essential services and asserting their rights. These efforts can lead to systemic improvements that benefit vulnerable children not just during emergencies but in the long term as well.





*Home visit and MHPSS to a discharger from Mpox in the Kinama district, Burundi.*

## CASE STUDY 4: Angola: Enhancing Protection for Children in Alternative Care during the Cholera Outbreak

In early 2025, Angola faced a significant cholera outbreak with over 27,000 cases reported by July, more than half among children. While initially viewed solely as a PHE, the outbreak quickly revealed serious child protection risks particularly for children experiencing neglect or living without parental care in alternative care and street situations. This became tragically clear when 15 children in a Luanda alternative care centre contracted cholera and three, all malnourished, newly admitted babies, died. The incident underscored the heightened risks for children in these settings and triggered urgent action.

Children (particularly aged 0-5) are inherently more vulnerable to the physical impacts of cholera and these risks are significantly heightened for those suffering from malnutrition. In institutional settings, the proximity of children can further amplify the risk of transmission and adverse outcomes. To address the cholera emergency in alternative care centres, UNICEF supported the distribution of WASH and recreational kits, delivered trainings to caregivers on cholera prevention and child protection measures and initiated coordination meetings to strengthen the emergency response. In the first few months of the response, a total of 26 centres with 1,921 children have been monitored and supported with UNICEF's cholera response in Luanda only.

The outbreak also revealed systemic weaknesses. Angola lacked national regulations to govern alternative care and adoption and existing case management systems were not implemented due to limited coordination across sectors. In response, UNICEF supported the Government to implement a child registration database and tracking system of children hosted in alternative care centres to strengthen information management processes and initiated policy dialogue to support the establishment of national alternative care standards. UNICEF also organized trainings and provided computers to alternative care centres in provinces with cholera outbreaks. These efforts aimed to reinforce the broader child protection system while also addressing specific challenges that arise during PHEs. Examples include preventing child trafficking and enabling family tracing and reunification for children who have been separated from their families due to illness or placed in alternative care during an outbreak.

At the same time, UNICEF has been building the capacity of the social service workforce to deliver appropriate case management for children orphaned or separated due to cholera including family tracing and reunification. In assessing child protection concerns, UNICEF also discovered other risks to children that are exacerbated during PHEs. These include child-parent separation and orphanhood as well as lack of proper death certification that can impact, for example, children's inheritance rights.

The cholera outbreak in Angola was a catalyst for reform. It enabled UNICEF to build new partnerships, mobilize resources and push forward much-needed investments in child protection systems. Angola's experience demonstrates the importance of integrating child protection into PHEs particularly for children without parental care and in other difficult situations. It also reinforces the need to promote family- and community-based care options, such as kinship or foster care, as part of broader care reform efforts. This offers valuable lessons for other countries confronting similar risks.

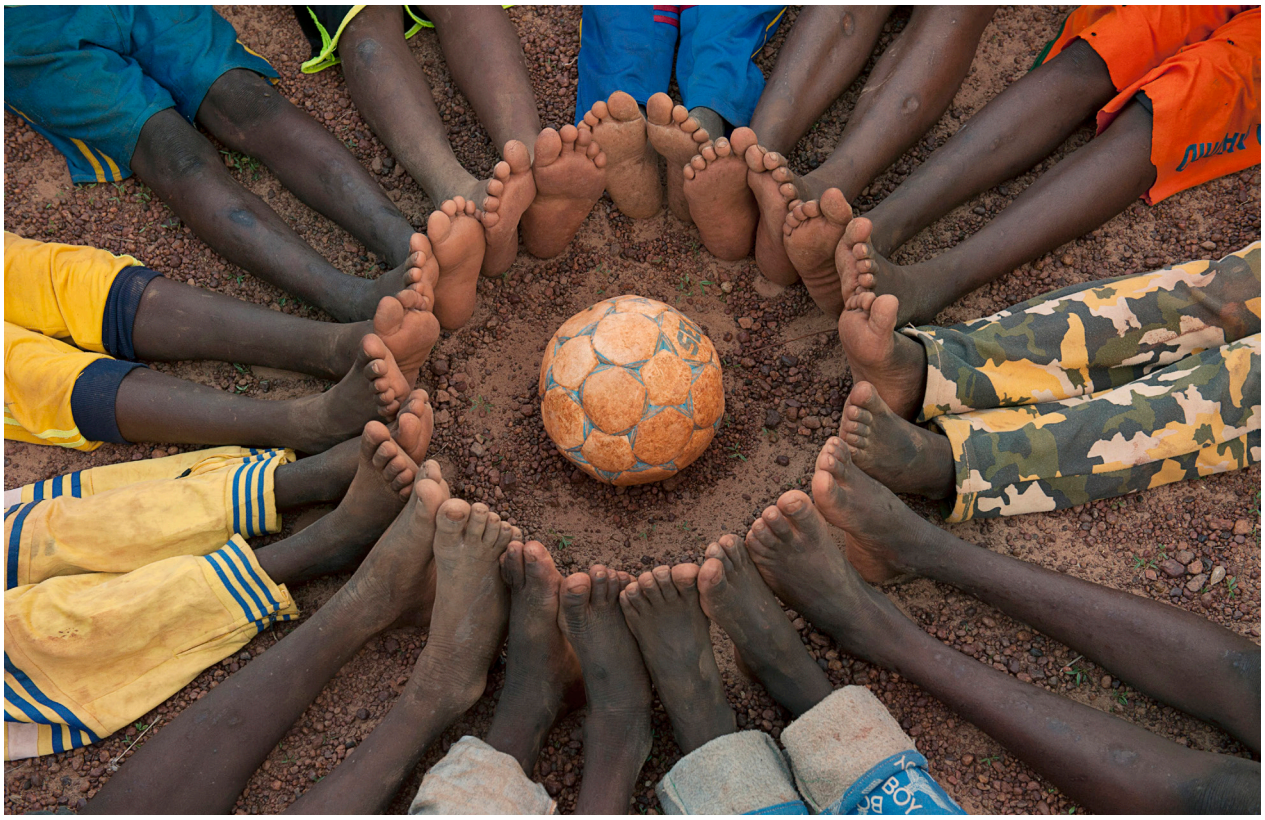
## Key area 5: Children without parental care

**Children who have lost one or both parents or even their primary caregivers are at increased risk of neglect, abuse and exploitation.** In such cases, it is essential to ensure that these children receive both immediate and long-term care, support and protection. This includes the provision of individual child protection case management services by trained social or para-social workers who can assess and provide an immediate response to the child's situation and needs. Based on the child's individual circumstances, social workers can undertake family tracing and reunification efforts and explore long-term care options preferably within family- or community-based settings such as kinship or foster care. Home visits help assess living conditions and ensure basic needs like food, shelter and health care are met.

**Child protection interventions should not only addresses the immediate care needs but also ensures that the affected children are supported in a way that promotes their long-term safety, stability and emotional recovery.** When a child has lost his/her caregivers, issues such as civil documentation (ensuring the child has all necessary documents related to themselves and their family), inheritance arrangements and long-term care should be addressed by social workers, as many of these issues extend far beyond the scope of the PHE itself.

Furthermore, ensuring that these children have access to education, psychosocial support and a supportive community network is essential for their holistic development and resilience especially during a public health crisis. Continued efforts must be made to reduce the stigma or isolation that orphans may face and offer a supportive environment to heal from the trauma of loss.





# Recommendations

## To governments

**Ensure protection concerns are integrated into response plans from the onset of public health emergencies.** Despite lessons learned from past crises, the systematic consideration of protection issues as a core component of PHE responses remains limited. Governments must ensure that ministries in charge of the protection of children are actively engaged in coordination mechanisms from the very outset with their roles extending beyond isolated interventions such as mental health and psychosocial support. Child protection services must also be fully engaged on preparedness and lessons learned exercises with other key relevant sectors.

**Strengthen community-based protection systems.** In many contexts where formal social services have limited reach, communities frequently serve as the frontline in identifying and supporting vulnerable children. These community-based protection systems are not only essential in delivering immediate assistance but also in facilitating long-term reintegration by reducing stigma, linking affected families to critical services and addressing persistent barriers to recovery. Recognizing and investing in these grassroots structures as integral components of PHE responses is essential. Strengthening their connections with health services and equipping their members with the knowledge and tools to adapt their work during emergencies will ensure more efficient and inclusive responses.

## To protection stakeholders

**Ensure that protection interventions remain consistent across the varying types of public health emergencies.** PHEs disrupt the protective environments that children rely on undermining families, critical services and community networks. Despite variations in the nature and scale of outbreaks, the core components of a child protection response must remain consistent. Child protection interventions-particularly community protection systems, case management, prevention and response to family separation, mental health and psychosocial support and prevention and response to violence and exploitation-are essential to responding to these diverse needs. Consistently framing child protection interventions around these core components and integrating them throughout the different settings (in communities, treatment and isolation centres or with children living in a vulnerable environment) clarifies the unique role and added value that child protection actors can bring in complementing other sectors. It also prevents the sector from being drawn into interventions for which its expertise might be less relevant (for example, awareness campaigns and community mobilization).

**Proactively and continuously engage with sectors in charge of public health emergencies.** UNICEF's Operational Framework for PHEs underscores the importance of child protection as a life-saving intervention that both enhances health interventions and the overall well-being of children. This collaboration is more effective when set up before shocks occur to speed up response and avoid overloading frontline workers during the onset of the response. Training frontline medical workers (e.g., nurses and doctors) on psychosocial first aid, deploying social workers in health facilities or including specific indicators related to protection on the health surveillance system can facilitate early identification and referral of children at risk or in need of protection and should preferably be included in preparedness work.

**Increase investment in preparedness and anticipatory action and ensure they become part of regular programming**. Preparedness and anticipatory action are essential to ensuring that child protection systems remain functional and responsive during PHEs. This begins with identifying and addressing bottlenecks that hinder service delivery during outbreaks. Key actions include pre-training the social service workforce on PHE protocols,

establishing SOPs across key services, developing rapid workforce recruitment mechanisms and ensuring that alternative care modalities and programs (family-based, community-based, temporary residential) are registered and equipped.

Collaborating with stakeholders to identify triggers that should activate anticipatory interventions is also critical. This helps mitigate the impact on child protection and supports more efficient and timely responses particularly in contexts that are increasingly marked by resource constraints and competing priorities.

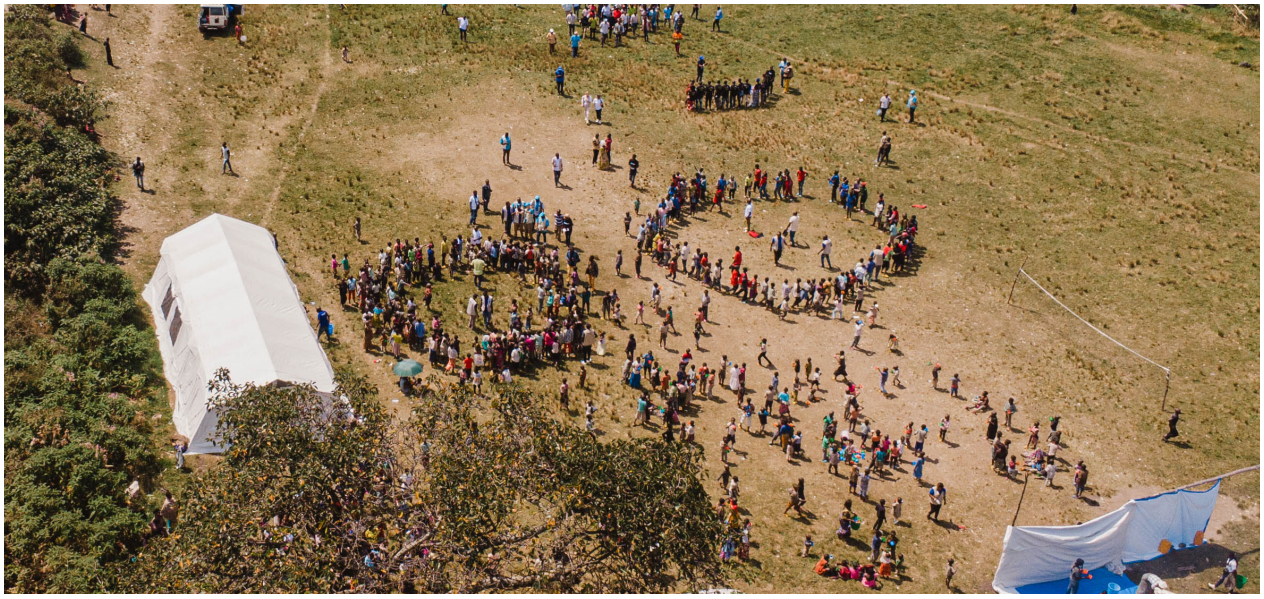
## To technical and financial partners

**Ensure the centrality of protection in public health emergencies responses.** PHEs heighten the vulnerability of affected populations and often lead to indirect protection risks such as economic or sexual exploitation. While sectors like health and WASH will be prioritized, it is essential that all interventions uphold the principle of the centrality of protection. Technical and financial partners should ensure that responses do not expose communities to further harm by supporting interventions such as safety audits or age- and gender-sensitive processes. They should actively contribute to preventing and responding to violence, for example, by establishing case managment and referral mechanisms or training health personnel to identify and manage protection cases.

**Continue investing in specific child protection interventions during public health emergencies.** PHEs expose and intensify existing vulnerabilities among children placing them at increased risk of violence, exploitation, neglect and abuse. Yet, child protection remains significantly underfunded. Targeted financial support for child protection interventions such as deploying trained social workers, integrating protection concerns into health surveillance systems and ensuring safe care arrangements is essential. These investments are critical not only to safeguard children but also to reduce long-term harm and strengthen the overall effectiveness of public health responses

**Address the long-term impact of public health emergencies on children and families.** The programmatic responses must go beyond immediate containment and control measures to address the long-term impacts of PHEs on children and their families. These emergencies often result in prolonged economic and emotional hardship, which can severely affect children's well-being. Such hardships may lead to school dropouts, child labour, early marriage or exploitation including prostitution. To mitigate these risks and support long-term family resilience, it is essential to provide in-kind support, support inclusive and agile national social safety nets or implement temporary cash transfer programs. These interventions play a critical role in reducing families' vulnerabilities to future public health crises and promoting the stability and well-being of children.





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Wherever he lives.

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A future.

A fair chance.

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