MINI-GUIDE: COLLABORATING

Child Protection in Outbreaks:

Collaborating with the health sector in infectious disease outbreaks

THE ALLIANCE
FOR CHILD PROTECTION
IN HUMANITARIAN ACTION

ACKNOWLEDGEMENTS

This Mini-Guide has been authored by Nidhi Kapur, with support from Hannah Thompson. Anita Queirazza of Plan International, Lauren Murray of the READY Initiative led by Save the Children, and Audrey Bollier of the Alliance for Child Protection in Humanitarian Action played a crucial role in overseeing the development of this guidance. Thanks also go to all those who generously shared their experiences of working in outbreak settings at local, regional and global levels, and those who invested time in reviewing earlier drafts, including colleagues with diverse backgrounds in child protection, health and MHPSS.

These Mini-Guides have been made possible by funding from USAID, the Oak Foundation and Irish Aid. The contents are the responsibility of the READY initiative and Plan International and do not necessarily reflect the views of USAID, the United States Government, the Oak Foundation or Irish Aid.

Who is this mini-guide for & how should it be used?

National and global efforts to prevent, respond to, and recover from outbreaks are typically led by the health sector, even when interventions are multi-sectoral in nature. This Mini-Guide demonstrates how and why child protection considerations can and should be integrated into outbreak management.

Wherever possible, the advice given here is aligned with the outbreak preparedness and response pillars described in the Operational Planning Guidelines[1] of the World Health Organization (WHO), with the health standards described in The Sphere Handbook,[2] and with Pillar 4: Working Across Sectors of the Minimum Standards for Child Protection in Humanitarian Action (CPMS)[3] from the Alliance for Child Protection in Humanitarian Action.

This Mini-Guide is intended for use by health and child protection practitioners during infectious disease outbreaks, preparedness, response and recovery. It can also be used by the social service workforce in settings impacted by infectious disease outbreaks.

The added value of working together: Nine reasons why

When child protection and health actors work together during infectious disease outbreaks, they can maximise positive outcomes for children and caregivers – and for their own sectors. Here are nine reasons why:

1

Together, both sectors are uniquely placed to identify and implement mitigation measures to reduce the potential harm experienced by children and caregivers as an indirect impact of outbreak containment and control measures.

2

They can adapt service provision so that it better addresses the needs of children. For example, health actors trained in effective communication with children may have greater success in the testing, treatment and immunisation of children. Child protection actors can be trained in necessary infection prevention and control (IPC) measures to continue operating safely during outbreaks.

3

They can work together with colleagues specialising in mental health and psychosocial support (MHPSS) to identify and address more holistically the increased immediate and long-term MHPSS needs of children and their caregivers during outbreaks.

4

Child protection and health actors can jointly roll out coordinated awareness-raising campaigns as part of risk communication and community engagement (RCCE) during outbreaks. In addition to being consistent, messages should be inclusive and accessible, as well as target children and their caregivers to increase knowledge, improve adherence to containment, control and mitigation measures, and strengthen preparedness for future outbreaks at community, household and individual levels.

5

More children and their caregivers can be reached with quality services. Child protection actors who are trained in the early detection of disease and preventive measures can recognise and refer cases of symptomatic children and caregivers. Health actors who are trained in child safeguarding and child protection are more likely to safely identify and appropriately refer cases of suspected abuse, neglect, exploitation, or violence, amongst children they meet.

Working together ultimately benefits children and their caregivers. When health and child protection actors collaborate closely, families can find holistic services through a single access point. Referrals can be made quickly, safely and sensitively. Children and their caregivers receive consistent messages.

6

Where child protection actors have suspended or restricted access to communities and health facilities, the provision of child protection services can continue in some form. This can be achieved when child protection practitioners collaborate with health counterparts to provide basic knowledge and skills in child protection.[5]

7

They can jointly develop and disseminate shared standard operating procedures (SOPs) – including common information-sharing and data protection protocols – in regard to the safe identification, documentation, and timely referral of children in need of further case management support.

8

Together, they can standardise the disaggregation of data collection, analysis and reporting by age, gender and disability – in turn enabling a more tailored response strategy informed by quality, joint data analysis.

9

Collective mobilisation of resources and joint advocacy to donors can lead to greater financing for integrated interventions.

'Supporting children's health increases children's protective factors, while supporting children's protection can, and should, improve children's physical health and well-being.'[4]

– Standard 24 of the Minimum Standards for Child Protection in Humanitarian Action (CPMS)

How to integrate child protection in outbreak management: Five critical actions

As a matter of good practice, **child protection practitioners should participate in joint preparedness and contingency planning with health counterparts**, thereby enabling a more effective and timely response if an outbreak occurs. Other joint actions, such as assessments, monitoring and fundraising, should also be envisaged. **Working together provides an opportunity for child protection actors to better understand the work of the health sector** and thus be better able to develop context-specific integrated approaches, consistent messaging, and coordinated action.

Child protection actors are well positioned to undertake risk mapping to identify: (i) potential harms to children that may be exacerbated or created by the outbreak or by potential public health measures; and (ii) possible mitigation measures. They should proactively anticipate scenarios in which infected or affected children may require additional support. Child protection actors can also help to promote meaningful child participation in, and accountability towards, affected populations.

Overall, the management of infectious disease outbreaks is typically led by health actors. Child protection actors must therefore identify opportunities to highlight key child protection issues, so that these can be addressed fully understood and comprehensively as part of preparedness, response, and recovery processes. Here are five critical actions:

1

Ensure that children and adolescents are included in RCCE efforts, and that messages, communication and community engagement efforts are tailored to these audiences.

See *'Awareness-raising among children and adolescents: Core considerations'* (page 6) for more detail.

2

Elaborate and integrate mitigation measures and protocols to reduce the risk of separation and promote family unity prior to, during and after medical treatment.

See *'Promoting family unity during outbreaks'* (page 8) for more detail.

3

Ensure that care, quarantine, isolation, and treatment centres are child-friendly and that they promote responsive caregiving practices which ensure adequate nutrition and overall well-being.

See *'Providing child-friendly facility-based care: Top tips'* (page 10) for more detail.

4

Develop common protocols for the safe identification, documentation and referral of children for further case management.

See *Safe identification, documentation and referral: common protocols* (page 12) for more **detail.**

5

Support strategies for an effective testing and vaccination campaign for children.

See *'Planning for a child-friendly vaccine roll-out'* (page 14) for more detail.

Awareness-raising amongst children and adolescents: Core considerations

When planning awareness-raising campaigns, child protection actors should engage with colleagues specialising in RCCE as part of outbreak response. Together they can ensure that campaigns are effective in targeting and addressing the information needs of younger audiences. While key messages will differ depending on the context and type of infectious disease outbreak, targeted strategies to engage children and adolescents should be guided by some core considerations:

- Engage formal or informal community leaders, religious leaders, and civil society representatives or organisations, such as youth, disability and/or women's rights groups, to orient and gain buy-in on any RCCE activities and materials related to child protection.
- Gather community input and feedback that provides context-specific information about challenges, concerns, rumours and perceptions related to children, adolescents and caregivers in regard to the infectious disease outbreak. Efforts should be made to better understand information needs as well as language and literacy requirements.
- Identify platforms or modes of communication that are typically accessed by younger children and adolescents, such as radio, television, radio, and social media. Consider how messages could vary depending on the time, day, or month. For example, the best methods for sharing messages with children may be different during school holidays.
- Identify preferred and trusted sources of information for caregivers to receive outbreak-related information affecting children (for example, SMS, social media, and in-person activities).
- Connect with RCCE focal points or working groups to ensure that assessments, community-feedback mechanisms, and surveys are considering the needs, practices and challenges related to children and adolescents and the outbreak. Ensure that community mobilisers are equipped with updated

information on referral pathways and related messaging.

- Wherever possible, facilitate the meaningful and representative participation of children and adolescents in the creation, piloting and dissemination of information, education, and communication (IEC) materials on the disease outbreak, including child-friendly reporting and referral pathways.[6]

- Ensure that IEC materials are inclusive, accessible and appealing for:
(i) younger children as well as adolescents;
(ii) children of different genders;
(iii) children with different abilities and disabilities (for example, large print, pictorial, braille or local language versions); and
(iv) children of diverse linguistic, religious, and socio-cultural backgrounds.

- Ensure that content is accurate and adequate in providing evidence-based and contextual information about:
  - Potential direct and indirect risks facing children due to their age, gender or disability, given that these factors influence their susceptibility to infectious disease and the possible impact of public health measures.
  - Verified reporting and referral pathways, including any available hotlines, helplines, and child-friendly and inclusive service providers.
  - Clinical and home-based treatment options.
  - Vaccinations.

- Content should include MHPSS-specific messaging for both infected and affected children. This should aim to address: (i) any fears children may have; and (ii) potential social stigma linked with infection and/or treatment. This can be enhanced with specific messaging for caregivers on positive parenting and other coping skills during outbreaks.[7] MHPSS coordination teams, such as MHPSS Technical Working Groups, can support and provide inputs.[8]

- Content may need to be continually adapted depending on the length, stage or severity of the outbreak. MHPSS needs, for example, may become more urgent over time due to sustained stress. In partnership with children, caregivers and communities, develop additional strategies that integrate RCCE with child protection as needed – for instance, to stimulate health-seeking behaviours based on data gathered on self-regulation skills or responsive caregiving, or to engage children, adolescents and caregivers on child self-regulation skills – with support being provided to caregivers to enable them to remain responsive to the needs of, and risks to, children despite sustained stress.

- Ensure there are community feedback mechanisms in place that capture the needs, rumours, concerns, suggestions and complaints of children, adolescents and their caregivers related to the outbreak and response.

Promoting family unity during outbreaks[9]

In implementing public health measures during infectious disease outbreaks, **authorities should take steps to prevent family separation, restore family links, and ultimately promote family unity,** both within facilities and in the wider community.

The following mitigation measures should be put into practice by authorities whenever possible:

- When announcing strict movement restrictions, provide as much advance notice as possible in order to minimise family separation by allowing time for children and caregivers to gather if necessary.
- In partnership with communities, develop and disseminate key messages on how to prevent family separation in the event of containment and control measures.
- Facilitate timely family tracing and reunification arrangements for separated and unaccompanied children, even during lockdowns, travel bans or border closures.
- Ensure the availability of both facility-based and home-based care options, if appropriate.
- Put in place a moratorium on international adoptions.

Intake, care and discharge protocols for facility-based care must **always prioritise the best interests of the child**. If unavoidable, **separation should be seen as a last resort and should be as short as possible**. Children who are separated should ideally be placed in family-based interim or alternative care.

- The decision to separate a child from their caregiver when applying any specific containment or care measures should be based on: (i) medical factors such as possible outcomes of infection for the child or caregiver; and (ii) on the possible emotional and social consequences of family separation on the child. All actors should bear in mind that nurturing care and the presence of a primary caregiver in the early years are crucial to short- and long-term outcomes.
- This means that it sometimes can be in the child's best interests for the caregiver and child to isolate or quarantine together – with strict adherence to clinical care and infection prevention and control (IPC) measures.

Children who are most likely to need interim or alternative care arrangements or exemptions include breastfeeding newborns, unaccompanied or separated children, children of parents who require isolation, quarantine or treatment, as well as children in single-parent households, child-headed households, or with older caregivers.

Temporary interim or alternative care action plans can be developed in partnership with caregivers in advance of potential separation from their children.

PROTOCOLS TO PUT INTO PRACTICE INCLUDE:

1

AT INTAKE:

- Document the child's name (including any nicknames), family name(s), date of birth, and place of origin or current residence, address, or home location. Also note the names and contact information of the child's primary caregivers, and names and contact details of other family members who could provide interim or alternative care if needed. If no family members are nearby or have contact details available, the name of a trusted neighbour or friend should be sought.

2

DURING PROVISION OF CARE:

- Facilitate regular family contact during the interim period – ideally on a daily basis.
- Support remote or virtual contact including through electronic media such as Skype, telephone, WhatsApp, or videos. Alternatively, communication can take place through the exchange of voice or video messages, letters, photos, or safe options for face-to-face visits (if proper precautions are in place).
- Facilitate regular (daily, if possible) updates on the child's condition and whereabouts to the child's family.

3

PRIOR TO DISCHARGE:

- Ensure that families and communities are engaged through targeted RCCE efforts to gather information on concerns, rumours and needs related to the outbreak, and dispel any misinformation and mitigate social stigma linked to the infectious disease. Accurate information should be offered in accessible formats that are easily understandable in terms of language and literacy level.

4

UPON DISCHARGE:

- Provide the child and caregiver with updated information about the child's health status and essential information about possible re-infection, transmission and recovery.
- Continue follow-up by child protection caseworkers after family reunification.

Unless it is a medical or other emergency, health actors or other authorities implementing public health measures should always contact child protection actors before separating a child from their family. Child protection actors can support appropriate care and contact arrangements during separation.

Providing child-friendly facility-based care: Top tips

The physical and psychological needs of children must continue to be addressed while in isolation, quarantine and treatment centres. Facility-based care can be made more child-friendly. Consider both the context as well as the specific needs of children, which may vary according to age, gender, disability or linguistic, religious or socio-cultural background. Adapt accordingly.

TOP TIPS

- Pre-position and provide personal hygiene, educational and recreational materials.
- Cater for children's specific nutritional needs.
- Designate **'child-friendly corners'** as a separate space (indoors or outdoors) for children to play and learn. These can be painted in bright colours and have child-sized furniture, art materials, and toys. Carefully select materials that can be easily and regularly sanitised. Ensure that infection prevention and control measures are strictly adhered to.
- Children typically need to eat smaller amounts more frequently throughout the day than adults. Scheduled **'happy hours'** during which to provide nutritious food and drinks that promote the well-being of children (for example, milk, fruit, and bread). This can be accompanied by stories, songs or other child-friendly activities (with due respect for infection prevention and control measures).
- Ensure that infection prevention and control measures are well understood by children and that they have the necessary tools and knowledge to follow guidance. Use creative communication methods such as song, music, and puppets to explain these measures – depending on the children's age and stage of development and taking into account any disabilities. ***For more ideas, see Mini-Guide: Communicating with Children in Infectious Disease Outbreaks***
- Depending on the mode of virus transmission, organise a schedule for children to play and learn individually, whether

in small physically distanced groups, or in larger groups.

- Where feasible, engage with education stakeholders to ensure continuity of learning using appropriate methods. This should include measures to enable children to take on-site national examinations.
- Wherever possible, provide a range of child-friendly MHPSS services, including Psychological First Aid[10] and referrals to more specialised services where necessary.
- If funding allows, aim to appoint a child protection caseworker or social worker in each health facility. At a minimum, identify two child protection focal points (one man, one woman).
- Ensure all health staff have received training in child safeguarding and have signed a code of conduct.
- Establish effective, child-friendly reporting and feedback mechanisms within the health facility and ensure they are known to each child.
- Ensure lockable and well-lit toilet facilities. Consider safe sleeping arrangements for children, including overnight monitoring of both different- and same-sex quarantine, isolation and treatment facilities.

CHILD-FRIENDLY CHECKLIST

PERSONAL HYGIENE AND NUTRITION

- ✔ Hand sanitiser, soap and water, toothbrush and toothpaste, toilet paper, body lotion, towel.
- ✔ Sanitary pads in adequate quantities for pre-adolescent/adolescent girls; shaving kits for adolescent boys; child-sized underwear or clothing; child-sized masks.
- ✔ Diapers, wet wipes, and diaper rash cream for babies; a plastic bucket and access to warm water for bathing; milk and bottles (if used) and age-appropriate food options (no salt, mashed food, etc.) for infants and younger children.
- ✔ Clean drinking water.

LEARNING MATERIALS

- ✔ Colouring pads, crayons, paper, paints, books, puzzles, chalkboard and chalks, building blocks, pencil sharpeners, erasers, and rulers; whiteboards and dry-erase markers; storybooks (in locally relevant languages and for different ages).

RECREATIONAL MATERIALS

- ✔ Footballs, basketballs, playing cards, dominoes, board games, plastic or washable toys, skipping ropes.

Safe identification, documentation and referral: Common protocols

During the course of their work, healthcare workers or volunteers in facilities and communities may come across children in need of additional child protection support. Child protection professionals can support the development and dissemination of common protocols for the safe recognition, documentation and timely referral of children in need of further child protection case management services.

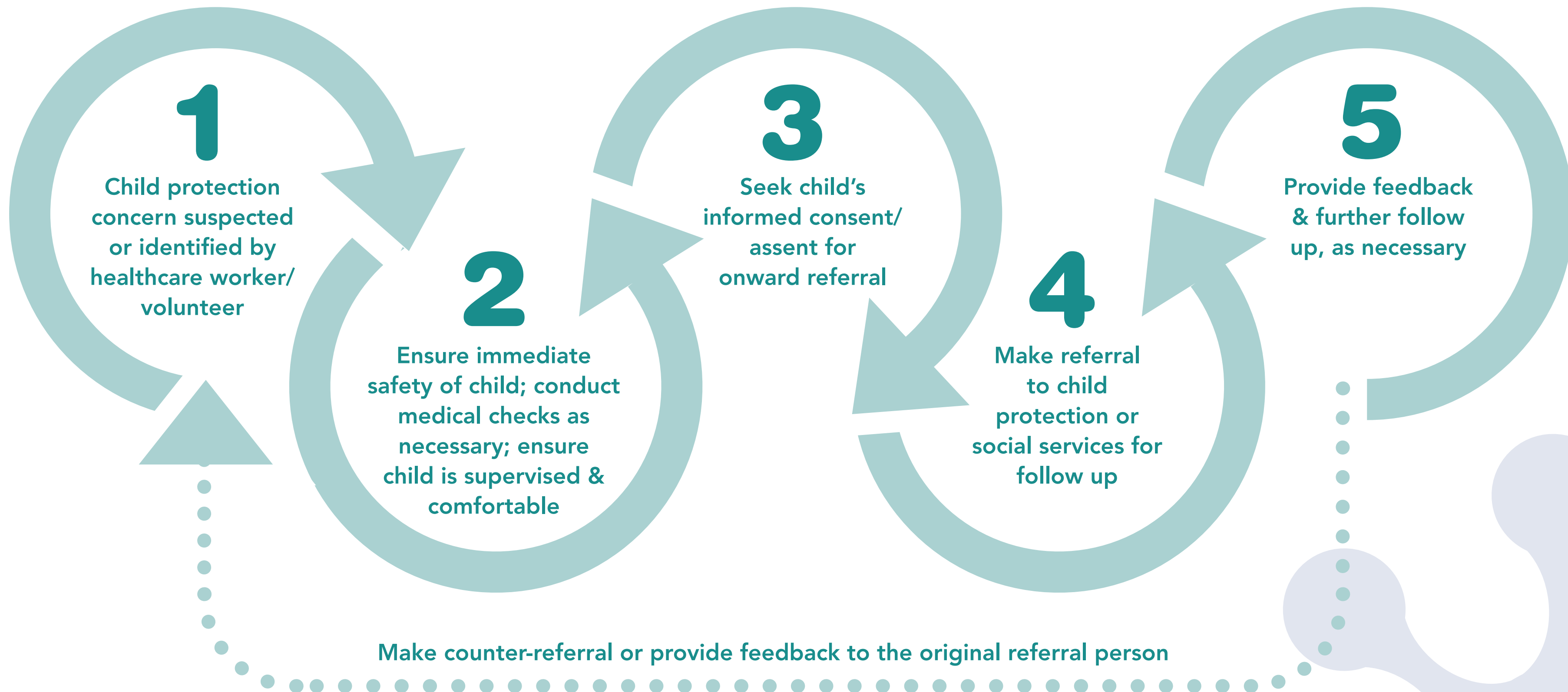
Reporting and referral pathways need to be adapted to each context, and can be sustained after the end of an outbreak. These should be user-friendly, easy to read and understand, and have up-to-date contact information. There should be a clear child protection focal point where health actors can report, share concerns, or ask questions.

POSSIBLE CHILD PROTECTION CONCERNS:

- Unaccompanied or separated child
- Abandoned child or baby
- Child showing signs of physical, psychological or sexual abuse
- Pregnant child
- Neglected child
- Child exposed to domestic violence or family conflict
- Caregiver with chronic or severe illness
- Death of child's caregiver
- Child denied healthcare by caregiver

REMEMBER: Use child-friendly language and approaches to reassure the child without making false promises. Listen openly to what the child has to say without probing. Do not leave a distressed child alone. Where possible, ensure the supervisor is a gender of the child's choosing.

The following reporting and referral pathway provides a general overview that can be applied in different contexts:



What to say*

'I would like to refer you to my colleague, a caseworker who helps children and families who have experienced similar challenges. Many children welcome their help. If you agree, they can meet with you and learn more about you and what has happened to you. They can provide you with useful information and also help you know what other help you'll be able to get. Anything you share will remain between us.'

* *modify according to individual and contextual characteristics*

Planning for a child-friendly vaccine roll-out

Depending on the infectious disease, paediatric vaccinations may already exist and become available during the course of an outbreak. The age at which children become eligible for particular vaccines or any boosters may vary. The needs of children are distinct from adults and will therefore require specific strategies to ensure successful vaccination campaigns.[11] Fear of needles, infection or side effects – in addition to misinformation or lack of information – can all pose significant barriers.

FILL ANY INFORMATION GAPS

- Provide parents or caregivers with accurate and adequate information about both the infectious disease and the vaccination, including where and how to access vaccination for children. This can help to dispel myths, answer questions and address vaccine hesitancy, thus enabling parents or caregivers to make an informed choice and give consent to vaccination.
- Use accessible language and diverse media for sharing information, including written, audio, and video messages.
- Evidence suggests that the best way to address rumours and misinformation is with empathy and understanding. Focus the conversation on evidence of the disease and its consequences. Using presumptive language with caregivers – for example, asking 'when' and not 'if' their child will be vaccinated – can help shift social norms around vaccinations.

COMMUNICATE WITH CHILDREN

- Provide children or adolescents with the information they need to enable them to give informed assent.
- Vaccinators should be prepared to address anxiety and distress amongst children. ***For more tips, see *Mini-Guide: Communicating with Children in Infectious Disease Outbreaks.***
- Use age-appropriate, accessible language and formats that are adapted to younger and older children with and without disabilities.

MAKE IT FUN AND REWARDING

- Depending on the context, offer children free give-aways like stickers, stamps, badges, balloons, or colouring sheets. Older children or adolescents may wish to take a selfie to share on social media, thereby encouraging their peers to get vaccinated as well.
- Designate and decorate a separate space for children to be accompanied by their caregivers.

PROVIDE FAMILY-CENTRED AND DISABILITY-SENSITIVE SERVICES

- Offer family-friendly service hours and flexible appointment times at accessible locations.
- Ensure rapid service provision to avoid keeping children waiting.
- Provide dedicated areas for children who need more time or privacy.
- Select vaccination sites that offer children space to move around freely while maintaining any necessary physical distance for safety.
- Prioritise vaccination of children from at-risk groups, including children with disabilities or medical conditions that may make them more susceptible to infection and/or limit their ability to safely follow public health measures.
- Remove financial and logistical barriers to vaccination.
- Where possible, facilitate breastfeeding or nursing during vaccination for infants and younger children to minimise pain and discomfort.
- Provide child-sized masks (if necessary).

ADAPT TO CONTEXT

- Offer drive-through or mobile clinics, if necessary. Provide in-school or after-hours vaccination services, if deemed appropriate.
- Depending on prevailing socio-cultural norms, provide privacy booths to adolescent girls, for example.
- Maximise the opportunity to verify timely uptake of other routine childhood immunisations that may have been interrupted due to the outbreak or other contextual realities.

Many of the tips here could be adapted for use during testing and treatment.

For example, when drawing blood or taking nasal swabs to test for infection.

ENDNOTES

1 World Health Organization (2020), Operational planning guidelines to support country preparedness and response: COVID-19 strategic preparedness and response plan, available at: https://www.who.int/publications/i/item/draft-operational-planning-guidance-for-un-country-teams.

2 Sphere (2018), The Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response, available at: https://handbook.spherestandards.org/en/sphere/#ch001.

3 The Alliance for Child Protection in Humanitarian Action (2019), Minimum standards for child protection in humanitarian action, available at: https://handbook.spherestandards.org/en/cpms/#ch001.

4 The Alliance for Child Protection in Humanitarian Action (2019), Minimum standards for child protection in humanitarian action, available at: https://handbook.spherestandards.org/en/cpms/#ch001.

5 See, for example, efforts by child protection and health actors in Cox's Bazar, Bangladesh, at the onset of the COVID-19 pandemic to appoint and train existing health workers as 'child carers' to support children admitted in isolation and treatment facilities, available at: https://www.humanitarianresponse.info/en/operations/bangladesh/document/child-protection-health-care-children-health-facilities-during-covid.

6 See Mini-Guide: Adapting Child Protection Programming in Infectious Disease Outbreaks (child participation section).

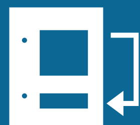
7 See, for example, End Violence against Children (2020), Resource Pack: Positive Parenting in COVID-19 Isolation, available at: https://www.end-violence.org/articles/new-resource-pack-positive-parenting-covid-19-isolation; Inter-Agency Standing Committee Reference Group (2020), My hero is you: Storybook for children, available at: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/my-hero-you-storybook-children-covid-19; and, Actions for heroes, A guide to heart-to-heart chats with children to accompany 'My hero is you', available at: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/actions-heroes-guide-heart-heart-chats-children-accompany-reading-my-hero-you-how-kids-can-fight.

8 See Inter-Agency Standing Committee Reference Group (2011), Advocacy package: IASC guidelines on mental health and psychosocial support in emergency settings, available at: https://interagencystandingcommittee.org/system/files/1304936629-UNICEF-Advocacy-april29-Enghlish.pdf.

9 Adapted from the Alliance for Child Protection in Humanitarian Action, UNICEF (2020), Children, isolation and quarantine: Preventing family separation and other child protection considerations during the COVID-19 pandemic, available at: https://www.alliancecpha.org/en/system/tdf/library/attachments/children_isolation_and_quarantine_-_cp_considerations_during_covid-19_-_final_-_2020.10-english_0.pdf?file=1&type=node&id=42299.

10 See International Federation of Red Cross and Red Crescent Societies (2020), Remote Psychological First Aid during a COVID-19 outbreak: Final guidance note, available at: https://pscentre.org/wp-content/uploads/2020/03/IFRC-PS-Centre.-Remote-PFA-during-a-COVID-19-outbreak.-Final.-ENG.pdf; World Health Organization, CBM, World Vision International, UNICEF (2014), Facilitation manual: Psychological First Aid during Ebola virus disease outbreaks, available at: https://www.who.int/publications/i/item/9789241548977.

11 For more information, see Busara Centre for Behavioral Economics, Common Thread, Save the Children (2021), The little jab book: 18 behavioural science strategies for increasing vaccination uptake, available at: https://resourcecentre.savethechildren.net/document/little-jab-book18-behavioral-science-strategies-increasing-vaccination-uptake/.



KEY REFERENCES AND RESOURCES

The Alliance for Child Protection in Humanitarian Action (2019), Minimum standards for child protection in humanitarian action, available at: https://handbook.spherestandards.org/en/cpms/#ch001.

Sphere (2018), The Sphere Handbook: Humanitarian charter and minimum standards in humanitarian response, available at: https://handbook.spherestandards.org/en/sphere/#ch001.

World Health Organization (2020), Operational planning guidelines to support country preparedness and response: COVID-19 strategic preparedness and response plan, available at: https://www.who.int/publications/i/item/draft-operational-planning-guidance-for-un-country-teams.

The Alliance for Child Protection in Humanitarian Action, Strengthening capacity of CPHA practitioners to response in times of COVID-19: An initiative of the learning & development working group, available at: https://alliancecpha.org/en/strengthening-capacity-cpha-practitioners-respond-times-covid-19#delivering.

Busara Centre for Behavioral Economics, Common Thread, Save the Children (2021), The little jab book: 18 behavioural science strategies for increasing vaccination uptake, available at: https://resourcecentre.savethechildren.net/document/little-jab-book18-behavioral-science-strategies-increasing-vaccination-uptake/.

READY Initiative (2022), Promoting collaboration between child protection and health sectors in the context of infectious disease outbreaks: Stakeholder consultations, available at: https://www.ready-initiative.org/child-protection-and-health-sector-collaboration-in-infectious-disease-outbreaks/.